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 02/05/2025

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 02/04/25 - 02/05/25.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION. The Type A1 Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure health care coordination and follow-up for 1 of 3 sampled residents (#2) including failing to obtain a chest scan for follow-up after the resident had pneumonia and failing to coordinate a referral for a sleep study to determine if the resident needed treatment for obstructive sleep apnea. The findings are: Review of Resident #2's current FL-2 dated 11/18/24 revealed diagnoses included chronic obstructive pulmonary disease, diabetes mellitus type 2, hypertension, hyperlipidemia, chronic kidney disease, coronary artery disease, depression, chronic back pain, and debility. Review of Resident #2's lung clinic provider visit note dated 11/26/24 revealed: -There was an order to have a follow-up chest	{D 273}	10A NCAC 13F.0902 (b) Health Care (D273) On 02/10/2025 RCC and Administrator did an immediation audit done on chart and physician order to ensure that all order is correctly done as the physician has order. On 02/12/2025 a immediation training was given to all med tech and RCC concerning of Health Care of referrals and following up and documentation by the administrator and LHPS nurse to ensure going forward that all residents healthcare needs are being met and going forward to ensure residents are protected from further risk, the facility has put in place staff will immediately make a phone call and log any documentation of reporting, concern, or overlooked medical needs of the resident to ensure that any referral and follow up are done as physician order. The RCC will continue to conduct daily audits reviews of documentation, and charts, the administrator will conduct a weekly audits to ensure that resident needs are being met.	complete by 03/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Parrish — TITLE: Administrator — (X6) DATE: 03-10-25

Reviewed and Acknowledged WW 3/20/25

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 273}	Continued From page 1 scan without contrast done in 3 months from 09/29/24 to follow-up on pneumonia. -The note on the order indicated the chest scan was to be done after 12/29/24. -There was an order for a sleep study to be requested to follow-up if the resident needed treatment for obstructive sleep apnea (a breathing disorder where the upper airway becomes blocked during sleep, leading to pauses in breathing). Review of Resident #2's provider visits notes dated November 2024 - February 2025 revealed: -There was no documentation of a chest scan being completed in 3 months from having pneumonia on 09/29/24. -There was no documentation of the resident completing a sleep study test. Interview with Resident #2 on 02/05/25 at 1:53pm revealed: -He never had a chest scan after he was in the hospital for pneumonia in September 2024. -He was not sure why one had not been done. -He denied any current symptoms of pneumonia. -He had a sleep study over 8 years ago and was told he had sleep apnea at that time. -He had not had any sleep studies since the one he had 8 years ago. Interviews with the Resident Care Coordinator (RCC) on 02/05/25 at 8:30am and 2:10pm revealed: -He was currently responsible for setting up referrals for the residents. -He did not set up a chest scan or a sleep study for Resident #2 because at the time the referrals were ordered, he was not responsible for referrals and he was not aware of the referrals.	{D 273}		

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(D 273)	Continued From page 2 Interview with the Administrator on 02/05/25 at 2:35pm revealed: -The RCC was responsible for setting up any referrals for the residents and the current RCC was responsible at the time of Resident #2's referrals. -There were no calls by the facility staff made until yesterday, 02/04/25, to follow-up on the referral for the resident's chest scan and sleep study. Attempted telephone interviews with Resident #2's lung clinic provider on 02/05/25 at 9:11am and 11:13am were unsuccessful.	(D 273)		
(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 A1 VIOLATION. The Type A1 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#2) sampled including errors with medications	(D 358)	10A NCAC 13F.1004 (a) Medication Administration (D358) On 02/10/2025 an charts, cart, and physician orders, and mar's audit was done to assure that order matched and are being follow as the physician order. On 02/12/2025 LHPS nurse retrained RCC and Med Tech on administration of medication with the importance of following the physician orders matched the prescribed of preparing and administering medication while ensuring that we continue to follow the policies and procedures of administration medication correctly. To prevent this happening again, the RCC will conduct an audit of reviewing orders, mar's, charts of 3 day a week of medication orders to ensure order are being follow, and med tech will conduct a daily audit to ensure order are being administered as the physician order. The administrator will conduct a weekly audit review monitoring to ensure that order is follow as the physician order.	completed by 02/28/2025

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{D 358}	Continued From page 3 used for anxiety, nerve pain, and nose bleeds. The findings are: Review of Resident #2's current FL-2 dated 11/18/24 revealed diagnoses included chronic obstructive pulmonary disease, diabetes mellitus type 2, hypertension, hyperlipidemia, chronic kidney disease, coronary artery disease, depression, chronic back pain, and debility. a. Review of Resident #2's physician's order sheet dated 11/18/24 revealed an order for Afrin 0.05% Nasal Spray, spray 2 sprays into each nostril every 12 hours as needed (prn) for nose bleeds. (Afrin Nasal Spray is a nasal decongestant that constricts blood vessels and may reduce or stop nose bleeds.) Review of Resident #2's facility progress notes dated 02/04/25 revealed: -The resident came to staff with a "really bad nose bleed" (no time noted). -The staff person called emergency medical services (EMS) to check the resident. -EMS took the resident to the hospital. -At 5:46am, the resident came back to the facility and had a device in his nose to stop the bleeding and was to follow-up with an ear, nose, and throat (ENT) provider within 24 - 72 hours. Review of Resident #2's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Afrin 0.05% Nasal Spray, spray 2 sprays into each nostril every 12 hours as needed for nose bleeds. -There was no documentation of any Afrin Nasal Spray being administered to the resident, including on 02/04/25 when the resident had a	{D 358}		

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{D 358}	Continued From page 4 nose bleed and was sent to the hospital. -Afrin Nasal Spray was not administered as ordered. Observation of Resident #2's medications on hand on 02/05/25 at 9:49am revealed: -There was a bottle of Afrin 0.05% Nasal Spray dispensed on 10/22/24. -The instructions were to spray 2 sprays into each nostril every 12 hours as needed for nose bleeds. -The bottle was sealed and had not been opened. Interview with the medication aide (MA) on 02/05/25 at 10:00am revealed: -Around 3:05am that morning, he heard Resident #2 yelling and saying he was about to "bleed to death". -The resident's nose was bleeding "very bad. -There was blood on the floor and a "big puddle of blood" on the resident's bed. -He pinched the resident's nose and tilted the resident's head forward and the bleeding stopped after about 30 seconds. -He cleaned the blood that was on the resident and let the resident sit for a while. -He was cleaning the resident's room when the resident's nose started bleeding again. -He called EMS and EMS took the resident to the hospital. -He was not aware the resident had a prn order for Afrin Nasal Spray for nose bleeds. -The prn orders did not automatically "pop up" on the eMAR since they were not routine medications. -He would have to manually pull up the resident's prn medications to see the list of prns on the eMAR system. Interview with Resident #2 on 02/04/25 at 3:42pm revealed:	{D 358}		

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{D 358}	Continued From page 5 -Around 2:00am that morning, his nose started bleeding and he went and got the MA. -He was on a blood thinner and his nose had bled several times in the past. -He did not receive any Afrin Nasal Spray at the facility that morning when his nose was bleeding. -EMS came and took him to the hospital. -He received Afrin Nasal Spray at the hospital but it did not stop the bleeding. -The hospital staff had to put a foam device in his nose to stop the bleeding. Review of Resident #2's emergency department (ED) after visit summary (AVS) dated 02/04/25 revealed: -The resident was seen for and diagnosed with a nose bleed. -The hospital ED provider administered Afrin Nasal Spray to the resident at 4:14am. -The hospital ED provider put a foam device into the resident's nostril to help stop the bleeding. -The resident was to follow-up with an ENT provider in 24 - 72 hours. Interview with the Resident Care Coordinator (RCC) on 02/05/25 at 2:10pm revealed: -He did not realize Resident #2 had a prn order for Afrin Nasal Spray for nose bleeds. -He thought the order had been discontinued. Interview with the Administrator on 02/05/25 at 2:35pm revealed: -Resident #2 was receiving a blood thinner and he had a history of nose bleeds. -She was not aware Resident #2 had a prn order for Afrin Nasal Spray for nose bleeds. -The prn Afrin should have been administered on 02/04/25 when he had a nose bleed at the facility. Telephone interview with Resident #2's primary	{D 358}		

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(D 358)	Continued From page 6 care provider (PCP) on 02/05/25 at 1:24pm revealed: -Resident #2 took a blood thinner and was at risk for bleeding. -If Resident #2 had been administered prn Afrin Nasal Spray when his nose was bleeding on 02/04/25, it may have prevented the resident from having to go to the ED. -Prolonged or frequent bleeding could cause a drop in the resident's blood count. b. Review of Resident #2's current FL-2 dated 11/18/24 revealed an order for Lorazepam 1mg 1 tablet 3 times a day. (Lorazepam is a controlled substance used to treat anxiety.) Review of Resident #2's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 1mg 1 tablet 3 times a day at 8:00am, 2:00pm, and 8:00pm for anxiety. -Lorazepam was documented as administered 3 times a day at 8:00am, 2:00pm, and 8:00pm from 01/01/25 - 01/31/25, for a total of 93 doses. Review of Resident #2's January 2025 controlled substance (CS) logs for Lorazepam revealed: -There was no Lorazepam documented as administered or deducted from the CS log count on 01/07/25 at 8:00pm and 01/09/25 at 8:00pm. -There were 91 doses of Lorazepam 1mg tablets documented as administered from 01/01/25 - 01/31/25, instead of 93 doses. -Lorazepam 1mg was not administered as ordered on 01/07/25 at 8:00pm and 01/09/25 at 8:00pm. Review of Resident #2's February 2025 CS logs for Lorazepam revealed there was a total of 93	(D 358)		

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{D 358}	Continued From page 7 Lorazepam 1mg tablets remaining. Observation of Resident #2's medications on hand on 02/05/25 at 9:57am revealed: -There was a supply of Lorazepam 1mg tablets dispensed on 01/06/25 with instructions to take 1 tablet 3 times a day at 8:00am, 2:00pm, and 8:00pm for anxiety. -There were 9 of 93 tablets remaining. -There was a second supply of Lorazepam 1mg tablets dispensed on 02/06/25 with instructions to take 1 tablet 3 times a day at 8:00am, 2:00pm, and 8:00pm for anxiety. -There were 84 of 84 tablets remaining. -There was a total of 93 Lorazepam 1mg tablets on hand for Resident #2. Interview with Resident #2 on 02/05/25 at 1:53pm revealed: -He took Lorazepam for his anxiety. -He was not sure if he had missed any doses. -He was more anxious if he did not receive Lorazepam. Interview with the medication aide (MA) on 02/05/25 at 11:31am revealed: -The MAs were supposed to document the administration of controlled substances on the eMAR and the CS log. -He was working on 01/09/25 and initialed Lorazepam as administered at 8:00pm on the eMAR system. -If he had administered the medication, it would have been documented and declined from the count on the CS log. -He must have documented it as administered in error. -He did not recall why Lorazepam was not administered at 8:00pm on 01/09/25.	{D 358}		

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(D 358)	Continued From page 8 Interview with the Resident Care Coordinator (RCC) on 02/05/25 at 2:10pm revealed: -The MAs were supposed to document the administration of controlled substances on the eMAR and the CS logs. -He checked the CS logs and the eMARs about 3 or 4 days per week. -He had not noticed Resident #2's eMARs and CS logs for January 2025 for Lorazepam did not match. -If a medication was not administered, there should be a reason documented on the eMAR. Interview with the Administrator on 02/05/25 at 2:35pm revealed: -The MAs should document the administration of controlled substances on the eMAR and the CS logs. -The RCC was responsible for checking the eMARs and CS logs daily. -The RCC had not reported any discrepancies. -She checked the eMARs and CS logs weekly. -She had not noticed any discrepancies with Resident #2's Lorazepam. -Resident #2's Lorazepam should have been administered as ordered. Telephone interview with Resident #2's primary care provider (PCP) on 02/05/25 at 1:24pm revealed: -Resident #2 took Lorazepam for anxiety. -Missing doses of the Lorazepam could cause the resident's anxiety to be uncontrolled or unstable. c. Review of Resident #2's current FL-2 dated 11/18/24 revealed an order for Pregabalin 100mg 1 capsule 3 times a day. (Pregabalin is a controlled substance that may be used to treat nerve pain.)	(D 358)		

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{D 356}	Continued From page 9 Review of Resident #2's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Pregabalin 100mg 1 capsule 3 times a day for neuropathy (nerve pain). -Pregabalin was scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Pregabalin was documented as administered 3 times a day at 8:00am, 2:00pm, and 8:00pm from 01/01/25 - 01/31/25, for a total of 93 doses. Review of Resident #2's January 2025 controlled substance (CS) logs for Pregabalin revealed: -There was no Pregabalin documented as administered or deducted from the CS log count on 01/09/25 at 8:00am and 01/09/25 at 8:00pm. -There were 91 doses of Pregabalin 100mg capsules documented as administered from 01/01/25 - 01/31/25, instead of 93 doses. -Pregabalin 100mg was not administered as ordered on 01/09/25 at 8:00am and 01/09/25 at 8:00pm. Review of Resident #2's February 2025 CS logs for Pregabalin revealed there was a total of 65 Pregabalin 100mg capsules remaining. Observation of Resident #2's medications on hand on 02/05/25 at 9:59am revealed: -There was a supply of Pregabalin 100mg capsules dispensed on 01/23/25 with instructions to take 1 capsule 3 times a day for neuropathy (nerve pain). -There were 65 of 90 capsules remaining. Interview with Resident #2 on 02/05/25 at 1:53pm revealed: -He took Pregabalin for nerve pain in his feet. -He was not aware of missing any doses.	{D 356}		

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{D 358}	Continued From page 10 Interview with the medication aide (MA) on 02/05/25 at 11:31am revealed: -The MAs were supposed to document the administration of controlled substances on the eMAR and the CS log. -He was working on 01/09/25 and initialed Pregabalin as administered at 8:00am and 8:00pm on the eMAR system. -If he had administered the medication, it would have been documented and declined from the count on the CS log. -He must have documented it as administered in error. -He did not recall why Pregabalin was not administered on those two occasions in January 2025. Interview with the Resident Care Coordinator (RCC) on 02/05/25 at 2:10pm revealed: -The MAs were supposed to document the administration of controlled substances on the eMAR and the CS logs. -He checked the CS logs and the eMARs about 3 or 4 days per week. -He had not noticed Resident #2's eMARs and CS logs for January 2025 for Pregabalin did not match. -If a medication was not administered, there should be a reason documented on the eMAR. Interview with the Administrator on 02/05/25 at 2:35pm revealed: -The MAs should document the administration of controlled substances on the eMAR and the CS logs. -The RCC was responsible for checking the eMARs and CS logs daily. -The RCC had not reported any discrepancies. -She checked the eMARs and CS logs weekly.	{D 358}		

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{D 358}	Continued From page 11 -She had not noticed any discrepancies with Resident #2's Pregabalin. -Resident #2's Pregabalin should have been administered as ordered. Telephone interview with Resident #2's primary care provider (PCP) on 02/05/25 at 1:24pm revealed: -Resident #2 took Pregabalin for diabetic nerve pain. -Missing doses of the Pregabalin could cause the resident's pain control to be inadequate.	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367	10A NCAC 13F.1004(j) Medication Administration (D367) On 02/10/2025 RCC and Administrator did review of Mar's tech charts and physician order to ensure that order is accuracy with mars. On 02/12/2025 an training was done by the administrator that the LHA's nurse on medication documentation, refreshes on controls policies and procedures on the correct way of medication administration to ensure that medications order is being follow as the physician order. A system list for med tech to complete have been put in place for med tech to follow daily to ensure documentation is done correctly To keep this from happen again the RCC will monitor the MARs and conduct hone daily along with the med tech monitoring daily to ensure that orders and their documentation is being follow and accuracy with the MARs and with the control book. The administrator will monitor and review three time a week to ensure that orders, and documentation are accuracy, and that policy is being follow	Completed by 03/28/2025

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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 367	Continued From page 12	D 367		

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 (#2) including inaccurate documentation for a controlled substances used to treat anxiety and a controlled substance used to treat nerve pain.

The findings are:

Review of Resident #2's current FL-2 dated 11/18/24 revealed:
-Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus type 2, hypertension, hyperlipidemia, chronic kidney disease, coronary artery disease, depression, chronic back pain, and debility.

a. Review of Resident #2's current FL-2 dated 11/18/24 revealed an order for Lorazepam 1mg 1 tablet 3 times a day. (Lorazepam is a controlled substance used to treat anxiety.)

Review of Resident #2's January 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 1mg 1 tablet 3 times a day at 8:00am, 2:00pm, and 8:00pm for anxiety.
-Lorazepam was documented as administered 3 times a day at 8:00am, 2:00pm, and 8:00pm from 01/01/25 - 01/31/25, for a total of 93 doses.

Review of Resident #2's January 2025 controlled substance (CS) logs for Lorazepam revealed:
-There was no Lorazepam documented as

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D 367	Continued From page 13 administered or deducted from the CS log count on 01/07/25 at 8:00pm and 01/09/25 at 8:00pm. -There were 91 doses of Lorazepam 1mg tablets documented as administered from 01/01/25 - 01/31/25, instead of 93 doses. -The documentation on the eMAR did not match the CS log for January 2025. Review of Resident #2's February 2025 CS logs for Lorazepam revealed there was a total of 93 Lorazepam 1mg tablets remaining. Observation of Resident #2's medications on hand on 02/05/25 at 9:57am revealed there was a total of 93 Lorazepam 1mg tablets on hand for Resident #2. Interview with the medication aide (MA) on 02/05/25 at 11:31am revealed: -The MAs were supposed to document the administration of controlled substances on the eMAR and the CS log. -He was working on 01/09/25 and initialed Lorazepam as administered at 8:00pm on the eMAR system. -If he had administered the medication, it would have been documented and deducted from the count on the CS log. -He must have documented it as administered in error. Refer to interview with the Resident Care Coordinator (RCC) on 02/05/25 at 2:10pm. Refer to interview with the Administrator on 02/05/25 at 2:35pm. b. Review of Resident #2's current FL-2 dated 11/18/24 revealed an order for Pregabalin 100mg 1 capsule 3 times a day. (Pregabalin is a	D 367		

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D 367	Continued From page 14 controlled substance that may be used to treat nerve pain.) Review of Resident #2's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Pregabalin 100mg 1 capsule 3 times a day for neuropathy (nerve pain). -Pregabalin was scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Pregabalin was documented as administered 3 times a day at 8:00am, 2:00pm, and 8:00pm from 01/01/25 - 01/31/25, for a total of 93 doses. Review of Resident #2's January 2025 controlled substance (CS) logs for Pregabalin revealed: -There was no Pregabalin documented as administered or deducted from the CS log count on 01/09/25 at 8:00am and 01/09/25 at 8:00pm. -There were 91 doses of Pregabalin 100mg capsules documented as administered from 01/01/25 - 01/31/25, instead of 93 doses. -The documentation on the eMAR did not match the CS log for January 2025. Review of Resident #2's February 2025 CS logs for Pregabalin revealed there was a total of 65 Pregabalin 100mg capsules remaining. Observation of Resident #2's medications on hand on 02/05/25 at 9:59am revealed there were 65 of 90 capsules remaining. Interview with the medication aide (MA) on 02/05/25 at 11:31am revealed: -The MAs were supposed to document the administration of controlled substances on the eMAR and the CS log. -He was working on 01/09/25 and initialed	D 367		

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D 367	Continued From page 15 Pregabalin as administered at 8:00am and 8:00pm on the eMAR system. -If he had administered the medication, it would have been documented and deducted from the count on the CS log. -He must have documented it as administered in error on the eMAR. -He did not recall why Pregabalin was not administered on those two occasions in January 2025. -He should have documented a reason for the missed doses on the eMAR. Refer to Interview with the Resident Care Coordinator (RCC) on 02/05/25 at 2:10pm. Refer to Interview with the Administrator on 02/05/25 at 2:35pm. Interview with the RCC on 02/05/25 at 2:10pm revealed: -The MAs were supposed to document the administration of controlled substances on the eMAR and the CS logs. -He checked the eMARs about 3 or 4 days per week. -He had not noticed Resident #2's eMARs and CS logs for January 2025 did not match. -If a medication was not administered, there should be a reason documented on the eMAR. Interview with the Administrator on 02/05/25 at 2:35pm revealed: -The MAs should document the administration of controlled substances on the eMAR and the CS logs. -The RCC was responsible for checking the eMARs for accuracy daily. -The RCC had not reported any discrepancies. -She checked the eMARs weekly.	D 367		

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D 367	Continued From page 16 -She had not noticed any discrepancies with Resident #2's eMARs.	D 367		
(D 451)	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county department of social services (DSS) of incidents/accidents for 1 of 3 sampled residents (#3) who required emergency medical treatment and hospital evaluation for a fall. The findings are: Review of Resident #3's current FL-2 dated 10/09/24 revealed diagnoses included schizophrenia, essential hypertension, vertigo, and chronic obstructive pulmonary disease. Review of Resident #3's Resident Register revealed he was admitted into the facility on 07/22/02. Review of Resident #3's facility progress note	(D 451)	10A NCAC 13F.1212(a) Reporting of Accidents and Incidents (D451) On 02/12/2025 a refreshed training was giving to all staff on incidents and Accidents report and what needs to be report and when it need to be reported. Going forward the med tech will immediately do the report paperwork and notify the RCC of resident situation and RCC will notify the physician with a phone call or email of any hospitalization, medical treatment or medical evaluation that need immediate attention of the resident and ensure documentation done in the resident chart along with the incident report. The administrator will follow up on the report within 48 hours and fax or email report to DSS and follow up with a phone call with POA/guardian to ensure they are aware of the incidents.	completed by 03/28/2025

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{D 451}	Continued From page 17 dated 01/04/25 at 1:39pm revealed: -The resident was walking down the hallway and fell. -The resident reported his knees and the side of his face hurt. -Emergency Medical Services (EMS) was called and the resident was taken to the hospital emergency room (ER). Review of Resident #3's hospital after visit summary dated 01/04/25 revealed: -The resident was seen for a fall. -A head, neck, and face scan were completed. -A X-ray was done on both knees and right elbow. Review of Resident #3's accident/incident report dated 01/04/25 revealed there was no documentation the county Department of Social Services (DSS) was notified of the fall requiring EMS and/or hospital evaluation and treatment. Interview with the medication aide (MA) on 02/05/25 at 8:15am revealed: -He wrote the progress note for Resident #3's fall on 01/04/25. -He filled out an accident/incident report on 01/04/25 and placed it in the Administrator's office. Interview with the Resident Care Coordinator (RCC) on 2/05/25 at 9:10pm revealed: -The MA or personal care aide (PCA) on duty at the time of an accident was responsible for completing an accident/incident report. -The MA or PCA then gave the report to him or the Administrator. -The Administrator was responsible for notifying the county DSS of accidents/incidents. -He could not find the accident/incident report for Resident #3's fall on 01/04/25.	{D 451}		

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(D 451)	Continued From page 18 Interview with the Administrator on 02/05/25 at 10:35am revealed: -The MA on duty at the time of the incident was responsible for completing the accident/incident report. -She was responsible for sending the accident/incident reports to the county DSS. -She found the accident/accident report on her desk. -She was behind on paperwork and had not sent the accident/accident report out to the county DSS. Telephone interview with the Adult Home Specialist (AHS) at the county DSS on 02/05/25 at 8:45am revealed: -She had not received an incident report for Resident #3's fall from 01/05/25. -She expected the facility to send her all incident reports when residents were sent out of the facility for medical attention.	(D 451)		