STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARES ADULT HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(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 a follow-up survey on 04/12/24.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#1, #3) sampled including errors with a medication used to treat nerve pain (#1), a long-acting insulin used to lower blood sugar levels (#1), and a controlled substance for moderate to severe pain (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 03/27/24 revealed diagnoses included type 2 diabetes mellitus, chronic obstructive pulmonary disease, chronic back pain, hypertension, coronary artery disease, hyperlipidemia, debility, chronic kidney disease, and depression.	{D 358}		

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{D 358}	Continued From page 1 a. Review of Resident #1's physician's order dated 12/13/23 revealed an order for Tresiba FlexTouch insulin pen, inject 25 units twice a day; do not give insulin if blood sugar is less than (<) 100; call physician if blood sugar is greater than (>) 450. (Tresiba is long-acting insulin used to lower blood sugar levels in diabetics.) Review of Resident #1's physician's order dated 01/21/24 revealed an order to increase Tresiba to 30 units twice a day. Review of Resident #1's current FL-2 dated 03/27/24 revealed an order for Tresiba FlexTouch insulin pen, inject 30 units twice a day; do not give insulin if blood sugar is < 100, or call physician if blood sugar is > 450. Review of Resident #1's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Tresiba FlexTouch inject 30 units under the skin 2 times a day for diabetes; do not give if blood sugar is < 100; if blood sugar > 450, call physician. -Tresiba FlexTouch was scheduled to be administered at 8:00am and 8:00pm. -Tresiba was documented as administered on 3 occasions when the blood sugar was < 100 and should not have been administered from 03/01/24 - 03/31/24. -On 03/03/24 at 8:00am, the blood sugar was 97 but Tresiba FlexTouch was documented as administered. -On 03/04/24 at 8:00am, the blood sugar was 80 but Tresiba FlexTouch was documented as administered. -On 03/21/24 at 8:00am, the blood sugar was 80 but Tresiba FlexTouch was documented as	{D 358}		

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{D 358}	Continued From page 2	{D 358}		

administered.
-The resident's blood sugar ranged from 60 - 308 from 03/01/24 - 03/31/24.

Review of Resident #1's April 2024 eMAR revealed:
-There was an entry for Tresiba FlexTouch inject 30 units under the skin 2 times a day for diabetes; do not give if blood sugar is < 100; if blood sugar > 450, call physician.
-Tresiba FlexTouch was scheduled to be administered at 8:00am and 8:00pm.
-Tresiba was documented as administered on one occasion when the blood sugar was < 100 and should have been held.
-On 04/04/24 at 8:00am, the blood sugar was 98 but Tresiba FlexTouch was documented as administered.
-The resident's blood sugar ranged from 98 - 337 from 04/01/24 - 04/12/24.

Attempted telephone interview on 04/12/24 at 3:22pm with a medication aide (MA) who documented administering the Tresiba when the blood sugar was < 100 in March 2024 was unsuccessful.

Attempted telephone interview on 04/12/24 at 3:24pm with a second MA who documented administering the Tresiba when the blood sugar was < 100 in March 2024 was unsuccessful.

Interview on 04/12/24 at 2:11pm with the MA who documented administering Tresiba to Resident #1 when the blood sugar was < 100 in April 2024 revealed:
-She probably administered Tresiba to Resident #1 on 04/04/24 when the resident's blood sugar was 98 because the resident would sometimes ask for it to be administered.

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{D 358}	Continued From page 3 -If Tresiba was held, she would document it as held on the eMAR. Interview with the Administrator on 04/12/24 at 4:27pm revealed: -The MAs were supposed to read the eMARs and follow the instructions when administering medications. -The MAs should hold Resident #1's Tresiba FlexTouch insulin when the resident's blood sugar was < 100 and document it as held on the eMAR. Telephone interview with Resident #1's primary care provider (PCP) on 04/12/24 at 3:55pm revealed: -The MAs needed to be more careful and should have held Resident #1's Tresiba when his blood sugar was < 100. -Receiving Tresiba when the resident's blood sugar was < 100 could cause the resident's blood sugar to be too low and cause symptoms such as shakiness. Interview with Resident #1 on 04/12/24 at 3:28pm revealed: -He usually received Tresiba FlexTouch insulin twice a day. -He thought the MAs held the Tresiba if his blood sugar was < 100. -His blood sugar was sometimes low. -The lowest blood sugar he had was about 6 weeks ago when it was 43. -He usually got nervous, sweaty, and ill when his blood sugar was low. -He had to drink orange juice when his blood sugar was low. b. Review of Resident #1's physician's order dated 02/23/24 revealed an order for Pregabalin 200mg 1 capsule 3 times a day. (Pregabalin is a	{D 358}		

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{D 358}	Continued From page 4 controlled substance used to treat nerve pain.) Review of Resident #1's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Pregabalin 200mg take 1 capsule 3 times a day for nerve pain scheduled for 8:00am, 2:00pm, and 8:00pm. -Pregabalin was documented as not administered at 8:00pm on 03/15/24 and at 8:00am on 03/16/24 due to "waiting on pharmacy". Review of Resident #1's March 2024 controlled substance record (CSR) for Pregabalin revealed: -There was a CSR for Pregabalin 200mg dispensed on 03/06/24 with 31 of 93 capsules in card 1 of 2. -The first documented dose was administered on 03/05/24 at 8:00pm. -The last dose documented was 03/15/24 at 2:00pm. -There was a CSR for Pregabalin 200mg dispensed on 03/06/24 with 62 of 93 capsules in card 2 of 2. -The first documented dose was administered on 03/16/24 at 2:00pm. -There were no documented doses administered for 8:00pm on 03/15/24 and 8:00am on 03/16/24. Review of Resident #1's pharmacy dispensing records dated 12/01/23 - 04/30/24 revealed: -There were 93 Pregabalin 200mg capsules billed on 03/01/24 (dispensed on 03/06/24). -There were 93 Pregabalin 200mg capsules billed on 04/01/24 (dispensed on 04/06/24). Observation of Resident #1's medications on hand on 04/12/24 at 2:12pm revealed: -There was a supply of Pregabalin 200mg capsules dispensed on 04/06/24.	{D 358}		

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{D 358}	Continued From page 5 -There were 7 of 28 capsules remaining in card 1 of 2. -There were 62 of 62 capsules remaining in card 2 of 2. Attempted telephone interview on 04/12/24 at 3:24pm with the medication aide (MA) who documented the 2 doses of Pregabalin as not administered due to waiting on pharmacy was unsuccessful. Interview with a second MA on 04/12/24 at 2:11pm revealed: -The MAs were responsible for calling a resident's provider for a new prescription for controlled substances when there were 10 pills remaining or when the supply got down to the colored strip on the medication card. -She was not working in March 2024 when Resident #1 ran out of Pregabalin. -She did not know why the resident ran out of Pregabalin. Interview with the Administrator on 04/12/24 at 4:27pm revealed: -Resident #1 had Pregabalin available for administration when the MA documented it as unavailable in March 2024. -She thought the MA may have not realized there was a card 2 of 2 in the controlled substance drawer of the medication cart. -Card 2 of 2 would have been turned backwards in the drawer with the label facing the back of the medication cart until staff started using the card. -The MA must have overlooked the card in the medication cart. Telephone interview with Resident #1's primary care provider (PCP) on 04/12/24 at 3:55pm revealed:	{D 358}		

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{D 358}	Continued From page 6 -Resident #1 took Pregabalin for diabetic nerve pain and generalized pain. -He was not concerned with the missed doses of Pregabalin since it was only 2 doses. Interview with Resident #1 on 04/12/24 at 3:28pm revealed: -He took Pregabalin to help with the nerve pain in his feet. -He was not aware of missing any doses of Pregabalin. 2. Review of Resident #3's current FL-2 dated 03/18/24 revealed diagnoses included degenerative disc disease and chronic midline lower back pain without sciatica. Review of Resident #3's physician's orders dated 03/19/24 and 03/29/24 revealed orders for Tramadol 50mg 1 tablet every 6 hours as needed (prn) for pain. (Tramadol is a controlled substance used to treat moderate to severe pain.) Review of Resident #3's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Tramadol 50mg take 1 tablet every 6 hours as needed for pain. -Tramadol 50mg was documented as administered on 25 occasions from 03/22/24 - 03/31/24. -Tramadol 50mg was documented as administered less than 6 hours apart on 6 occasions from 03/22/24 - 03/31/24, ranging from 4 minutes to 1 hour and 8 minutes too soon. -Tramadol was documented as administered at 1:59pm on 03/23/24 and again at 7:16pm on 03/23/24, 43 minutes too soon. -Tramadol was documented as administered at	{D 358}		

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{D 358}	Continued From page 7 8:27am on 03/26/24 and again at 2:23pm on 03/26/24, 4 minutes too soon. -Tramadol was documented as administered at 2:10pm on 03/27/24 and again at 7:02pm on 03/27/24, 1 hour and 8 minutes too soon. -Tramadol was documented as administered at 1:49pm on 03/30/24 and again at 7:14pm on 03/30/24, 35 minutes too soon. -Tramadol was documented as administered at 8:08am on 03/31/24 and again at 1:44pm on 03/31/24, 24 minutes too soon. -Tramadol was documented as administered at 1:44pm on 03/31/24 and again at 7:18pm on 03/31/24, 26 minutes too soon. Attempted telephone interview on 04/12/24 at 3:24pm with the medication aide (MA) who documented administering the Tramadol too soon on all 6 occasions was unsuccessful. Interview with a second MA on 04/12/24 at 2:32pm revealed she usually administered Resident #3's Tramadol when the resident asked for it but she had to make sure it was administered after 6 hours between doses because it was a prn medication. Interview with the Administrator on 04/12/24 at 1:44pm revealed: -Resident #3's prn Tramadol should not be administered less than every 6 hours apart. -The former Resident Care Coordinator (RCC) was responsible for checking the eMARs for accuracy at least weekly. -The former RCC was supposed to check prn documentation when she checked the eMARs. -She did not know if the former RCC had done any eMAR checks because she had not had a chance to check behind the former RCC. -She would be responsible for checking the	{D 358}		

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{D 358}	Continued From page 8 eMARs now since the RCC position was vacant. Telephone interview with Resident #3's primary care provider (PCP) on 04/12/24 at 3:55pm revealed if doses of Tramadol were administered too close together, it could cause some sedation. Interview with Resident #3 on 04/12/24 at 3:30pm revealed: -He took Tramadol for pain in his back and right ankle. -He was supposed to get Tramadol every 6 hours but he had to ask for it sometimes. -Tramadol "don't really help" with his pain and it did not make him sleepy.	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be	D 367		

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documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#3) including inaccurate documentation for a controlled substance used to treat moderate to severe pain and a laxative used to treat and prevent constipation.

The findings are:

Review of Resident #3's current FL-2 dated 03/18/24 revealed diagnoses included schizoaffective disorder - depressed type, essential hypertension, hypercholesterolemia, degenerative disc disease and chronic midline lower back pain without sciatica.

a. Review of Resident #3's physician's orders dated 03/19/24 and 03/29/24 revealed orders for Tramadol 50mg 1 tablet every 6 hours as needed (prn) for pain. (Tramadol is a controlled substance used to treat moderate to severe pain.)

Review of Resident #3's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Tramadol 50mg take 1 tablet every 6 hours as needed for pain.
-Tramadol 50mg was documented as administered 25 times from 03/22/24 - 03/31/24.
-No Tramadol was documented as administered prior to 6:21pm on 03/22/24.
-There were 2 doses documented as administered within 3 minutes of each other on

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03/22/24 at 6:21pm and 6:24pm by 2 different staff.
-The documentation on the eMAR did not match the controlled substance record (CSR) for March 2024.

Review of Resident #3's March 2024 CSR for Tramadol revealed:
-There was a CSR for a supply of 20 Tramadol 50mg tablets dispensed on 03/18/24 with a received date of 03/20/24.
-There were 20 doses documented as administered from 03/20/24 - 03/29/24, leaving a balance of 0.
-There were 3 doses documented as administered on the CSR that were not documented as administered on the eMAR including 8:00am and 8:00pm on 03/21/24 and 8:00am on 03/22/24.
-There was a second CSR for a supply of 120 tablets of Tramadol 50mg dispensed on 03/29/24.
-There were 6 doses of Tramadol 50mg documented as administered from 03/30/24 - 03/31/24.
-There was a total of 26 doses of Tramadol 50mg documented as administered on CSR from 03/20/24 - 03/31/24.

Attempted telephone interview on 04/12/24 at 3:24pm with the medication aide (MA) who documented administering the Tramadol on the eMAR and CSR in March 2024 was unsuccessful.

Interview with a second MA on 04/12/24 at 2:32pm revealed:
-The MAs were supposed to document on the eMAR and the CSR when a controlled substance was administered.
-She did know why Resident #3's prn Tramadol

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documentation was not accurate on the eMAR.

Interview with the Administrator on 04/12/24 at 1:44pm revealed:
-There were 2 doses of Tramadol documented as administered within 3 minutes of each other on 03/22/24 because a resident had walked by the computer and hit some keys on the keyboard.
-This caused Resident #3's Tramadol to get double documented on the eMAR and she was unable to figure out how to reverse or delete one of the entries on the eMAR.

A second interview with the Administrator on 04/12/24 at 4:32pm revealed:
-The MAs were supposed to document on the eMARs and the CSR sheets each time a controlled substance was administered.
-The documentation for Resident #3's prn Tramadol should be accurate on the eMAR and match the CSR.

Refer to interview with the Administrator on 04/12/24 at 1:44pm.

b. Review of Resident #3's physician's order dated 04/05/24 revealed an order for Lactulose 10gm/15ml take 30ml at bedtime. (Lactulose is a laxative used to treat and prevent constipation.)

Review of Resident #3's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Lactulose 10gm/15ml solution take 30ml every night at bedtime for constipation scheduled for 8:00pm.
-Documentation for the administration of Lactulose started on 04/07/24.
-Lactulose was documented as administered on 04/07/24, 04/09/24, and 04/11/24.

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(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 12 -Documentation for the administration of Lactulose was blank with no reasons for the omissions on 04/05/24, 04/06/24, 04/08/24, and 04/10/24. Observation of Resident #3's medications on hand on 04/12/24 at 2:36pm revealed: -There were 2 bottles of Lactulose 10gm/15ml solution dispensed on 04/06/24. -The instructions were to take 30ml every night at bedtime for constipation. Interview with a medication aide (MA) on 04/12/24 at 3:02pm revealed: -She thought Resident #3 had refused the Lactulose on 04/08/24 and 04/10/24 because it was making him have diarrhea. -She should have documented the medication as refused on the eMAR instead of leaving it blank. Interview with Resident #3 on 04/12/24 at 3:30pm revealed: -He did not recall if he received Lactulose every night. -He denied having any bowel movements today, 04/12/24. Refer to interview with the Administrator on 04/12/24 at 1:44pm. _____ Interview with the Administrator on 04/12/24 at 1:44pm revealed: -The former Resident Care Coordinator (RCC) was responsible for checking the eMARs for accuracy at least weekly. -The former RCC was supposed to check prn documentation when she checked the eMARs. -She did not know if the former RCC had done any eMAR checks because she had not had a chance to check behind the former RCC.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051072	A. BUILDING: _____ B. WING _____	R 04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARES ADULT HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(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 13 -She would be responsible for checking the eMARs now since the RCC position was vacant.	D 367		