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CLASSIC CARE HOMES	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on August 29-30, 2018.	D 000		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the furniture in 6 resident rooms, the dining room and day room were kept clean and in good repair. The findings are: Observation of resident room #1 on 08/29/18 at 3:51pm revealed the top and front of both nightstands had worn brown laminate. Observation of resident room #3 on 08/29/18 at 3:53pm revealed the there was a missing knob on the nightstand. Observation of resident room #4 on 08/29/18 at 3:54pm revealed: -The brown laminate on the top of the nightstand was worn. -The dresser had a missing laminate strip along the top front. Observation of resident room #5 on 08/29/18 at 3:55pm revealed: -The dresser had a missing laminate strip along	D 076		

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the top front.
-The brown laminate on the edges of both drawers was chipped and peeling.
-The laminate on the top edge of the footboard of the bed was chipped and peeling.

Observation of resident room #6 on 08/29/18 at 3:57pm revealed:
-The brown laminate on the top of the nightstand was completely worn.
-The laminate on the top edge of the footboard of the bed was chipped and peeling.
-The blue cloth chair by the entry door had white and gray stains throughout.
-The dresser had a missing laminate strip along the top front.

Interview with the resident who resided in room #6 on 08/29/18 at 3:58pm revealed:
-The furniture had been in the same condition since her arrival 2 years ago.
-She had not notified staff of the condition of the furniture in her room.
-She wanted the blue chair replaced as it was heavily stained.
-She had not noticed the peeling laminate of the nightstand and dresser.
-She had not reported it as it was not a "major concern."

Observation of resident room #7 on 08/29/18 at 3:59 pm revealed:
-The brown laminate on the night stand by the bed near the window was worn on the top and front.
-The brown laminate on the nightstand by the bed near the entry door was chipped on all edges and the drawer was off its track.

Observation of the dining room on 08/29/18 at

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D 076	Continued From page 2 4:05 pm revealed: -The top of the brown wooden dining table was cracked and peeling. -There was a gray metal filing cabinet with bent drawers that was covered in drip marks. Observation of the day room on 08/30/18 at 8:02am revealed a telephone table with a missing laminate strip along the top edge with cracked laminate on the top. Interview with 5 residents on 08/29/18 at between 10:30am and 10:41am revealed: -The furniture had been in the same condition for years. -They had not notified staff of the condition of the furniture as it was not a concern. -The facility needed some new nightstands in the bedrooms. Interview with the Administrator on 08/29/18 at 11:09am revealed: -The residents had not complained about the condition of the furniture in their rooms nor in the facility. -She was aware of the condition of the furniture in the facility. -She was aware that the laminate on the furniture in the resident rooms was worn. -The furniture was old and needed to be replaced. -The facility was being sold and the new owners were ordering new furniture.	D 076		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care	D 282		

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D 282	Continued From page 3 Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the food pantry was cleaned and protected from contamination. The findings are: Observation of the food pantry on 08/29/18 at 8:05am revealed: -The four white wire shelves were covered in a thick gray grime throughout. -There was a clear container with a white lid labeled "Hush Puppy Mix" that was sticky and covered with orange-colored drip marks. -There was a clear container with a white lid labeled "Sugar" that was sticky and covered with a gray sticky substance. -There was a clear container with a white lid labeled "Rice" that was sticky and covered with a gray sticky substance. -There was a clear container with a white lid labeled "Corn Meal" that was sticky and covered with a gray sticky substance. -There was a clear container with a blue lid labeled "Flour" that had a gray sticky substance around the lid. -There was an open package of chocolate chip cookies with three cookies on the second shelf without a date. Interview with a kitchen staff on 08/29/18 at 8:22pm revealed: -The kitchen staff cleaned the kitchen, but did not sign any cleaning schedule sheet. -She could not recall the last time she cleaned	D 282		

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D 282	Continued From page 4 the pantry. -She used the food containers but had not noticed that they were dirty. -Staff were supposed to clean the entire kitchen after each meal. -The staff responsibilities for the kitchen were posted on the refrigerator. Observation of the shift duty sheets posted on the refrigerator on 08/29/18 at 8:28 revealed: -There were first, second and third-shift cleaning responsibilities posted for the entire facility. -Cleaning of the pantry was not listed among the cleaning responsibilities. Interview with the Administrator on 08/29/18 at 9:22am revealed: -She supervised the kitchen staff. -She was unaware that the pantry was not being cleaned. -The pantry containers and shelving should be wiped down regularly. -She did not inspect the pantry at regular intervals. -She did not know when the last deep cleaning of the pantry occurred. -Her expectation was for dietary staff to clean all areas daily and as needed. -She needed to add pantry cleaning to the list of responsibilities for staff. -She would instruct staff to wipe down the food canisters after use. -She would have the pantry cleaned immediately.	D 282		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes:	D 306		

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D 306	Continued From page 5 (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure water was served with meals to all residents. The findings are: Observation of the breakfast meal on 08/29/18 from 8:00 to 8:30am revealed: -Ten residents were in the dining room eating breakfast. -Each resident was served milk and juice with their meal. -There was no water served to any of the residents throughout the meal. Interview with a resident on 08/29/18 at 8:22am revealed: -Water was never served with meals. -The only water they served was with medication administration. -The resident did not request water with meals. Observation of the lunch meal on 08/29/18 from 12:15pm to 12:45pm revealed: -Ten residents were in the dining room eating lunch. -Each resident was served tea with their meal. -There was no water served to any of the residents throughout the meal. Interviews with two residents on 08/29/18 at 12:45pm revealed: -Water was never served with meals unless a resident requested it.	D 306		

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D 306	Continued From page 6 -If water was served at each meal, they would drink the water. -The residents never requested water to be served with their meal. Interview with the kitchen supervisor on 08/29/18 at 2:45pm revealed: -Water was not served with meals. -The residents got water with their medications. -She did not know that water was supposed to be served with all meals. -She would ensure residents received water with all meals. Interview with the Administrator on 08/29/18 at 9:22am revealed: -She supervised the kitchen staff. -She was unaware that water was not being served with meals. -None of the residents had mentioned not receiving water with their meals. -She was responsible for supervising the kitchen staff. -She would ensure all residents received water with their meals.	D 306		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so.	D 319		

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D 319	Continued From page 7 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide residents with the opportunity to participate in at least one outing every other month. The findings are: Review of the August 2018 activities calendar revealed no planned/scheduled outings on the calendar. Interview with six residents on 08/29/18 at 10:45am revealed: -There were no outings away from the facility offered. -"We do not get to go out on outings at all unless you count going outside as an outing." -Residents only go on an outing if their family members take them. -The facility did not have transportation to take residents on an outing. -"It would be nice if the staff could take us out." -The residents could not recall the last time they had an outing at the facility. -Residents were taken to doctor appointments by car with facility staff. Interview with a personal care aide on 08/29/18 at 10:59am revealed: -The facility did not have transportation to accommodate taking the residents on an outing. -The residents frequently walked around the neighborhood or to the local stores. -Some of the family members of the residents would take them out of the facility. -The facility was part of two other buildings but those buildings did not have any transportation such as a van or bus either to take out the residents on an outing. Interview with the Administrator on 08/29/18 at	D 319		

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D 319	Continued From page 8 11:14am revealed: -She created the activities calendar. -She was aware that resident outings were supposed to be provided every other month. -She was aware that the residents were not offered outings. -The facility did not own a bus or a van to provide outings for residents. -She admitted that the facility had "fallen short" of providing outings to residents. -She could not recall the last outing.	D 319		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of	D 344		

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medication orders for 1 of 1 sampled residents (#1) regarding an order for a blood thinning medication.

The findings are:

Review of Resident #1's current FL-2 dated 07/05/18 revealed diagnoses included hypothyroidism, hyperlipidemia, bipolar disorder, coronary artery aneurysm, chronic obstructive pulmonary disease, muscle weakness, chronic respiratory failure, oxygen dependence and deep vein thrombosis (DVT).

Review of Resident #1's discharge summary from the emergency department dated 07/31/18 revealed:
-The resident was brought to the emergency room for leg pain.
-Resident #1 was diagnosed with a DVT.
-Resident #1 was given a prescription for Xarelto (a blood thinner used to treat blood clots) for 21 days and scheduled a follow-up visit on 08/15/18.

Review of Resident #1's physician orders dated 07/31/18 revealed an order for 21 days of Xarelto 15mg to be taken in the morning and evening with meals.

Review of Resident #1's August 2018 medication administration record (MAR) revealed:
-An entry for Xarelto 15mg to be administered at 8:00am and 8:00pm.
-The 21-day order of Xarelto 15mg was started on 08/01/18 with the evening dose at 8:00pm.
-The last documented administration of Xarelto 15mg was on 08/22/18 in the morning at 8:00am.

Review of Resident #1's follow-up visit summary dated 08/15/18 revealed:

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-Resident #1 was seen for a DVT in her left leg two weeks ago.
-Resident #1 was informed she had a blood clot in her left leg.
-The discharge paragraph noted various labs and exams were ordered and "Instructed to stay on Xarelto" appeared after the list of lab orders, followed by "follow-up in 2 weeks"
-Resident #1's medication list included "Xarelto 15mg for 21 days" order from the emergency room which appeared on the discharge summary.
-Resident #1 was "tolerating her current medication regimen well" and a follow-up visit was scheduled for 09/05/18.

Interview with Resident #1 on 08/29/18 at 2:25pm revealed:
-She recalled going to the hospital on 07/31/18 after having pain in left leg.
-She was told she had bad circulation in her leg while at the hospital.
-Her pain level since her hospital visit on 07/31/18 had improved and she was currently not in any pain.
-She remembered taking a "red pill" with her medications since her hospital visit.
-She could not state what medications she was currently taking.

Interview with Resident #1's hospital provider on 08/29/18 at 4:10pm revealed:
-Resident #1 was seen on 08/15/18 by the provider.
-The provider wanted Resident #1 to continue taking Xarelto 15mg until her 09/05/18 follow-up visit.
-When Resident #1 was seen at the office, she was currently on Xarelto 15mg, but they did not see that it was only a 21-day order from the emergency department encounter on 07/31/18.

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D 344	Continued From page 11 -The provider did not notice that the Xarelto order was expiring in 6 days otherwise he would have written a new prescription. -The provider wanted to keep Resident #1 on Xarelto and would submit a new order. -The facility had not contacted the provider after Resident #1's visit for clarification of the Xarelto order. -The provider did not feel that the resident was in any danger by not currently taking Xarelto and "preferred that she be on it again until her follow-up visit." Interview with Resident #1's primary care provider on 08/30/18 at 8:45am revealed: -She saw Resident #1 on 08/23/18. -She reviewed her emergency department discharge summary and her DVT diagnosis from 07/31/18. -She was aware that she had seen another provider for her follow-up appointment related to her DVT on 08/15/18. -She was aware that she was prescribed Xarelto 15mg and observed that Resident #1 was "doing much better and in no pain." -She did not notice that the discharge summary from the 08/15/18 appointment noting "Instructed to stay on Xarelto." -She expected that Resident #1 would be prescribed Xarelto at least until her September 2018 follow-up. -She was unaware that the 21-day Xarelto order expired on 08/21/18 or she would have written a prescription to continue her on it. -She was going to send an order to continue the prescription because she "preferred that she be on it until her follow-up appointment." -Her encounter with Resident #1 on 08/23/18 did not lead her to believe that the resident was at a significant risk by not currently being on Xarelto"	D 344		

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D 344	Continued From page 12 since the resident had no pain but it was "better to have [Xarelto] on board." Interview with the Administrator and Resident Care Coordinator (RCC) on 08/29/18 at 2:45pm revealed: -The RCC took Resident #1 to the emergency room on 07/31/18 and received some starter Xarelto pills to get the resident started that day after the DVT diagnosis and provider order. -Resident #1 went to her follow-up appointment on 08/15/18 and was given a discharge summary and no new prescriptions. -They interpreted that the "Instructed to stay on Xarelto" meant until it ran out after 21 days. -The provider on the 08/15/18 follow-up visit had the 21-day Xarelto order in hand which was printed on the discharge summary on the medication reconciliation page. -The provider did not ask if they had enough Xarelto until the next visit nor did he address the 21-day order during the visit. -Resident #1 was seen by her primary care provider on 08/23/18 who reviewed her follow-up visit notes and was not restarted on Xarelto. -They would make sure they review every discharge order for all residents in the future for clarification. -She was responsible for ensuring that all orders were reviewed. -There was no written policy to review medication orders, but it was expected that all orders were reviewed. The failure of the facility to clarify the medication orders for Xarelto for Resident #1 with a recent hospital treatment with a diagnosis of a DVT resulted placing the resident at increased risk for clotting. This failure of the facility to clarify medication orders was detrimental to the health,	D 344		

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D 344	Continued From page 13 safety and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/29/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 10/14/18.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #1) regarding an order for a blood thinning medication for clot prevention. The findings are: Review of Resident #1's current FL-2 dated 07/05/18 revealed diagnoses included hypothyroidism, hyperlipidemia, bipolar disorder,	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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coronary artery aneurysm, chronic obstructive pulmonary disease, muscle weakness, chronic respiratory failure, oxygen dependence and deep vein thrombosis (DVT).

Review of Resident #1's discharge summary from the emergency department dated 07/31/18 revealed:
-The resident was brought to the emergency room for leg pain.
-Resident #1 was diagnosed with a DVT.
-Resident #1 was given a prescription for Xarelto 15mg (used for clot prevention) twice daily for 21 days and scheduled a follow-up visit on 08/15/18.

Review of Resident #1's physician orders dated 07/31/18 revealed an order for 21 days of Xarelto 15mg to be taken in the morning and evening with meals.

Review of Resident #1's August 2018 medication administration record (MAR) revealed:
-An entry for Xarelto 15mg to be administered at 8:00am and 8:00pm.
-The 21-day order of Xarelto 15mg was started on 08/01/18 with the evening dose at 8:00pm.
-Of the 21 morning doses, there were 8 morning does not documented as being administered on 08/02, 08/03, 08/05, 08/06, 08/07, 08/08, 08/09, and 08/16.
-The last documented administration of Xarelto 15mg was on 08/22/18 in the morning at 8:00am.
-All 21 evening doses of Xarelto were documented as administered.
-The last documented administration of Xarelto 15mg was on 08/22/18 at 8:00am.

Observation of Resident #1's medications on hand on 08/29/18 at 2:09pm revealed:
-There were two medication cards for Xarelto

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	HAL051018	A. BUILDING: _____ B. WING _____	R 08/30/2018

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CLASSIC CARE HOMES	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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15mg, one labeled "morning" and one labeled "evening" dispensed on 07/31/18.
-The morning Xarelto medication card had 8 pills remaining.
-The evening Xarelto medication card had 9 pills remaining.

Telephone interview with a representative from the facility contracted pharmacy on 08/29/18 at 3:02pm revealed:
-The pharmacy received the Xarelto prescription on 07/31/18 and filled it the same day.
-The prescription was acquired by the facility on 08/01/18.
-There were 2 medication cards dispensed with 21 pills in a card labeled "morning" and 21 pills in a card labeled "evening."
-They had not received any further prescriptions for Xarelto for Resident #1.
-Their records showed that this was the first prescription of Xarelto for Resident #1.
-There were no refills for Xarelto on record for Resident #1.
-There were no reminders or order clarifications made by the pharmacy regarding the 21-day prescription of Xarelto after it was dispensed.

Interview with the medication aide (MA) on 08/29/18 at 1:52pm revealed:
-She recalled administering Xarelto and signing the MAR after each administration.
-She was not working on the days when the Xarelto was not documented as being administered.
-She worked in the facility's other buildings most of the time and only covered the current building when needed.
-She did not know which MA worked the days when the medication was not given.
-Resident #1 was pleasant and a never refused

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D 358	Continued From page 16 any of her medication. Attempted telephone interview with a second MA on 08/29/18 at 2:05pm was unsuccessful. Attempted telephone interview with a third MA on 08/29/18 at 2:08pm was unsuccessful. Interview with Resident #1 on 08/29/18 at 2:25pm revealed: -She recalled going to the hospital on 07/31/18 after having pain in left leg. -She was told he had bad circulation in her leg while at the hospital. -Her pain level since her hospital visit on 07/31/18 had improved and she was currently not in any pain. -She remembered taking a "red pill" with her medications after the hospital visit. -She always received her "red pill" every morning and evening until "a few days ago." -She could not state what medications she was currently taking. -She had never refused medications. Interview with Resident #1's hospital provider on 08/29/18 at 4:10pm revealed: -Resident #1 was seen on 08/15/18 by the provider related to her DVT. -The provider was aware that Resident #1 was prescribed Xarelto 15mg in the emergency department and had been taking them since 08/01/18. -The provider was unaware there were 17 remaining pills of Xarelto of the 42 pills dispensed by the pharmacy on 07/31/8. -The provider did not feel that the resident was in any danger by not currently taking Xarelto and "preferred that she be on it again until her follow-up visit."	D 358		

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-The provider was not concerned that there were 17 pills left on hand from the 07/31/18 prescription.
-He expected the facility to administered medications as ordered.
-Resident #1 appeared to be doing well during her visit on 08/15/18.

Interview with Resident #1's primary care provider on 08/30/18 at 8:45am revealed:
-She saw Resident #1 on 08/23/18.
-She reviewed her emergency department discharge summary and her DVT diagnosis from 07/31/18.
-She was aware that she had seen another provider for her follow-up appointment related to her DVT on 08/15/18.
-She was aware that she was prescribed Xarelto 15mg and observed that Resident #1 was "doing much better and in no pain."
-She was not aware that Resident #1 had 17 Xarelto pills remaining from her 42-pill supply that she should have completed.
-She was not concerned with the 17 remaining pills of Xarelto as she had seen Resident #1 on 08/23/18.
-Her encounter with Resident #1 on 08/23/18 did not lead her to believe that the resident was at risk not currently being on Xarelto or if she had missed some administrations since the resident had no pain" but it was "better to have [Xarelto] on board."

Interview with the Administrator and Resident Care Coordinator (RCC) on 08/29/18 at 2:45pm revealed:
-The RCC took Resident #1 to the emergency room on 07/31/18 and received "maybe 7 starter pills" of Xarelto pills to get the resident started that day after the DVT diagnosis and doctor

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D 358	Continued From page 18 order. -There should not have been an overage of pills on hand and the medication cards shouldn't contain 17 pills. -The 17 pills remaining in the cards and the starter pills given at the emergency department would make it 10 pills not given. -They had no explanation why there were 8 omissions in the MAR for administrations. -They could not explain why "10 or 17 pills" did not match the 8 omissions on the MAR. -"There should be 7 pills overage at best if stopped after 21 days when you include the emergency department starter pills." -The pharmacy delivered the medication cards with 42 pills of Xarelto on 08/01/18. -They would retrain MAs to document medication administrations properly as well as ensuring refusals were documented accordingly. -Resident #1 had never refused her medications since admission to the facility. -They could not explain why the MAR and the medications on hand did not match. The failure of the facility to administer medications as ordered, related to Xarelto for Resident #1 who had a diagnosis of a DVT placed her at risk for increased risk of for clotting, which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/29/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 10/14/18.	D 358		

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D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to medication administration and medication orders. The findings are: 1) Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 1 of 1 sampled residents (#1) regarding an order for a blood thinning medication. [Refer to Tag 344 10A NCAC 13F .1002(a) (Type B Violation)] 2) Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #1) regarding an order for a blood thinning medication for clot prevention. [Refer to Tag 358 10A NCAC 13F .1004(a) (Type B Violation)]	D912		