STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AMERICARES ADULT HOMES # 1	101 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 an annual survey and complaint investigation on February 18, 2025 through February 21, 2025. The complaint investigation was initiated by the Johnston County Department of Social Services on February 10, 2025.	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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up with the primary care provider for 2 of 5 residents sampled including a resident (#3) with multiple falls resulting in hospital emergency department evaluations, and a resident (#2) with ordered blood pressure parameters. The findings are: 1. Review of Resident #3's current FL-2 dated 05/01/24 revealed diagnoses included hypertension, asthma, type 2 diabetes mellitus, cerebral palsy, osteoarthritis left knee, bipolar disorder, depression, and gastroesophageal reflux disease. Review of hospital after visit summaries for Resident #3 revealed: -On 10/30/24, Resident #3 was seen at the local	D 273		

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hospital emergency department and diagnosed with fall and head injury. The discharge instructions included the resident needed to follow up with the Primary Care Provider (PCP) in one week (around 11/06/24).
-On 11/13/24, Resident #3 was seen at the local hospital emergency department and diagnosed with accidental fall out of bed. The discharge instructions included the resident needed to follow up with the PCP within the next few days to ensure appropriate healing.
-On 11/17/24, Resident #3 was seen at the local hospital emergency department and diagnosed with fall. The discharge instructions included the resident needed to follow up with the PCP and schedule an appointment as soon as possible for a visit.
-On 11/21/24, Resident #3 was seen at the local hospital emergency department and diagnosed with fall. The discharge instructions included the resident needed to follow up with the PCP in two days (around 11/23/24).
-On 11/25/24, Resident #3 was seen at the local hospital emergency department after falling and upon examination the resident was diagnosed with low blood sugar. The discharge instructions included the resident needed to follow up with the PCP, and return to the emergency department if symptoms worsen.
-On 11/27/24, Resident #3 was seen at the local hospital emergency department after falling and was diagnosed with a decreased blood glucose "symptomatic". The discharge instructions included the resident needed to follow up with the PCP for a reassessment in 2-4 days.

Review of Resident #3's progress notes dated 10/15/24 through 12/09/24 revealed:
-On 10/15/24, staff documented the resident returned to the facility from a hospital stay and

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would follow-up with the PCP on 12/02/24.
-On 11/17/24, staff documented the resident returned to the facility from a hospital emergency department visit with a request for an appointment to be scheduled with the PCP. The staff documented the appointment "has already been done" (no appointment date provided).
-On 11/27/24, the Administrator documented the resident was back in the facility and would "follow-up with her provider on 12/02/24".
-On 11/30/24, the Administrator documented that Resident #3 went on a home visit with the responsible person who would be taking the resident to an appointment with the resident's PCP.
-There was no documentation of facility contact with the PCP notifying the PCP of hospital emergency department visits on 10/30/24, 11/13/24, 11/17/24, 11/21/24, 11/25/24, and 11/27/24 or requesting any follow-up appointments after each hospital emergency department visits.

Interview with a medication aide (MA) on 02/21/25 at 11:21am revealed:
-If a physician was contacted there would be documentation of the contact in the resident progress notes.
-The MAs were responsible to call the physician.

Telephone interview with Resident #3's responsible person on 02/19/25 at 4:24pm revealed:
-She transported Resident #3 to her PCP appointments.
-She picked up Resident #3 for a home visit on 11/30/24 and was supposed to take the resident to a visit with the PCP on 12/02/24.
-Resident #3 was transported from her home to the local hospital emergency department on

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D 273	Continued From page 3 12/02/24 after a fall. Telephone interview with the medical assistant for Resident #3's PCP on 02/20/25 at 3:10pm revealed: -The PCP office never got calls from the facility for Resident #3. -Resident #3's responsible person called to request appointments most of the time. -The facility did not contact the PCP's office about the 10/30/24, 11/13/24, 11/17/24, 11/21/24, 11/25/24, or 11/27/24 hospital emergency department visits for a follow-up appointment assessment to the hospital emergency department visits. -Resident #3 was last seen on 06/11/24 at the PCP's office. -The PCP would have wanted to see Resident #3 to assess the low blood sugar episodes and monitor the resident's blood glucose. -There was an expectation that Resident #3 would be seen by the PCP after each hospitalization. -The PCP told the responsible person that he could no longer service Resident #3 at the facility. -The POA moved Resident #3 from the facility and relocated her in a facility nearby. Telephone interview with Resident #3's mental health provider (MHP) on 02/20/25 at 4:41pm revealed: -She increased Resident #3's psychiatric medications on 10/08/24 and 10/30/24 due to outbursts and aggressive behaviors. -She did not have any documentation of notification from the facility about any falls on 11/13/24, 11/17/24, 11/21/24, 11/25/24, or 11/27/24. -She would have wanted to be notified because there could have possibly been some relation to	D 273		

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the increase in medications.
-Resident #3 was prescribed Clonazapam (used to treat anxiety), Prozasin (used to treat behaviors), and Depakote (used to treat behaviors) medications which could cause dizziness and light-headedness and could cause an increased potential for falls.

Interview with the Administrator on 02/21/25 at 5:00pm revealed:
-She expected the facility to contact the PCP for follow up when needed by fax and telephone.
-The Resident Care Coordinator (RCC) was expected to ensure residents PCP was contacted for follow up.

2. Review of Resident #2's current FL-2 dated 02/12/25 revealed:
-Diagnoses included hypertension, asthma, depression, diabetes, unspecified neurological disorder/severe thyrotoxicosis without crisis, and incontinence.
-There was a physician's order to check blood pressure daily in the morning and call physician if systolic blood pressure was greater than 180 or less than 100, and diastolic blood pressure greater than 100 or less than 50.

Review of a previous physician order sheet dated 12/16/24 revealed a physician's order to check blood pressure daily in the morning and call physician if systolic blood pressure was greater than 180 or less than 100, and diastolic blood pressure greater than 100 or less than 50 . (According to the National Institute of Health, low blood pressure, or hypotension, is systolic blood pressure lower than 90 or diastolic blood pressure lower than 60. Normal blood pressure for most adults is defined as a systolic pressure of less than 120 and a diastolic pressure of less

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than 80. High blood pressure is defined as systolic pressure of 130 or higher, or a diastolic pressure of 80 or higher).

Review of Resident #2's December 2024 electronic medication administration records (eMARs) revealed:
-There was a printed entry to check blood pressure daily in the morning and call physician if systolic blood pressure was greater than 180 or less than 100, and diastolic blood pressure greater than 100 or less than 50 and scheduled for 8:00am.
-Resident #2's diastolic blood pressure was documented as 102 on 12/09/24.
-There was no documentation the primary care provider (PCP) was notified of the elevated diastolic blood pressure reading.

Review of Resident #2's January 2025 eMARs revealed:
-There was a printed entry to check blood pressure daily every day in the morning and call physician if systolic blood pressure was greater than 180 or less than 100, and diastolic blood pressure greater than 100 or less than 50 and scheduled for 8:00am.
-Resident #2's diastolic blood pressure was documented as 104 on 01/15/25 and 104 on 01/16/25.
-There was no documentation the PCP was notified of the elevated diastolic blood pressure reading.

Review of Resident #2's progress notes for 12/2025 and 01/2025 revealed there was no documentation that Resident #2's PCP had been notified of the diastolic blood pressure readings greater than 100.

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D 273	Continued From page 6 Interview with the medication aide (MA) on 02/21/25 at 11:21am revealed: -She checked Resident #2's blood pressure every day. -She recorded the blood pressure reading on the vital sign sheet. -She would need to "make sure" about the PCP notification for blood pressure parameters. -She had never called Resident #2's PCP about a blood pressure reading. -If the PCP needed to be contacted, she would notify the Resident Care Coordinator (RCC). -She obtained Resident #2's blood pressure reading on 12/09/24 which was 151/102 according to what she documented on the eMAR. -She did not call the PCP. -The MAs were responsible for calling the PCP to notify them of blood pressure results if ordered. -She was not aware of the blood pressure parameters for Resident #2. -She did not have a reason for why she would not have known to call the PCP for the diastolic blood pressure reading of 102 on 12/09/24. -She did not normally work in that facility and "just probably forgot to call". -The MA who documented the diastolic blood pressure reading of 104 on 01/16/25 was no longer employed. -The MA who documented the diastolic blood pressure reading of 104 on 01/15/25 was not working at the facility until 03/01/25. Interview with the Resident Care Coordinator (RCC) on 02/21/25 at 1:33pm revealed: -He did not recall notifying the PCP for Resident #2 about any blood pressure readings obtained at the facility. -He did not know anything about any blood pressure readings out of the prescribed parameters for which the PCP wanted to be	D 273		

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D 273	Continued From page 7 notified. Interview with the Administrator on 02/21/25 at 5:00pm revealed: -She expected the facility MAs and RCC to contact the PCP for follow up when needed by fax and telephone. -The RCC was expected to ensure PCP follow up was completed. Attempted interview with Resident #2's PCP on 02/21/25 at 3:05pm was unsuccessful. _____ The facility failed to ensure health care referral and follow-up for Resident #3 who had multiple falls resulting in hospital emergency room visits and diagnosed with low blood sugars, and for Resident #2 who had blood pressure parameters for which the primary care provider wanted to be notified. The facility's failure to follow-up with the PCP's was detrimental to the health, safety, and welfare of the residents and constitues a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 134D-34 on 03/07/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 7, 2025.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) Facilities with a licensed capacity of 7 to 12	D 282		

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D 282	Continued From page 8 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents' food was free from contamination as evidence by the cook using her hands to serve food. The findings are: Review of the facility's most recent sanitation inspection report dated 09/06/24 revealed: -There were 4 demerits for food protection. -There was a total of 14 demerits. Observation of the meal delivery on 02/18/25 between 11:50am and 12:00pm revealed: -There were two residents who were served their lunch meal in their room. -The personal care aide (PCA) walked in the hall carrying two uncovered plates of food in gloved hands and entered the room where the two residents resided together. -The PCA served the residents the plated food. -The PCA returned to the kitchen/dining room area and retrieved two glasses of tea and one glass of water. -The PCA returned to the residents' room carrying one uncovered glass in each gloved hand and the	D 282		

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third uncovered glass rested in the bend of her clothed arm.
-The PCA returned to the kitchen/dining room area and retrieved another uncovered glass of water for the second resident in the room.

Observation of the meal delivery in the dining room on 02/18/25 between 12:00pm and 12:25pm revealed:
-The PCA served the residents' seated in the dining room the plated food.
-The PCA wore gloves on both her hands.
-A resident requested a second serving of french-fried potatoes.
-The PCA used her right gloved hand to pick up the french-fried potatoes and placed them on the residents' plate.

Interview with the PCA on 02/18/25 at 4:53pm revealed:
-She did not cover the plate of food delivered to the residents for the lunch meal because she was taking the plates directly to the residents in their room.
-She was trained to cover a resident's plate if the resident was not seated in the dining room.
-She had never served a resident their meal in the residents' room.
-She usually used a serving cart when meals were served to residents.
-She was responsible for ensuring the food was pulled and ready to cook for the next day.
-She knew she was not supposed to pick up the french-fried potatoes with her hands.

Interview with the Administrator on 02/18/25 at 5:00pm revealed:
-She and the Resident Care Coordinator (RCC) were responsible for supervising all the staff.
-She expected the staff to serve food with the

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D 282	Continued From page 10 proper utensils and not their hands. -She expected the staff to use the plate covers when food was served outside the dining room. -She had concerns about proper sanitation issues when a staff touched the food with gloved hands or carried food outside the dining room uncovered.	D 282		
D 431	10A NCAC 13F .1106 (e) Settlement Of Cost Of Care 10A NCAC 13F .1106 Settlement Of Cost Of Care (e) When a resident leaves the facility and the resident or his or her responsible person has notified the facility of the intent of returning to it, the following apply: (1) If the resident or their responsible party reserves their bed for a set number of days, the facility shall have a written agreement for the payment for the days the bed is held in accordance with Rule .0704(a)(1)(A) of this Subchapter. (2) If, after leaving the facility, the resident decides not to return to it, the facility shall require no more than a 14-day written notice that he or she is not returning. (3) If the facility requires a 14-day written notice, the requirement shall be a part of the written agreement and explained by the facility to the resident and his or her family or responsible person before signing. (4) When a resident or someone acting on his or her behalf notifies the facility that he or she will not be returning to the facility, the facility shall refund the remainder of any advance payment to the resident or his or her responsible person. The refund shall include the amount equal to the cost of care for the period covered by the	D 431		

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D 431	Continued From page 11 agreement. The refund shall be made within 14 days after notification that the resident will not be returning to the facility. (5) The facility shall not require payment from a resident that receives State County Special Assistance for more than 30 days unless the resident is actually residing in the facility or it is anticipated that he or she will return to the facility within 30 days. (6) Exceptions to the 14-day notice, if required by the facility, are cases where returning to the facility would jeopardize the health or safety of the resident or others in the facility as certified by the resident's physician or approved by the county department of social services, and in the case of the resident's death. In these cases, the facility shall provide a refund the rest of any advance payment calculated beginning with the day the facility is notified. The facility shall provide the refund to the authorized representative with 14 days after the resident leaves the facility or within 30 days after the resident's death. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a refund was issued for 1 of 1 sampled resident (resident #3) within 14 days of discharge. The findings are: Review of Resident #3's Resident Register dated 05/03/24 revealed: -Resident #3 was admitted to the facility on	D 431		

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05/02/24.
-Resident #3 was discharged from the facility on 12/09/24.
-There was a guardian/power of attorney/payee listed for Resident #3.
-The discharge was not initiated by the facility.
-There was a handwritten note in the Review/Revision section of "monthly payment is $943.00".
-There was a signature on the Resident Register dated 05/03/24 for the resident responsible person.

Review of the Resident Contract for Resident #3 dated 05/03/24 revealed:
-Resident #3 received Medicaid services from another county.
-The amount the resident was responsible for paying monthly was $943.00 from SSI (social security).
-If a discharge was initiated by the resident or responsible person, the administrator may require up to a 14-day written notice from the resident or responsible person.
-The facility would refund the resident the remainder of any advance payment following settlement of the cost of care.
-The refund should be made within 14 days from the date of notice, or if no notice was given within 14 days after the resident left the facility.
-There was a signature dated 05/03/24 for the resident/responsible person.

Review of progress notes for Resident #3 revealed:
-On 11/30/24, the Administrator documented that Resident #3 went home for the weekend with her family member to attend a physician appointment.
-On 12/09/24, the Administrator documented that she received a call from Resident #3's

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responsible person and the resident would be going to a facility closer to the responsible person.

Review of an email dated 01/14/25 from the person responsible for Resident #3 revealed:
-Resident #3 entered the facility on 05/02/24.
-Resident #3's last day at the facility was 11/30/24.
-The total paid to the facility from the person responsible was $7,312.00.
-The facility was entitled to $6,398.00.
-There was a refund amount due of $914.00.

Interview with Resident #3's responsible person on 02/19/25 at 4:24pm revealed:
-She talked to the Administrator and informed her that Resident #3 would not be returning to the facility when the resident was admitted to a local hospital on 12/02/24 while visiting with her.
-She had not received a refund from the facility.
-She spoke to a Medicaid representative last week in the county where Resident #3 received Medicaid services and was told the county had not received a refund from the facility.

Review of a letter dated 02/12/25 from the facility Administrator revealed:
-The letter was addressed to the county where Resident #3 received Medicaid services.
-A check for $955.00 would be mailed on 02/14/25.

Interview with the Administrator on 02/21/25 at 4:58pm revealed:
-She thought the responsible person should receive a refund check within 30 days after the resident was discharged.
-The facility Owner was responsible for writing the refund check to the responsible person.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051070	A. BUILDING: _____ B. WING _____	C 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARES ADULT HOMES # 1	101 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 431	Continued From page 14 -She made the facility Owner aware of the need to send the refund check to the responsible person (no date provided). -She was not aware if the refund check had been mailed yet.	D 431		
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 complete incident/accident reports and notify the county department of social services (DSS) for 1 of 3 residents sampled (#3) who required emergency medical and hospital evaluations for falls. The findings are: Review of Resident #3's current FL-2 dated 05/01/24 revealed diagnoses included hypertension, asthma, type 2 diabetes mellitus, cerebral palsy, osteoarthritis left knee, bipolar disorder, depression, and gastroesophageal reflux disease.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051070	A. BUILDING: _____ B. WING _____	C 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARES ADULT HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 451	Continued From page 15	D 451		

Review of Resident #3's progress notes dated 10/15/24 through 12/09/24 revealed:
-On 10/30/24, the resident was "sent out due to a fall" and returned to the facility the same day.
-On 11/17/24, the resident reported to staff that she fell on the floor "yesterday (11/16/24)" and was confused. Emergency medical service was called, the resident was transported to the hospital for an examination and returned to the facility on 11/17/24.

Review of hospital after visit summaries for Resident #3 revealed:
-On 10/30/24, Resident #3 was seen at the local hospital emergency department and diagnosed with fall and head injury.
-On 11/13/24, Resident #3 was seen at the local hospital emergency department and diagnosed with accidental fall out of bed.
-On 11/17/24, Resident #3 was seen at the local hospital emergency department and diagnosed with fall.

Review of incident/accident reports for Resident #3 provided by the facility from 09/2024 through 12/2024 revealed there were no incident/accident reports for the resident's fall on 10/30/24, 11/13/24, or 11/17/24.

Interview with a medication aide (MA) on 02/21/25 at 1:41pm revealed:
-The MA on duty at the time of an incident was responsible for completing an incident/accident report and giving the report to the Administrator.
-She could not remember completing any incident/accident reports for Resident #3 because she did not work in that facility much.

Telephone interview with the Adult Home Specialist (AHS) at the county DSS on 02/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051070	A. BUILDING: _____ B. WING _____	C 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARES ADULT HOMES # 1	101 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 451	Continued From page 16 at 3:48pm revealed: -She had received some incident/accident reports for Resident #3 but had not received an incident/accident report for Resident #3's falls on 11/13/24 or 11/17/24. -She expected the facility to send her all incident reports when residents were sent out of the facility for medical attention. Interview with the Administrator on 02/21/25 at 4:50pm revealed: -The MAs or personal care aides (PCAs) were responsible for completing an incident/accident report at the time of an incident. -She expected to receive the written incident/accident report within 24 hours of the incident/accident occurrence and within 48 hours of the incident/accident occurrence during the weekend. -She or the Resident Care Coordinator (RCC) were responsible for sending the incident/accident reports to the local county department of social services (DSS). -She did not think an incident/accident report was completed for 10/30/24 because she had not found an incident/accident report in any of her records. -She did not know about incident/accident reports for 11/13/24 or 11/17/24. No incident/accident reports for 10/30/24, 11/13/24, or 11/17/24 were presented for review by the end of the survey.	D 451		