

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/09/2025
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NAME OF PROVIDER OR SUPPLIER MILL CREEK MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1902 ORA DRIVE STATESVILLE, NC 28625
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D 000	Initial Comments	D 000		
D 137	<p>10A NCAC 13F .0407(a)(5) Other Staff Qualifications</p> <p>10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) prior to hire.</p> <p>The findings are:</p> <p>Review of Staff C's, personal care aide (PCA), personnel record revealed: -There was not a documented hire date. -There was not an application for employment. -There was no documentation a HCPR check was completed prior to hire.</p> <p>Interview with Staff C on 09/05/25 at 1:09pm revealed: -She was hired on 07/09/25 as a PCA. -She worked full time in the Special Care Unit (SCU) and provided care to the residents.</p> <p>Interview with the Resident Care Director (RCD) on 09/09/25 at 2:18pm revealed:</p>	D 137		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 137	<p>Continued From page 1</p> <p>-She did not know that Staff C did not have a HCPR check in her personnel record. -The Administrator was responsible for obtaining HCPR checks when employees were hired.</p> <p>Interview with the Administrator on 09/09/25 at 2:46pm revealed: -Staff C was hired as a PCA on 07/09/25. -She was responsible for ensuring HCPR checks were completed for all staff upon hire. -She was sure that she completed one for Staff C but must have misplaced it.</p> <p>Review of a HCPR check for Staff C revealed it was dated 09/09/25 and there were no substantiated findings.</p>	D 137		
D 259	<p>10A NCAC 13F .0802 (a) (c) Resident Care Plan</p> <p>10A NCAC 13F .0802 Resident Care Plan</p> <p>(a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan.</p> <p>(c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed;</p>	D 259		

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D 259	<p>Continued From page 2</p> <p>(3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section;</p> <p>(4) licensed health professional tasks required according to Rule .0903 of this Subchapter;</p> <p>(5) a dated signature of the assessor upon completion; and</p> <p>(6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a care plan was developed for 1 of 5 sampled residents (Resident #5) within 30 days following admission.</p> <p>The findings are:</p> <p>Review of Resident #5's current FL2 dated 06/17/25 revealed: -The recommended level of care was Memory Care. -Diagnoses included dementia, cognitive</p>	D 259		

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D 259	<p>Continued From page 3</p> <p>impairment, and mood disorder.</p> <ul style="list-style-type: none"> -Resident #5 was constantly disoriented and ambulatory. -There was no information for level of assistance required for activities of daily living. <p>Review of Resident #5's Resident Register revealed there was an admission date of 05/01/25.</p> <p>Interview with a medication aide (MA) on 09/09/25 at 11:25am revealed:</p> <ul style="list-style-type: none"> -She knew residents should have a care plan. -She did not know that Resident #5 did not have a care plan. -She would talk to the resident to gain knowledge about them or go to the Resident Care Director (RCD) and ask about the resident if there was not a care plan. <p>Interview with a second MA on 09/09/25 at 1:07pm revealed:</p> <ul style="list-style-type: none"> -She knew residents should have a care plan. -A resident's care would be directed by their behavior if there was not a care plan for the resident. -She did not know who was responsible for ensuring care plans were completed. <p>Interview with the RCD on 09/09/25 at 11:20am revealed:</p> <ul style="list-style-type: none"> -She was hired in May 2025 and worked as a MA until the second week of June 2025. -She was now responsible for ensuring care plans were completed and Resident #5's care plan was in a file for the primary care provider (PCP) to review. -She did not know why the care plan was not completed for Resident #5 after she was admitted. 	D 259		

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D 259	Continued From page 4 -Staff would not know how to care for a resident without a care plan. Interview with the Administrator on 09/08/25 at 3:25pm revealed: -She did not know that Resident #5 did not have a care plan and did not know why. -The RCD was responsible for ensuring all residents had a completed care plan and ensured the primary care physician reviewed the care plans. -Staff would not know how to care for residents without a care plan.	D 259		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 1 resident (Resident #1) was free from neglect relating to injuries of unknown origin involving his neck, right shoulder, and left and right anterior thighs. The findings are: Review of Resident #1's current FL2 dated 03/12/25 revealed: -Diagnoses included diabetes, dementia, and schizoaffective disorder bipolar type.	D 338		

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D 338	<p>Continued From page 5</p> <ul style="list-style-type: none"> -There was no information about Resident #1's orientation. -There was no information about Resident #1's skin condition. <p>Review of Resident #1's care plan dated 04/22/25 revealed he required supervision with eating, and extensive assistance with ambulation, transfers, bathing, dressing, grooming, and toileting.</p> <p>Review of an incident/accident report dated 08/29/25 revealed:</p> <ul style="list-style-type: none"> -Resident #1 had an unwitnessed fall around 2:00pm with a laceration to the right eyebrow and right elbow. -There was documentation of "skin peeling and bleeding on back of neck." -Indication of location of injury on the incident/accident body diagram revealed a circle around the back of the neck, and circles around the right eyebrow and right elbow. -There was documentation the primary care provider (PCP) was notified at 2:10pm but gave no instructions on how to treat the skin peeling and bleeding on the back of Resident #1's neck. -Resident #1 was not taken to a hospital but did require first aid that was documented as "bandaging." -There was no additional documentation regarding any skin issues on Resident #1's right shoulder, or his left and right anterior thighs. <p>Review of hospital admission records for Resident #1 dated 08/30/25 revealed:</p> <ul style="list-style-type: none"> -Resident #1 was in distress secondary to "course of illness, pain." -Resident #1 had "partial-thickness burns to bilateral anterior thighs, right lateral upper arm, and posterior neck." 	D 338		

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D 338	<p>Continued From page 6</p> <p>Interview with a personal care aide (PCA) on 09/05/25 at 12:51pm revealed: -Resident #1 was able to take his own shower with stand-by assistance. -She did not observe any skin issues to his neck, shoulder or left and right anterior thighs.</p> <p>Interview with a second PCA on 09/05/25 at 1:08pm revealed: -She gave Resident #1 a shower on 08/28/25 and washed him "head to toe but let him do his groin area." -He had no skin issues anywhere except for some bruising on his right arm. -She did not observe any ski issues to his neck, shoulder or left and right anterior thighs.</p> <p>Interview with a third PCA on 09/05/25 at 1:35pm revealed: -She was present in the bathroom when Resident #1 showered on 08/28/25. -She did not remember seeing any skin issues except a mark on his right elbow. -She did not observe skin issues with his neck, right shoulder or left and right anterior thighs. -She did not find out Resident #1 was in the hospital for burns until she returned to work on 09/02/25. -She did not know what happened to cause Resident #1's injuries.</p> <p>Interview with Resident #1's Responsible Party (RP) on 09/05/25 at 4:06pm revealed: -He was notified by the hospital on 08/30/25 that Resident #1 had been admitted to the hospital with "injuries that looked like burns." -He was told by hospital staff that he was being treated for second degree burns to his back, shoulder and both upper legs.</p>	D 338		

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D 338	<p>Continued From page 7</p> <p>Interview with a fourth PCA on 09/08/25 at 10:07am revealed: -She had observed a "quarter-sized" scab with some bleeding around it on Resident #1's neck on 08/29/25. -She observed the MA place a bandage over the area sometime after lunch on 08/29/25. -She did not know what happened to Resident #1's neck.</p> <p>Interview with a fifth PCA on 09/08/25 at 10:32am revealed: -She noticed Resident #1 had a "dime-sized scab" on his neck around breakfast time on 08/29/25. -She reported it to the MA who looked at it but did not treat it. -Around lunch time on 08/29/25, she saw Resident #1 in the dining room and noticed his neck again and the scab still looked the same. -Sometime after lunch, she noticed the scab on Resident #1's neck had come off. -The skin around the area was peeling and a clear liquid drainage from the area. -She described it as having the appearance of "white meat." -She did not see any blisters. -The MA cleaned and bandaged the area on Resident #1's neck.</p> <p>Interview with a medication aide (MA) on 09/08/25 at 10:48am revealed: -On 08/29/25 around 7:45am, a PCA informed her that Resident #1 had a scab on the lower part of his neck. -It looked like it was healing so she did nothing to it. -Between 1:30pm and 2:00pm on 08/29/25 she saw the scab on his neck again and it looked no different than it had that morning.</p>	D 338		

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D 338	<p>Continued From page 8</p> <p>-Around 4:45pm, when Resident #1 was walking to the dining room, she noticed the scab was gone and the skin was bleeding and peeling on his neck.</p> <p>-She contacted the PCP about the skin peeling and bleeding on the back of Resident #1's neck.</p> <p>-She did not receive any instructions regarding treatment of Resident #1's neck.</p> <p>-She did not want to leave the area on Resident #1's neck with an open area on it without cleaning and covering it.</p> <p>-She chose to clean the area where Resident #1's skin was peeling and bleeding on the back of his neck with a wound cleanser, then applied Vaseline, and covered with gauze and secured the edges with surgical tape.</p> <p>Interview with the Resident Care Director (RCD) on 09/08/25 at 1:49pm revealed:</p> <p>-The last time she observed Resident #1 he was wearing a long sleeve t-shirt.</p> <p>-She did not observe any wounds to his neck, shoulder or left and right anterior thighs and did not know how he sustained the burns.</p> <p>-Staff did not report any burns or blisters.</p> <p>Interview with Resident #1's PCP on 09/09/25 at 8:10am revealed:</p> <p>-He had not been contacted by staff at the facility for any treatment orders for skin peeling and bleeding on the back of Resident #1's neck.</p> <p>-He did not know why no one called him because he should have been notified.</p> <p>-He did not give any orders for wound cleanser, Vaseline, or bandaging for Resident #1's neck.</p> <p>-He was not contacted that Resident #1 was sent out to the hospital on 08/30/25.</p> <p>-He was unaware Resident #1 had any skin issues on his right shoulder or left and right anterior thighs.</p>	D 338		

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D 338	<p>Continued From page 9</p> <ul style="list-style-type: none"> -After reviewing pictures taken on 08/30/25 of Resident #1's injuries, the PCP noted that Resident #1's skin issues would have taken at least 3-4 days to look the way they did. -The skin on his neck and right shoulder looked like it had been burned. -He was not sure the areas on Resident #1's upper legs were burns, but thought they could have been from contact dermatitis. -Someone should have seen Resident #1's skin issues and reported them. -It would be neglectful if staff did not report this. <p>Interview with the Registered Nurse (RN) caring for Resident #1 at the hospital on 09/09/25 at 10:26am revealed Resident #1 had injuries to his neck, shoulder and both upper legs that were consistent with burns.</p> <p>Interview with a second MA on 09/09/25 at 1:06pm revealed:</p> <ul style="list-style-type: none"> -She was working on the morning of 08/30/25. -The off-going MA did not mention Resident #1 had any skin issues. -The PCA assigned to Resident #1 on 08/30/25 called her to his room. -She observed Resident #1 had a bandage taped down on his neck. -She asked Resident #1 was in pain and he stated he was. -With assistance from the PCA, they undressed Resident #1 to perform a total body skin observation. -Resident #1 had an area on his neck, right shoulder and both legs that looked like his skin was sloughing off. -She contacted Emergency Medical Services (EMS) to send Resident #1 to the hospital to be evaluated for his pain. 	D 338		

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D 338	<p>Continued From page 10</p> <p>Interview with a sixth PCA on 09/09/25 at 1:30pm revealed:</p> <ul style="list-style-type: none"> -She was working on the morning of 08/30/25. -The off-going PCA did not mention any skin issues that Resident #1 had. -She was walking down the hallway and heard a resident screaming for help. -She entered Resident #1's room and he said that he was in pain. -She asked him where and he pulled up his pants leg and showed her a reddened, swollen area several inches long on his right leg. -Resident #1 then pulled his pants down and showed her his left leg that also had a reddened, swollen area. -She asked him if he was hurting anywhere else and he said yes and pointed to the back of his neck. -She called for the MA who came to Resident #1's room immediately. -The MA and PCA assisted Resident #1 in removing his clothes so the MA could look at his skin. -She observed that Resident #1's left shoulder was bright red and bleeding, his neck and back were discolored with sheets of skin coming off, and he had an intact blister in his groin. -The MA left the room and contacted EMS for Resident #1. <p>Interview with the Administrator on 09/09/25 at 2:44pm revealed:</p> <ul style="list-style-type: none"> -She was not aware the MA had administered a treatment to Resident #1 without an order from the PCP. -MAs were never supposed to treat residents without having an order from the PCP. -If the MA had difficulty contacting or communicating with the PCP, the MA could have called her or the Resident Care Coordinator for 	D 338		

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D 338	<p>Continued From page 11</p> <p>assistance.</p> <p>-She was notified by the MA on 08/30/25 that Resident #1 was being sent out for pain.</p> <p>-The MA did not tell her about his neck, shoulder, or either of his legs.</p> <p>-The MA was responsible for calling her and giving complete details about why a resident was being sent out to the hospital.</p> <p>-After seeing the pictures of his wounds that were taken on 08/30/25 by hospital staff, she realized there was no way her staff could not have seen this significant skin issue earlier.</p> <p>-If the facility staff were doing their job correctly, someone would have noticed the significance of this injury before Resident #1 was sent to the hospital on 08/30/25.</p> <p>Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.</p> <p>_____</p> <p>The facility failed to ensure Resident #1 was free from neglect when staff observed injuries of unknown origin to the back of his neck, right shoulder, and the front of his left and rights thighs and administered wound care without a physician's order and delaying contacting EMS to transport him to the hospital for greater than 24 hours. This failure resulted in neglect of Resident #1 and constitutes a Type A1 Violation.</p> <p>_____</p> <p>The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 09/09/25.</p> <p>CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 9, 2025.</p>	D 338		

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D 358 D 358	<p>Continued From page 12</p> <p>10A NCAC 13F .1004 (a) Medication Administration</p> <p>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:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to obtain treatment orders from the primary care provider (PCP) to administer a wound cleanser, skin protectant ointment, and bandaging for 1 of 1 resident (#1) in the Special Care Unit (SCU).</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 03/12/25 revealed: -Diagnoses included diabetes, dementia, and schizoaffective disorder bipolar type. -There was no information about Resident #1's orientation. -There was no information about Resident #1's skin condition.</p> <p>Review of Resident #1's care plan dated 04/22/25 revealed he required supervision with eating, and extensive assistance with ambulation, transfers, bathing, dressing, grooming, and toileting.</p> <p>Review of Resident #1's physician's orders from 08/01/25 - 08/31/25 revealed there were no orders for any skin treatments or wound care.</p>	D 358 D 358		

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D 358	<p>Continued From page 13</p> <p>Review of an incident/accident report dated 08/29/25 revealed:</p> <ul style="list-style-type: none"> -Resident #1 had an unwitnessed fall around 2:00pm with a laceration to the right eyebrow and right elbow. -There was also documentation of "skin peeling and bleeding on back of neck." -Indication of location of injury on the incident/accident body diagram revealed a circle around the back of the neck, and circles around the right eyebrow and right elbow. -There was documentation the PCP was notified at 2:10pm but gave no instructions on how to treat the skin peeling and bleeding on the back of Resident #1's neck. -Resident #1 was not taken to a hospital but did require first aid that was documented as "bandaging." <p>Interview with the medication aide (MA) on 09/08/25 at 3:27pm revealed:</p> <ul style="list-style-type: none"> -She contacted the PCP on 08/29/25 about Resident #1's fall and the skin peeling and bleeding on the back of Resident #1's neck. -She did not hear back from the PCP and received no instructions regarding treatment of Resident #1's neck. -She did not want to leave the area on Resident #1's neck with an open to air without cleaning and covering it. -She chose to clean the area where Resident #1's skin was peeling and bleeding on the back of his neck with a wound cleanser, applied Vaseline, covered the back of his neck with gauze, and secured the edges of the gauze with surgical tape. <p>Interview with the PCP on 09/09/25 at 8:10am revealed:</p>	D 358		

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D 358	<p>Continued From page 14</p> <p>-He had not been contacted on 08/29/25 by staff at the facility for any treatment orders for Resident #1's skin peeling and bleeding on the back of his neck.</p> <p>-He did not know why no one called him because he should have been notified.</p> <p>-He did not give any orders for wound cleanser, Vaseline, or bandaging for Resident #1's neck.</p> <p>Interview with the Administrator on 09/09/25 at 2:44pm revealed:</p> <p>-She was not aware the MA had administered a treatment to Resident #1 without an order from the PCP.</p> <p>-MAs were never supposed to treat residents without having an order from the PCP.</p> <p>-If the MA had difficulty contacting or communicating with the PCP, the MA could have called her or the Resident Care Coordinator for assistance.</p>	D 358		
D 438	<p>10A NCAC 13F .1205 Health Care Personnel Registry</p> <p>10A NCAC 13F .1205 Health Care Personnel Registry</p> <p>The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within 24 hour and 5 day requirements for 1 of 1 sampled resident (#1)</p>	D 438		

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D 438	<p>Continued From page 15</p> <p>who sustained burns to the back of his neck, back, right shoulder and both thighs from unknown origin.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 03/12/25 revealed: -Diagnoses included diabetes, dementia, and schizoaffective disorder bipolar type. -There was no information about Resident #1's orientation. -There was no information about Resident #1's skin condition.</p> <p>Review of hospital admission records for Resident #1 dated 08/30/25 revealed: -Resident #1 had "areas of wounds uncovered, they do appear to be burns." -"Scabbed area to bilateral anterior thighs, right upper arm and shoulder and the back of his neck."</p> <p>Review of hospital wound care notes for Resident #1 dated 09/01/25 revealed: -Resident #1 had wounds to the "anterior and medial thighs of both right and left legs." -The wounds on Resident #1's right neck and right shoulder "are shallow but have full tissue thickness loss" with some dark brown tissue and sloughing maroon tissue of the wound beds.</p> <p>Interview with a medication aide on 09/09/25 at 1:06pm revealed: -On 08/30/25, a personal care aide (PCA) called her on the walkie-talkie and asked her to come to Resident #1's room. -She went directly to Resident #1's room where the PCA told her Resident #1 had been calling out for help and said he was in pain.</p>	D 438		

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D 438	<p>Continued From page 16</p> <p>-When asked about his pain, Resident #1 pulled up both pants legs to revealed reddened, swollen areas that looked like his skin was sloughing (peeling of the outer layer of the skin) off.</p> <p>-She asked him if he was hurting anywhere else and he reached toward the back of his neck where she observed that he had a bandage covering his neck.</p> <p>-She and the PCA assisted Resident #1 to remove all his clothes so she could observe his skin.</p> <p>-She noted he had skin sloughing and redness to his right shoulder, both upper thighs, and the bandage did not fully cover the wound on his neck and upper back with dark discoloration and skin sloughing.</p> <p>-Since he was complaining of pain, she contacted EMS, who came and transported him to the emergency room.</p> <p>-When she came into work on 08/30/25, she had not been told Resident #1 had any skin issues, any bandages, or what had happened.</p> <p>-She did not complete an incident accident report about what happened and sending him out to the hospital.</p> <p>-She informed the Administrator on 08/30/25 that she had sent Resident #1 out to the hospital for pain.</p> <p>Interview with the Administrator on 09/08/25 at 3:25pm revealed:</p> <p>-She was responsible for all 24 hour and 5-day investigative reports and ensured the reports were submitted to the HCPR.</p> <p>-She was not aware that a 24 hour and 5-day report was required for an injury of unknown origin and did not complete them for Resident #1's burns to his skin.</p> <p>_____</p> <p>The facility failed to ensure an injury of unknown</p>	D 438		

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D 438	<p>Continued From page 17</p> <p>origin was reported to the Health Care Personnel Registry with a 24-hour and 5-day report for Resident #1 who had sustained burns to his neck, right shoulder, and left and right thighs. This failure was detrimental to the health, safety, and welfare of Resident #1 and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on September 18, 2025, for this Type B Violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 25, 2025.</p>	D 438		
D 451	<p>10A NCAC 13F .1212(a) Reporting of Accidents and Incidents</p> <p>10A NCAC 13F .1212 Reporting of Accidents and Incidents</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county Department of Social Services (DSS) of incidents resulting in injury requiring emergency medical evaluation and treatment for 2 of 5 sampled residents (#1 and #5).</p>	D 451		

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D 451	<p>Continued From page 18</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 03/12/25 revealed diagnoses included diabetes, dementia, and schizoaffective disorder bipolar type.</p> <p>Interview with a medication aide on 09/09/25 at 1:06pm revealed: -Resident #1 was transferred to the emergency department (ED) via emergency medical services (EMS) due to pain on 08/31/25. -She should have completed an incident/accident report but she forgot to complete it. -She did not notify the county DSS that Resident #1 was sent to the hospital for emergency medical evaluation and treatment.</p> <p>Review of Resident #1's ED triage report for Resident #1 dated 08/30/25 revealed Resident #5 was brought to the hospital due to "bilateral leg burns and burns to the back."</p> <p>Telephone interview with the local county Adult Home Specialist on 09/08/09 at 9:18am revealed: -She did not receive an incident/accident report regarding Resident #1's hospitalization on 08/30/25. -The Resident Care Director (RCD) told her that she had completed one for Resident #1, but the Administrator was responsible to send them to DSS.</p> <p>Telephone interview with the local county Adult Services Supervisor on 09/08/09 at 9:31am revealed: -She never received an incident/accident report regarding Resident #1's hospitalization on 08/30/25.</p>	D 451		

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D 451	<p>Continued From page 19</p> <p>-She told the Administrator that she was required to review the DSS report, sign off on it, and file it for future reference if needed</p> <p>-She expected to have an incident/accident report from a facility within 24 hours of an occurrence with a resident requiring treatment at a hospital.</p> <p>2. Review of Resident #5's current FL2 dated 06/17/25 revealed diagnoses included dementia, mood disorder, and cognitive impairment.</p> <p>Review of the Incident and Accident Report for Resident #5 dated 05/31/25 revealed:</p> <p>-Resident #5 fell in the hallway and hit the side of her face on 05/31/25 at 8:05am.</p> <p>-Resident #5 refused to be assessed for injury by staff.</p> <p>-Staff telephoned emergency medical services (EMS) for an evaluation of Resident #5.</p> <p>-EMS responded and transported Resident #5 to a local hospital at 8:54am.</p> <p>Review of an emergency department (ED) triage report for Resident #5 dated 05/31/25 revealed:</p> <p>-Resident #5 had an unwitnessed fall at the facility.</p> <p>-Resident #5 had a small laceration to the left orbital area and received treatment.</p> <p>Refer to the telephone interview with the local county Adult Home Specialist on 09/08/09 at 9:18am.</p> <p>Refer to the telephone interview with the local county Adult Services Supervisor on 09/08/09 at 9:31am</p> <p>Refer to the interview with the RCD on 09/08/25 at 1:49pm.</p>	D 451		

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D 451	<p>Continued From page 20</p> <p>Refer to the interview with the Administrator on 09/08/25 at 3:25pm.</p> <p>Telephone interview with the local county Adult Home Specialist on 09/08/09 at 9:18am revealed she had not received any accident/incident reports from the facility in several months.</p> <p>Telephone interview with the local county Adult Services Supervisor on 09/08/09 at 9:31am revealed it had been over 6 months since she had received any incident/accident reports from the facility.</p> <p>Interview with the RCD on 09/08/25 at 1:49pm revealed: -The MA on duty during an incident or accident was responsible for completing a report, and notifying the family, primary care provider (PCP), and the Administrator of the event. -The Administrator was responsible for notifying DSS of the incident or accident.</p> <p>Interview with the Administrator on 09/08/25 at 3:25pm revealed: -She was responsible for faxing all reports to DSS when a resident had an accident or incident requiring treatment at the local hospital. -She knew she faxed all reports to DSS and always received a confirmation of the fax but she could not locate the confirmations.</p>	D 451		
D 454	<p>10A NCAC 13F .1212(e) Reporting of Accidents and Incidents</p> <p>10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person,</p>	D 454		

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D 454	<p>Continued From page 21</p> <p>as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification:</p> <p>(1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and</p> <p>(2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the Responsible Party (RP) for 1 of 2 sampled residents (Resident #1) regarding an accident/incident resulting in an injury requiring emergency medical evaluation and treatment at a local hospital.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 03/12/25 revealed diagnoses included diabetes, dementia, and schizoaffective disorder bipolar type.</p>	D 454		

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D 454	<p>Continued From page 22</p> <p>Interview with a medication aide on 09/09/25 at 1:06pm revealed: -Resident #1 was sent out to the hospital due to pain on 08/31/25. -She should have completed an incident/accident report but she forgot to complete it. -She did not notify the RP that Resident #1 was sent to the hospital for emergency medical evaluation and treatment because the Administrator told her that she would contact the RP.</p> <p>Review of the emergency department (ED) triage report for Resident #1 dated 08/30/25 revealed Resident #5 was transferred to the emergency department (ED) via emergency medical services (EMS) due to "bilateral leg burns and burns to the back."</p> <p>Telephonpe interview with the RP for Resident #1 on 09/05/25 at 4:06pm revealed: -He received notification from the hospital staff that Resident #1 was admitted on 08/30/25 for treatment due to injuries. -He had yet to receive any notification from staff at the facility of Resident #1's hospitalization.</p> <p>Interview with the RCD on 09/08/25 at 1:49pm revealed the MA on duty during an incident or accident was responsible for completing a report, and notifying the family, primary care provider (PCP), and the Administrator of the event.</p> <p>Interview with the Administrator on 09/08/25 at 3:25pm revealed: -The MA who sends out a resident to the hospital was responsible to notify the RP, the primary care provider (PCP) and her. -She was not aware the MA had not contacted the</p>	D 454		

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