| 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 06/05/2026 |

| 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<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on 06/03/26 - 06/05/26. | D 000 | | |
| D 079 | 10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings<br><br>10A NCAC 13F .0306 Housekeeping and Furnishings<br><br>(a) Adult care homes shall:<br>(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;<br>Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure 3 of 3 bathrooms used by residents were clean and free of hazards.<br><br>The findings are:<br><br>Observation of the shared bathroom between resident rooms 1 and 2 on 06/03/26 at 9:20am revealed:<br>-There was a large brownish black stain on the floor tiles in front of the toilet.<br>-There was no shower curtain for the shower stall.<br><br>Observation of the shared bathroom between resident rooms 5 and 6 on 06/03/26 at 10:08am revealed:<br>-The blue shower curtain was ripped and torn with a hole in the upper right corner.<br>-There was dirt on the shower floor and a buildup | D 079 | | |

| 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 06/05/2026 |

| 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 079 | Continued From page 1 | D 079 | | |

of a pink and light brown film on the floor of the shower stall.
-There was buildup of a black substance around the metal grab bars, on the underside of the attached folding shower bench, and on the shower wall where the shower bench was attached.
-There was a buildup of a black substance on the floor tiles in front of the shower stall on the right side with multiple cracks in the floor tiles.
-There was a crumpled piece of rusted metal sticking out near the bottom of the wall on the left side of the shower stall and missing paint and baseboard.
-There were brownish stains and peeling paint on the wall near the grab bar beside the toilet.

Interview with a resident residing in resident room 6 on 06/03/26 at 10:08am revealed:
-The resident's shower was not clean enough and needed cleaning.
-He was not sure how often the bathroom was cleaned but he did not feel like it was cleaned enough.
-The rusted piece of metal sticking out of the wall near the floor had been that way since he had been at the facility (about 9 months).

Observation of the bathroom in resident room 7 on 06/03/26 at 10:18am revealed:
-The metal drain cover in the middle of the shower floor was missing and had a buildup of green and white stains on metal around the open drain hole.
-There were dark brown stains on the floor tiles in front of the toilet.

Interview with the Administrator on 06/03/26 at 4:01pm revealed:
-The facility did not have housekeeping staff.

| 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 06/05/2026 |

| 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 079 | Continued From page 2 | D 079 | | |

-The personal care aides (PCAs) were at the facility 24 hours a day, 7 days a week and they cleaned up everyday.
-The PCAs usually deep cleaned once a week.
-She usually observed every room in the facility about once a month for cleanliness.
-She was not aware the residents' bathrooms were not clean.
-There was a work order on 06/01/26 with a contractor to get the rusted metal in the shared bathroom between resident rooms 5 and 6 repaired.
-The stained floor tiles in the bathroom would probably have to be replaced because she did not think the stains could be removed by cleaning the tiles.
-She would have to call a contracted maintenance company about the missing shower drain cover.

Second observation of the shared bathroom between resident rooms 1 and 2 on 06/04/26 at 1:49pm revealed there was still a stain on the floor tiles in front of the toilet and no shower curtain for the shower stall.

Interview with a resident residing in resident room 1 on 06/04/26 at 1:49pm revealed:
-His roommate cleaned the shower stall yesterday, 06/03/26.
-There was still no shower curtain in their bathroom.
-The floor in front of the toilet was still stained.

Second observation of the shared bathroom between resident rooms 5 and 6 on 06/04/26 at 12:37pm revealed:
-The blue shower curtain was ripped and torn with a hole in the upper right corner.
-There was a small amount of buildup of a pink

| 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 06/05/2026 |

| 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 079 | Continued From page 3 | D 079 | | |

and light brown film on the floor of the shower stall.
-There was buildup of a black substance around the metal grab bars, on the underside of the attached folding shower bench, and on the shower wall where the shower bench was attached.
-There was a buildup of a black substance on the floor tiles in front of the shower stall on the right side with multiple cracks in the floor tiles.
-There was a crumpled piece of rusted metal sticking out near the bottom of the wall on the left side of the shower stall and missing paint and baseboard.
-There were brownish stains and peeling paint on the wall near the grab bar beside the toilet.

Interview with a resident residing in resident room 5 on 06/04/26 at 1:41pm revealed:
-The shower curtain in his bathroom had been torn "a while".
-He wanted the shower and shower bench to be cleaner.
-He sometimes tried to clean it himself.
-The PCA cleaned the shower that morning, 06/04/26.

Second observation of the bathroom in resident room 7 on 06/04/26 at 12:46pm revealed:
-The metal drain cover in the middle of the shower floor was missing and had a buildup of green and white stains on metal around the open drain hole.
-There were dark brown stains on the floor tiles in front of the toilet.

Interview with a PCA on 06/04/26 at 12:42pm revealed:
-There were no housekeepers for the facility.
-The PCAs were supposed to clean the

| 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 06/05/2026 |

| 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 079 | Continued From page 4<br>bathrooms in the facility once a week but she usually cleaned them about every other day because the residents got urine on the floor in the bathrooms.<br>-She also tried to clean the showers every other day.<br>-She usually cleaned the attached shower benches when she cleaned the shower stalls.<br>-The PCAs had other duties to do besides cleaning and keeping the facility clean depended on whether other PCAs cleaned like they were supposed to clean when they were on duty.<br><br>Second interview with the Administrator on 06/05/26 at 11:25am revealed:<br>-She, the Resident Care Coordinator (RCC), and the medication aides (MAs) were responsible for random checks to ensure the PCAs were cleaning the facility.<br>-She usually checked to make sure the laundry was done but she did not usually check bathrooms every day. | D 079 | | |
| D 125 | 10A NCAC 13F .0403(a) Qualifications Of Medication Staff<br><br>10A NCAC 13F .0403 Qualifications Of Medication Staff<br>(a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021.<br><br>This Rule is not met as evidenced by: | D 125 | | |

| 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 06/05/2026 |

| 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 125 | Continued From page 5<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled staff (A, B) who administered medications had completed medication administration clinical skills validation checklist and the state approved 5-hour, 10-hour and/or 15-hour medication aide training courses as required.<br><br>The findings are:<br><br>1. Review of Staff A's personnel record revealed:<br>-Staff A was hired as a medication aide (MA) / personal care aide (PCA) on 05/01/26.<br>-Staff A passed the state written MA examination on 11/02/24.<br>-There was no documentation that Staff A completed the medication administration clinical skills validation checklist.<br>-There was no documentation of Staff A completing the state approved 5-hour, 10-hour, and/or 15-hour MA training courses.<br><br>Observation on 06/03/26 at 9:00am revealed Staff A was in the dining room administering medications to the residents.<br><br>Review of May 2026 electronic medication administration records (eMARs) revealed there was documentation Staff A administered medications on 05/05/26 - 05/12/26 and 05/15/26 - 05/31/26.<br><br>Review of June eMARs revealed there was documentation Staff A administered medications on 06/01/26 - 06/03/26.<br><br>Interview with Staff A on 06/04/26 at 6:00pm | D 125 | | |

| 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 06/05/2026 |

| 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 125 | Continued From page 6<br>revealed:<br>-She started working at the facility on 05/01/26.<br>-She had administered medications in May 2026 and June 2026 to residents.<br>-She had completed the state approved 5-hour and 10-hour training at a previous facility but did not have a copy of the signed certificates.<br>-She had been checked off by a nurse at the facility, and she thought that documentation was in her personnel file.<br>-She was not sure which checklist the nurse completed.<br><br>Interview with the Administrator on 06/04/26 at 6:30pm revealed:<br>-She was not familiar with the medication administration clinical skills validation checklist.<br>-She thought the Licensed Health Professional Support (LHPS) validation check-off was the checklist needed for medication administration.<br>-Staff A had not completed the state approved 5-hour, 10-hour, and/or 15-hour MA training courses because she thought they had 6 months to complete that training.<br>-Staff A was the only MA currently administering medications because prior MAs were no longer employed with the facility.<br>-She and the Resident Care Coordinator (RCC) were back-up to help with administering medications when needed.<br>-There were no current staff at the facility who had completed all requirements to administer medications to the residents.<br>-She would contact a registered nurse (RN) to complete the required training.<br><br>Review of physician's orders, eMARs, and controlled substance records revealed:<br>-Staff A made medications errors related to a delay in starting and administering a complete | D 125 | | |

| 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 06/05/2026 |

| 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 125 | Continued From page 7 | D 125 | | |

course of an antibiotic to a resident.
-Staff A failed to reorder a controlled substance for insomnia for a resident resulting in the resident missing a dose of the medication.

[Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration.]

Refer to telephone interview with the facility's contracted RN on 06/05/26 at 9:20am.

2. Review of Staff B's personnel record revealed:
-Staff B was hired on 03/16/26.
-There was no job description in Staff B's personnel file.
-Staff B passed the state written medication aide (MA) examination on 04/24/14.
-There was no documentation that Staff B completed the medication administration clinical skills validation checklist.
-There was no documentation of Staff B completing the state approved 5-hour, 10-hour, and/or 15-hour MA training courses.

Review of April 2026 electronic medication administration records (eMARs) revealed there was documentation Staff B administered medications on 04/28/26 - 04/30/26.

Review of May 2026 eMARs revealed there was documentation Staff B administered medications on 05/01/26.

Interview with Staff B on 06/04/26 at 2:43pm revealed:
-She started working at the facility on 03/16/26 as the Resident Care Coordinator (RCC).
-She supervised the MAs, processed medication orders, approved orders on the eMARs, and filled in to administer medications if needed.

| 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 06/05/2026 |

| 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 125 | Continued From page 8<br><br>Interview with the Administrator on 06/04/26 at 6:30pm revealed:<br>-She was not familiar with the medication administration clinical skills validation checklist.<br>-She thought the Licensed Health Professional Support (LHPS) validation check-off was the checklist needed for medication administration.<br>-Staff B had not completed the state approved 5-hour, 10-hour, and/or 15-hour MA training courses because she thought they had 6 months to complete that training.<br>-Staff B was the RCC and administered medications only as a back-up if needed.<br>-There were no current staff at the facility who had completed all requirements to administer medications to the residents.<br>-She would contact a registered nurse (RN) to complete the required training.<br><br>Refer to telephone interview with the facility's contracted RN on 06/05/26 at 9:20am.<br><br>_____<br>Telephone interview with the facility's contracted Registered Nurse (RN) on 06/05/26 at 9:20am revealed no one from the facility had contacted her to do the medication aide (MA) training prior to yesterday, 06/04/26.<br><br>_____<br>The facility failed to ensure Staff A and Staff B had completed the medication administration clinical skills validation checklist or completed at least the 5-hour state approved medication aide (MA) training course prior to administering medications to residents resulting in medication errors including errors with a resident's antibiotic for infection and another resident's controlled substance for insomnia. Staff A administered medications in May 2026 and June 2026 and Staff B administered medications in April 2026 | D 125 | | |

| 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 06/05/2026 |

| 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 125 | Continued From page 9<br>and May 2026 without meeting the qualifications to administer medications. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/04/26 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 20, 2026. | D 125 | | |
| D 137 | 10A NCAC 13F .0407(a)(5) Other Staff Qualifications<br><br>10A NCAC 13F .0407 Other Staff Qualifications<br>(a) Each staff person at an adult care home shall:<br>(5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure 1 of 3 sampled staff (C) had documentation of no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire.<br><br>The findings are:<br><br>Observations of Staff C from 06/03/26 - 06/05/26 at various times revealed:<br>-Staff C cooked and served meals and snacks to the residents.<br>-Staff C assisted residents with care and cleaned. | D 137 | | |

| 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 06/05/2026 |

| 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 137 | Continued From page 10<br><br>Interviews with Staff C on 06/03/26 at 8:58am and 9:13am revealed:<br>-She was working as a personal care aide (PCA) at the facility and provided care to residents.<br>-She was live-in staff and she either worked every 2 weeks with one week off or every 3 weeks with one week off.<br>-She was also responsible for cooking, serving meals, and cleaning.<br><br>Interviews with the Administrator on 06/04/26 at 6:10pm and 06/05/26 at 11:25am revealed:<br>-She was unable to locate Staff C's personnel record.<br>-She remembered seeing Staff C's personnel record in her office in January 2026, February 2026, and April 2026 when she was auditing personnel files.<br>-Staff C's personnel record should have been filed with the other staff personnel records.<br>-Staff C was hired as a PCA.<br>-Staff C provided care for the residents, cooked, cleaned, and did laundry.<br>-She was responsible for ensuring health care personnel registry (HCPR) checks were completed for all staff upon hire.<br>-A HCPR check was completed for Staff C upon hire but she was unable to locate it.<br><br>Interview with the Facility Owner on 06/05/26 at 12:45pm revealed:<br>-Staff C had been working at the facility since February 2024.<br>-Staff C had a personnel file and it should be in the facility.<br>-The Administrator was responsible for making sure HCPR checks were completed for staff upon hire. | D 137 | | |

| 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 06/05/2026 |

| 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 273 | Continued From page 11 | D 273 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on interviews and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 3 sampled residents (#1, #2) related to an ophthalmology appointment for eye injections and a cardiology referral after an emergency room (ER) visit for a fainting episode (#1) and high blood pressure readings outside the ordered parameters (#2).<br><br>The findings are:<br><br>1. Review of Resident #1's current FL-2 dated 10/13/25 revealed diagnoses included diabetes mellitus type 2, bilateral cataracts, hypertension, coronary artery disease, hyperlipidemia, gastroesophageal reflux disease, peripheral edema, and memory loss.<br><br>Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 09/16/25.<br><br>a. Review of Resident #1's ophthalmology provider visit note dated 03/03/26 revealed:<br>-The resident had proliferative diabetic retinopathy in both eyes. (Proliferative diabetic retinopathy is an advanced stage of diabetic eye disease where abnormal new blood vessels grow on the retina, increasing the risk of severe vision loss and blindness.) | D 273 | | |

| 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 06/05/2026 |

| 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 273 | Continued From page 12 | D 273 | | |

-The resident had diabetic macular edema in both eyes. (Diabetic macular edema is swelling in the central retina caused by fluid leakage from damaged blood vessels in people with diabetes, leading to vision impairment.)
-The resident had severe neovascular glaucoma in both eyes. (Neovascular glaucoma is a severe, aggressive form of secondary glaucoma caused by abnormal blood vessel growth in the eye, leading to elevated intraocular pressure and potential vision loss.)
-The reason for the resident's visit was to get a Vabysmo injection in both eyes. (Vabysmo is an eye injection used to treat diabetic macular edema by reducing abnormal blood vessel growth and swelling.)
-The resident had "a long history of being lost to follow up intermittently".
-The resident's last Vabysmo eye injections were 4 months ago in November 2025 with significant improvement in intraretinal fluid (accumulation of fluid within the layers of the retina).
-The resident's Vabysmo injections should be every 2 months.
-The resident was to follow-up in 2 months for Vabysmo injection in both eyes.

Review of Resident #1's provider visit notes revealed there was no documentation that Resident #1 had been seen by the ophthalmology provider to receive Vabysmo eye injections since 03/03/26.

Telephone interview with front desk staff at Resident #1's ophthalmology provider's office on 06/04/26 at 12:50pm revealed:
-Resident #1 had an appointment at their office on 05/07/26 but the resident was "a no show".
-The resident did not show up for the appointment, and no one called their office to let

| 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 06/05/2026 |

| 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 273 | Continued From page 13 | D 273 | | |

them know he was not coming or to reschedule the appointment.

Review of Resident #1's facility progress notes revealed:
-There was no documentation that Resident #1 refused or was unavailable to go to his ophthalmology appointment on 05/07/26.
-There was no documentation that the ophthalmology appointment was cancelled or rescheduled.

Interview with Resident #1 on 06/04/26 at 12:30pm revealed:
-He received injections in his eyes at an eye clinic, but he was not sure how often.
-He had cataracts removed from his eyes and a shunt placed in his right eye in the past.
-His eye pressure was checked when he went to the eye clinic because he had glaucoma.
-He did not know if he had missed any appointments at the eye clinic and he did not recall refusing to go to any appointments.
-The vision in his right eye was very blurry and the vision in his left eye was not as blurry as his right eye.
-His vision had been the same for "a while" (could not specify a timeframe).

Interview with the Resident Care Coordinator (RCC) on 06/04/26 at 2:43pm revealed:
-She started working as the RCC on 03/16/26.
-She was not aware Resident #1 had an appointment with the ophthalmologist for eye injections on 05/07/26.
-The Administrator may have rescheduled it.

Interview with the Administrator on 06/04/26 at 3:58pm revealed:
-She had been the Administrator at the facility

| 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 06/05/2026 |

| 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 273 | Continued From page 14<br>since 01/16/26.<br>-Resident #1's family member had contacted her after she started working at the facility (date/time not specified).<br>-The family member was upset because the resident did not go to his eye appointment when the previous Administrator was at the facility.<br>-She made Resident #1 an appointment to see the ophthalmologist on 03/03/26.<br>-Resident #1 went to the ophthalmologist appointment on 03/03/26 and received eye injections.<br>-She was not sure why Resident #1 missed the appointment on 05/07/26.<br>-If a resident refused to go to an appointment, it should be documented in the progress notes and rescheduled.<br>-The RCC was responsible for rescheduling appointments.<br><br>Telephone interview with a triage staff person at Resident #1's ophthalmology provider's office on 06/05/26 at 2:48pm revealed:<br>-Resident #1 missed an appointment on 05/07/26 for eye injections at their office.<br>-She spoke with Resident #1's ophthalmology provider regarding the resident missing the Vabysmo eye injections on 05/07/26.<br>-The ophthalmology provider reported to her that missing Vabysmo eye injections put the resident at increased risk of worsening his eye conditions and decreasing his vision.<br>-The resident's blood vessels could leak and cause his eyes to bleed.<br>-If the resident received his eye injections consistently, his vision would stay more stable.<br><br>Attempted telephone interview with Resident #1's family member on 06/05/26 at 10:09am was unsuccessful. | D 273 | | |

| 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 06/05/2026 |

| 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 273 | Continued From page 15<br><br>b. Review of Resident #1's facility progress note dated 02/27/26 at 3:30pm revealed:<br>-Resident #1's family member called the facility with a concern that the resident needed a follow-up cardiology appointment.<br>-The facility made a cardiology appointment for Resident #1 for 03/31/26 at 9:30am.<br><br>Review of Resident #1's facility progress note dated 03/03/26 at 3:00pm revealed:<br>-Resident #1 fainted while at his eye appointment for eye injections.<br>-Emergency medical services (EMS) were called, and the resident was taken to the emergency room (ER) for evaluation and treatment.<br><br>Review of Resident #1's ER after visit summary (AVS) dated 03/03/26 revealed:<br>-Resident #1 was seen for dizziness and syncope (fainting or passing out).<br>-The resident presented to the ER after having a syncopal episode or "falling out".<br>-This occurred after the resident had been sitting, got up quickly, and felt lightheaded and sweaty.<br>-This was consistent with "vasovagal syncope" (a reflex fainting caused by a sudden drop in blood pressure and heart rate).<br>-The resident was diagnosed with fainting.<br>-There was a referral for the resident to follow-up with cardiology.<br>-There was documentation the resident had a cardiology appointment on 03/31/26 at 9:30am.<br><br>Review of Resident #1's provider visit notes revealed no documentation of the resident seeing a cardiologist on 03/31/26 or after.<br><br>Review of Resident #1's facility progress notes revealed: | D 273 | | |

| 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 06/05/2026 |

| 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 273 | Continued From page 16<br>-There was no documentation that Resident #1 refused or was unavailable to go to his cardiology appointment on 03/31/26.<br>-There was no documentation that the appointment was cancelled or rescheduled.<br><br>Interview with Resident #1 on 06/04/26 at 12:30pm revealed:<br>-The last time he saw a cardiologist was about 1 ½ years ago.<br>-He had not refused or missed any appointments to his knowledge.<br>-He thought he passed out on 03/03/26 because he was at the eye clinic to get injections in his eyes and he was terrified of needles.<br><br>Telephone interview with a representative at Resident #1's cardiology provider's office on 06/04/26 at 1:01pm revealed:<br>-Resident #1 was a new patient and had never been seen at their office.<br>-Resident #1 had an appointment on 03/31/26 but he was "a no show", meaning he did not come for the appointment, and no one contacted their office to let them know he was not coming.<br>-No one had contacted their office to reschedule the appointment.<br><br>Interview with the Resident Care Coordinator (RCC) on 06/04/26 at 2:43pm revealed:<br>-She started working as the RCC on 03/16/26.<br>-She was not sure why Resident #1 missed his cardiology appointment on 03/31/26.<br>-She was responsible for rescheduling any missed appointments, but she did not know if Resident #1's cardiology appointment had been rescheduled.<br><br>Interview with the Administrator on 06/04/26 at 3:58pm revealed: | D 273 | | |

| 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 06/05/2026 |

| 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 273 | Continued From page 17 | D 273 | | |

-She had been the Administrator at the facility since 01/16/26.
-She was not sure why Resident #1 did not go to his cardiology appointment on 03/31/26.
-If a resident refused to go to an appointment, it should be documented in the progress notes.
-The RCC was responsible for rescheduling any missed appointments.

Telephone interview with a triage provider at the facility's contracted primary care provider (PCP) office on 06/04/26 at 4:43pm revealed:
-Resident #2's PCP was on leave until next week.
-He was a triage provider for the group and had access to the resident's record.
-The cardiology referral from the ER visit on 03/03/26 needed to be done for an evaluation of the resident's symptoms.

Attempted telephone interview with Resident #1's family member on 06/05/26 at 10:09am was unsuccessful.

2. Review of Resident #2's current FL-2 dated 07/30/25 revealed:
-Diagnoses included insomnia, anxiety, major depressive disorder, type 2 diabetes mellitus, diabetic polyneuropathy, chronic kidney disease, gastroesophageal reflux disease, mixed hyperlipidemia, Vitamin B12 deficiency, and Vitamin D deficiency.
-There was an order to check the resident's blood pressure (BP) once a month, call primary care provider (PCP) for systolic blood pressure (SBP) greater than (>) 180 or diastolic blood pressure (DBP) > 90.

Review of Resident #2's physician's orders dated 03/31/26 revealed an order to check the resident's BP once a month, call PCP for SBP >

| 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 06/05/2026 |

| 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 273 | Continued From page 18<br>180 or DBP > 90.<br><br>Review of Resident #2's May 2026 electronic medication administration record (eMAR) revealed:<br>-There was an entry to check BP once a month for monitoring, call PCP for SBP > 180 or DBP >90.<br>-The resident's BP was scheduled to be checked at 8:00am and it was checked daily instead of monthly.<br>-The resident's BP was documented as 151/108 on 05/07/26 and 147/102 on 05/30/26.<br>-There was no documentation the resident's PCP was notified of the DBPs > 90 on 05/07/26 and 05/30/26.<br>-The resident's BP ranged from 92/62 - 151/108 from 05/01/26 - 05/31/26.<br><br>Review of Resident #2's facility progress notes for May 2026 revealed no documentation the PCP was notified of the resident's DBP > 90 on 05/07/26 or 05/30/26.<br><br>Interview with Resident #2 on 06/04/26 at 1:41pm revealed:<br>-His BP was checked every day at the facility.<br>-His BP had been running "good".<br>-He denied any symptoms of high or low BP.<br><br>Interview with the medication aide (MA) on 06/04/26 at 10:15am revealed:<br>-She usually checked Resident #2's BP every day because it "popped up" on the eMAR to check it.<br>-She was aware of BP parameters to contact Resident #2's PCP, but his BP had not been outside of the parameters so she had not called the PCP.<br>-If the PCP had to be contacted, she would document in on the eMAR in the exception | D 273 | | |

| 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 06/05/2026 |

| 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 273 | Continued From page 19 | D 273 | | |

section.
-For Resident #2's BPs on 05/07/26 and 05/30/26, she did not contact the PCP because she thought both the SBP and DBP had to be high.
-She did not notice the order and instructions indicated to contact the PCP if the SBP "or" DBP were out of the parameters.
-She should have contacted the PCP on 05/07/26 and 05/30/26 for the high DBPs.

Interview with the Resident Care Coordinator (RCC) on 06/04/26 at 2:43pm revealed:
-She was not aware of any discrepancies with Resident #2's BP order.
-The MAs should contact Resident #2's PCP if his BPs were out of the parameters ordered.
-She usually checked the eMARs during monthly chart audits, but she had not checked the eMARs for May 2026 yet.

Interview with the Administrator on 06/04/26 at 3:58pm revealed:
-The MAs should follow orders with parameters and contact the PCP if outside of the parameters.
-The MAs should document in the eMAR system when the PCP was contacted.

Telephone interview with a triage PCP at the facility's contracted PCP office on 06/04/26 at 4:43pm revealed:
-Resident #2's PCP was on leave until next week.
-He was a triage provider for the group and had access to the resident's record.
-He would expect the facility staff to follow Resident #2's order to contact the PCP when the BP was out of the ordered parameters.
-If their office had been contacted, the PCP on call would have probably ordered an additional dose of medication for high blood pressure.

| 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 06/05/2026 |

| 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 273 | Continued From page 20<br>-A high DBP could cause stress on the heart over a period of time.<br>_____<br>The facility failed to coordinate health care needs for 2 of 3 sampled residents (#1, #2). Resident #1 missed an ophthalmology appointment on 05/07/26 to receive eye injections for both eyes to treat an eye condition caused by diabetes that put the resident at increased risk of worsened eye conditions, decreased vision, and could have caused his eyes to bleed. Resident #1 missed a cardiology appointment on 03/31/26 to evaluate and treat the resident's symptoms after an emergency room (ER) visit for fainting on 03/03/26. Resident #2's primary care provider (PCP) was not notified on two occasions when the residents diastolic blood pressure (DBP) was greater than (>) 90 as ordered and having high DBP could cause stress on the resident's heart. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/04/26 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 20, 2026. | D 273 | | |
| D 358 | 10A NCAC 13F .1004 (a) Medication Administration<br><br>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: | D 358 | | |

| 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 06/05/2026 |

| 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 358 | Continued From page 21<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#1, #2) sampled including errors with two eye drops for glaucoma and an antibiotic for infection (#1) and a controlled substance used to treat insomnia (#2).<br><br>The findings are:<br><br>1. Review of Resident #1's current FL-2 dated 10/13/25 revealed diagnoses included diabetes mellitus type 2, bilateral cataracts, hypertension, coronary artery disease, hyperlipidemia, gastroesophageal reflux disease, peripheral edema, and memory loss.<br><br>Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 09/16/25.<br><br>a. Review of Resident #1's physician's orders dated 01/09/26 revealed:<br>-There was an order for Dorzolamide-Timolol 22.3-6.8mg/ml eye drops instill 1 drop into both eyes two times a day for glaucoma. (Dorzolamide-Timolol is a combination eye drop used to lower elevated intraocular pressure in patients with glaucoma or ocular hypertension.)<br>-There was an order for Latanoprost 0.005% eye drops, instill 1 drop in both eyes at bedtime for glaucoma. (Latanoprost is an eye drop used to | D 358 | | |

| 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 06/05/2026 |

| 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 358 | Continued From page 22 | D 358 | | |

treat glaucoma and high eye pressure.)
-Documentation for Dorzolamide-Timolol eye drops and Latanoprost eye drops on the physician's order sheet noted the original date of the prescription for both eye drops was 11/06/25.

Review of Resident #1's ophthalmology provider visit note dated 03/03/26 revealed:
-The resident had proliferative diabetic retinopathy in both eyes. (Proliferative diabetic retinopathy is an advanced stage of diabetic eye disease where abnormal new blood vessels grow on the retina, increasing the risk of severe vision loss and blindness.)
-The resident had diabetic macular edema in both eyes. (Diabetic macular edema is swelling in the central retina caused by fluid leakage from damaged blood vessels in people with diabetes, leading to vision impairment.)
-The resident had severe neovascular glaucoma in both eyes. (Neovascular glaucoma is a severe, aggressive form of secondary glaucoma caused by abnormal blood vessel growth in the eye, leading to elevated intraocular pressure and potential vision loss.)
-The reason for the resident's visit was to get an injection in both eyes for diabetic macular edema.
-The resident resided in an assisted living facility.
-It was unclear if the facility was administering the resident's eye drops for glaucoma.
-There was an order for Latanoprost 0.005% instill 1 drop in both eyes every evening.
-There was an order for Dorzolamide-Timolol 1 drop in both eyes twice a day.
-The resident was to follow-up in 2 months.

Review of Resident #1's physician's orders and provider visit notes revealed no documentation of any discontinued orders for Dorzolamide-Timolol eye drops or Latanoprost eye drops.

| 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 06/05/2026 |

| 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 358 | Continued From page 23<br><br>Review of Resident #1's January 2026 eMAR revealed:<br>-There was an entry for Dorzolamide-Timolol 22.3-6.8mg/ml instill 1 drop into both eyes 2 times a day for glaucoma scheduled at 7:00am and 9:00pm.<br>-Dorzolamide-Timolol eye drops were documented as administered from 7:00am on 01/01/26 through 7:00am on 01/16/26.<br>-Dorzolamide-Timolol eye drops were documented as not administered from 9:00pm on 01/16/26 through 7:00am on 01/19/26 due to "waiting on pharmacy to deliver".<br>-Dorzolamide-Timolol was noted to be discontinued on 01/19/26 at 7:00pm.<br>-There was an entry for Latanoprost 0.005% eye drops instill 1 drop into both eyes at bedtime for glaucoma scheduled at 8:00pm.<br>-Latanoprost was documented as administered from 01/01/26 - 01/18/26.<br>-Latanoprost was noted to be discontinued on 01/19/26 at 7:00pm.<br><br>Review of Resident #1's February 2026 - June 2026 eMARs revealed:<br>-There were no entries for Dorzolamide-Timolol eye drops and none was documented as administered from February 2026 - June 2026.<br>-There were no entries for Latanoprost eye drops and none was documented as administered from February 2026 - June 2026.<br><br>Observation of Resident #1's medications on hand on 06/04/26 at 9:42am revealed:<br>-There were no Dorzolamide-Timolol eye drops available for administration.<br>-There were no Latanoprost eye drops available for administration. | D 358 | | |

| 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 06/05/2026 |

| 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 358 | Continued From page 24<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/04/26 at 11:23am revealed:<br>-The pharmacy received an order for Resident #1's Dorzolamide-Timolol eye drops on 11/06/26 and one 10ml bottle was dispensed on 11/06/26. (On average, there are 20 drops in 1ml of eye solution so a 10ml bottle would provide approximately 200 drops. If Dorzolamide-Timolol was administered 1 drop in both eyes twice a day (4 drops per day), a 10ml bottle would last 50 days.)<br>-The pharmacy received an order for Resident #1's Latanoprost on the same prescription on 11/06/25 and dispensed one 2.5ml bottle of Latanoprost eye drops on 11/06/26. (On average, there are 20 drops in 1ml of eye solution so a 2.5ml bottle would provide approximately 50 drops. If Latanoprost was administered 1 drop in both eyes at bedtime (2 drops per day), a 2.5ml bottle would last 25 days.)<br>-Their records showed Dorzolamide-Timolol and Latanoprost eye drops were still active orders in their system.<br>-They had not received any orders to discontinue Dorzolamide-Timolol or Latanoprost eye drops.<br>-The facility would have to request refills for these eye drops because eye drops were not sent with the monthly cycle fills to the facility.<br>-There had been no requests by the facility to refill either of these two eye drops for Resident #1.<br>-The pharmacy entered orders into the eMAR system and the facility also had access to enter or change orders in the eMAR system.<br>-She did not know why the facility's eMAR showed the two eye drops as discontinued because the pharmacy did not have discontinued orders for either medication. | D 358 | | |

| 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 06/05/2026 |

| 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 358 | Continued From page 25<br><br>Interview with Resident #1 on 06/04/26 at 12:30pm revealed:<br>-His eye pressure was checked when he went to the eye clinic because he had glaucoma.<br>-He received eye drops in the morning and at night, but he was not sure which eye drops.<br>-He did not know if he was supposed to get more than one eye drop.<br>-The vision in his right eye was very blurry and the vision in his left eye was not as blurry as his right eye.<br>-His vision had been the same for "a while" (could not specify a timeframe).<br><br>Interview with the medication aide (MA) on 06/04/26 at 9:57am revealed:<br>-She started working at the facility on 05/01/26.<br>-She was not aware of Resident #1 receiving any eye drops other than Artificial Tears (lubricant eye drop for dry eyes) since she started working there.<br>-The only eye drops Resident #1 had on hand was Artificial Tears.<br>-Resident #1 had not complained of any vision problems to her.<br><br>Interview with the Resident Care Coordinator (RCC) on 06/04/26 at 2:43pm revealed:<br>-She started working as the RCC on 03/16/26.<br>-She and the MAs did chart audits weekly.<br>-She was not aware of and had not noticed any discrepancies with Resident #1's medications.<br>-She had not noticed the orders for Resident #1 to receive Dorzolamide-Timolol and Latanoprost eye drops.<br><br>Interview with the Administrator on 06/04/26 at 3:58pm revealed:<br>-She had been the Administrator at the facility since 01/16/26. | D 358 | | |

| 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 06/05/2026 |

| 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 358 | Continued From page 26<br>-The RCC did chart/cart audits weekly which included checking medication orders, eMARs, and medications on hand.<br>-She was not aware Resident #1 had orders for Dorzolamide-Timolol and Latanoprost eye drops and was not receiving them.<br><br>Telephone interview with a triage representative at Resident #1's ophthalmology provider's office revealed:<br>-During Resident #1's last visit on 03/03/26, it was unclear to the ophthalmologist whether the resident was receiving Dorzolamide-Timolol eye drops or Latanoprost eye drops so she included orders for those two medications.<br>-Resident #1 had neovascular glaucoma and "it was never a good idea" to be without medications for glaucoma.<br>-Resident #1 had leaking blood vessels and not getting the eye drops for glaucoma could make his glaucoma worse.<br><br>Telephone interview with a representative at a second ophthalmology provider's office for Resident #1 on 06/05/26 at 9:21am revealed:<br>-Resident #1's eye provider or eye technician were not available.<br>-They had been managing Resident #1's glaucoma but they had not seen the resident since January 2025.<br>-They had Latanoprost eye drops as an active order, but they did not have Dorzolamide-Timolol eye drops as active in their system.<br>-The orders with Resident #1's ophthalmology provider at the retina center could be different because they had not seen the resident since January 2025.<br><br>b. Review of Resident #1's facility progress note dated 05/15/26 (no time specified) revealed: | D 358 | | |

| 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 06/05/2026 |

| 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 358 | Continued From page 27 | D 358 | | |

-Staff was called to Resident #1's room.
-Resident #1 was in the chair with his leg elevated.
-Resident #1's right leg was swollen and warm to touch.
-The resident denied any pain.
-The resident would be sent to the emergency room (ER) for evaluation and treatment.

Review of Resident #1's ER after visit summary (AVS) dated 05/15/26 revealed:
-Resident #1 was seen for leg swelling.
-No blood clots were identified in the resident's leg.
-The resident was being started on Cephalexin and received his first dose in the ER at 2:59pm on 05/15/26. (Cephalexin is an antibiotic for infection.)
-The resident's next dose was due tonight (05/15/26) at 6:00pm and every 6 hours.
-There was a note to pick up Cephalexin from any pharmacy with the printed prescription.

Review of Resident #1's printed prescription from a local hospital ER dated 05/15/26 revealed:
-There was an order for Cephalexin 500mg 1 capsule 4 times a day for 10 days.
-The start dated was noted as 05/15/26 and the end date was 05/25/26.

Review of Resident #1's May 2026 electronic medication administration record (eMARs) revealed:
-There was an entry for Cephalexin 500mg 1 capsule 4 times a day for 10 days for infection.
-Cephalexin was scheduled for administration at 8:00am, 11:00am, 4:00pm, and 8:00pm.
-The first dose of Cephalexin was documented as administered on 05/20/26 at 11:00am.
-Cephalexin was documented as administered

| 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 06/05/2026 |

| 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 358 | Continued From page 28<br>from 11:00am on 05/20/26 through 8:00pm on 05/28/26.<br>-There were 35 doses of Cephalexin documented as administered instead of 40 doses as ordered.<br><br>Observation of Resident #1's medications on hand on 06/04/26 at 9:42am revealed there was no Cephalexin available for administration.<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/04/26 at 11:23am revealed:<br>-They received Resident #1's order for Cephalexin via fax from the facility on 05/18/26.<br>-They dispensed 40 Cephalexin 500mg capsules on 05/18/26 when the order was received.<br>-Cephalexin would have been delivered to the facility the night of 05/18/26 or in the early morning hours on 05/19/26.<br>-She could not tell if any of Resident #1's Cephalexin had been returned to the pharmacy because there was no access to that information in their computer system.<br><br>Interview with Resident #1 on 06/04/26 at 12:30pm revealed:<br>-In May 2026, he went to the ER for swelling in both legs and feet.<br>-The ER provider prescribed an antibiotic for his legs.<br>-There was a delay in starting the antibiotic when he returned to the facility, but he did not know why it was delayed.<br>-He was supposed to take it for 10 days; he took it for "a day or so" (could not specify how long).<br><br>Observation of Resident #1 on 06/04/26 at 12:30pm revealed Resident #1 currently had no swelling or redness in his legs or feet. | D 358 | | |

| 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 06/05/2026 |

| 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 358 | Continued From page 29<br><br>Interview with the medication aide (MA) on 06/04/26 at 9:57am revealed:<br>-Providers usually sent orders to the pharmacy and the pharmacy entered orders into the eMAR system.<br>-The Resident Care Coordinator (RCC) was responsible for reviewing and approving orders in the eMAR system, but the medication had to be in the facility before the RCC approved the orders.<br>-The MAs did not have access to approve orders in the eMAR system, only the RCC and the Administrator.<br>-If a paper prescription was received by the facility for a resident, the RCC or the MAs could fax the order to the pharmacy.<br>-Medications were usually sent either the same night or the next day after the order was sent to the pharmacy.<br>-The pharmacy usually sent antibiotics right away even if they only sent a partial supply initially and then the full supply later.<br>-The facility also had a local back-up pharmacy that would deliver medications to the facility if needed.<br><br>Second interview with the MA on 06/04/26 at 10:51am revealed:<br>-Resident #1 was getting Cephalexin for cellulitis in his leg. (Cellulitis is a common bacterial skin infection with symptoms of redness, swelling, and warmth to the affected area.)<br>-She started administering Cephalexin to Resident #1 as soon as they received it from the pharmacy.<br>-She did not know why there was a delay in receiving Cephalexin from the pharmacy.<br>-The MAs usually called the pharmacy if an antibiotic was not received.<br>-She did not speak to anyone from the pharmacy | D 358 | | |

| 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 06/05/2026 |

| 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 358 | Continued From page 30 | D 358 | | |

about Resident #1's Cephalexin.
-She gave no explanation for not contacting the pharmacy about the delay in receiving Resident #1's Cephalexin in May 2026.
-If the order expired and there was any medication remaining in the bubble back, she would have written up a return sheet and the leftover would have been sent back to the pharmacy.
-She did not remember if Resident #1 had any Cephalexin left over and if any was sent back.
-She could check for a return sheet.

Review of Resident #1's records requested from the facility revealed there was no pharmacy return sheet for Resident #1's Cephalexin.

Interview with the RCC on 06/04/26 at 2:43pm revealed:
-She started working as the RCC on 03/16/26.
-The pharmacy usually entered orders into the eMAR system, and she or the Administrator approved the orders in the eMAR system.
-The MA on duty was responsible for faxing medication orders or she would fax orders as soon as she returned to the facility if she was not there when it was received.
-She did not usually approve orders in the eMAR system until the medication was physically in the facility.
-Resident #1's order for Cephalexin dated 05/15/26 was on a Friday and he did not return from the ER until later that evening.
-She faxed the order to the pharmacy when she returned to work on Monday, 05/18/26.
-The facility did not have a back-up pharmacy to her knowledge.

Interview with the Administrator on 06/04/26 at 3:58pm revealed:

| 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 06/05/2026 |

| 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 358 | Continued From page 31 | D 358 | | |

-She had been the Administrator at the facility since 01/16/26.
-The pharmacy entered orders into the eMAR system and she or the RCC approved orders when the medication was received.
-The RCC was responsible for faxing orders to the pharmacy or the MAs could also fax if the RCC was not there.
-The facility had a back-up pharmacy and orders for antibiotics should be sent to the back-up pharmacy.
-The back-up pharmacy usually delivered medications to the facility in a few hours.

Telephone interview with a triage primary care provider (PCP) at the facility's contracted PCP office on 06/04/26 at 4:43pm revealed:
-Resident #2's PCP was on leave until next week.
-He was a triage provider for the group and had access to the resident's record.
-The delay in starting Resident #1's Cephalexin or if the full course of treatment was not administered could cause the resident to have sepsis which could lead to low blood pressure, high heart rate, or eventually septic shock. (Sepsis is a life-threatening condition that occurs when the body's response to an infection causes widespread inflammation, potentially leading to organ failure and septic shock.)

2. Review of Resident #2's current FL-2 dated 07/30/25 revealed:
-Diagnoses included insomnia, anxiety, major depressive disorder, type 2 diabetes mellitus, diabetic polyneuropathy, chronic kidney disease, gastroesophageal reflux disease, mixed hyperlipidemia, Vitamin B12 deficiency, and Vitamin D deficiency.
-There was an order for Zaleplon 10mg 1 capsule at bedtime. (Zaleplon is a controlled substance

| 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 06/05/2026 |

| 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 358 | Continued From page 32<br>and sedative used to treat insomnia.)<br><br>Review of Resident #2's mental health provider (MHP) visit note dated 05/22/26 revealed:<br>-Resident #2 was seen for a routine follow-up for medication management.<br>-The resident had chronic insomnia.<br>-The resident was to continue taking Zaleplon 10mg 1 capsule at bedtime for insomnia.<br><br>Review of Resident #2's June 2026 electronic medication administration record (eMAR) revealed:<br>-There was an entry for Zaleplon 10mg 1 capsule at bedtime scheduled at 8:00pm.<br>-Zaleplon was documented as administered daily at 8:00pm on 06/01/26 and 06/02/26.<br>-Zaleplon was documented as not being administered on 06/03/26 at 8:00pm due to the medication being unavailable.<br><br>Review of Resident #2's controlled substance record (CSR) for Zaleplon revealed:<br>-The facility received 30 Zaleplon 10mg capsules on 04/29/26.<br>-The Zaleplon capsules were dispensed on 04/29/26 with instructions to take 1 capsule at bedtime for insomnia.<br>-The first dose was documented as administered on 05/04/26 at 8:00pm and the last dose documented was 06/02/26 at 8:00pm, leaving a balance of zero.<br><br>Observation of Resident #2's medications on hand on 06/04/26 at 10:04am revealed there was no Zaleplon available for administration for the resident.<br><br>Interview with Resident #2 on 06/04/26 at 1:41pm revealed: | D 358 | | |

| 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 06/05/2026 |

| 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 358 | Continued From page 33<br>-He did not receive Zaleplon last night (06/03/26) because there was none.<br>-The MA had ordered some more Zaleplon for him.<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/04/26 at 11:23am revealed:<br>-The pharmacy dispensed 30 Zaleplon 10mg capsules for Resident #2 on 03/28/26.<br>-The pharmacy dispensed 30 Zaleplon 10mg capsules for Resident #2 on 04/29/26.<br>-There were no refills remaining for Zaleplon for Resident #2.<br><br>Interview with the medication aide (MA) on 06/04/26 at 10:15am revealed:<br>-Resident #2 did not have any Zaleplon on hand for administration.<br>-She administered the last dose on 06/02/26.<br>-Resident #2 did not receive Zaleplon last night on 06/03/26 because there was none available in the facility.<br>-A refill for Resident #2's Zaleplon was requested on 05/28/26.<br>-She had not called the pharmacy about Resident #2's Zaleplon because it was one missed dose and she was hoping it would come in last night.<br>-Controlled substances did not come on automatic cycle fills and had to be ordered.<br>-The MAs were responsible for reordering controlled substances when the supply got down to the blue strip on the bubble card which was usually 5 to 10 pills.<br>-If the medication did not come in after 2 missed doses, the MAs were supposed to follow up with a phone call to the pharmacy.<br>-She would now let the Resident Care Coordinator (RCC) know and the RCC would follow up. | D 358 | | |

| 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 06/05/2026 |

| 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 358 | Continued From page 34<br>-If a controlled substance had no refills, the RCC would contact the prescribing provider to get a new prescription.<br><br>Interview with the RCC on 06/04/26 at 2:43pm revealed:<br>-Controlled substances did not come in the monthly cycle fills and had to be reordered.<br>-The MAs were responsible for reordering controlled substances.<br>-Some MAs waited to reorder until the supply got to the blue strip on the bubble card.<br>-She would prefer the MAs reorder when there were 8 pills remaining.<br>-The MAs usually let her know when they reordered a controlled substance and did not receive it.<br>-She would follow up with the pharmacy.<br>-She was not aware Resident #2 was out of Zaleplon.<br><br>Interview with the Administrator on 06/04/26 at 3:58pm revealed:<br>-The MAs were responsible for reordering controlled substance when the supply got to the blue strip on the bubble card.<br>-If a controlled substance was not received the next day after it was ordered, the MAs should call the pharmacy and notify the RCC.<br><br>Telephone interview with a triage primary care provider (PCP) at the facility's contracted PCP office on 06/04/26 at 4:43pm revealed:<br>-Resident #2's PCP was on leave until next week.<br>-He was a triage provider for the group and had access to the resident's record.<br>-Missing a dose of Zaleplon could cause lack of sleep and exacerbate any underlying issues that contribute to his chronic insomnia. | D 358 | | |

| 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 06/05/2026 |

| 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 358 | Continued From page 35<br><br>Telephone interview with Resident #2's MHP on 06/05/26 at 9:27am revealed:<br>-There was always a provider on call at all times if the facility needed to contact them for refills.<br>-She did not see any documentation that the facility had contacted them to get refills for Resident #2's Zaleplon.<br>-Resident #2's Zaleplon should be administered every night.<br>-Not receiving Zaleplon could cause the resident to not sleep as well.<br><br>_____<br>The facility failed to administer medications as ordered to 2 of 3 sampled residents (#1, #2). Resident #1 did not receive two eye drops for glaucoma for over 4 months which put the resident at risk of worsening or decreased vision. Resident #1's antibiotic for infection for his legs was ordered on 05/15/26 but not started until 05/19/26 and the full course was not administered putting the resident at risk for sepsis which could lead to low blood pressure, high heart rate, or eventually septic shock. Resident #2 did not receive a controlled substance for insomnia as ordered which could cause lack of sleep and exacerbate underlying issues contributing to his chronic insomnia. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.<br><br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/04/26 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 20, 2026. | D 358 | | |