STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL051062	B. WING		R 07/24/2019
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 0==0.10
01.40010	CARE HOMEO #4		PARKER CIR		
CLASSIC	CARE HOMES # 1	SMITHFIEI	_D, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
{D 000}	Initial Comments		{D 000}		
		sure Section conducted a uly 22, 2019 - July 24, 2019.			
{D 273}	10A NCAC 13F .0902	(b) Health Care	{D 273}		
		Health Care assure referral and follow-up ad acute health care needs			
	interviews, the facility care provider (PCP) for (#1) that an anti-flamm	record reviews, and failed to notify the primary or 1 of 3 sampled residents matory medication was not red; and to arrange home bund care for one of 3			
	The findings are:				
	06/03/19 revealed: -Diagnoses included of constipation, insomnia disease, vitamin D de pulmonary disease, macute pain, nausea, obipolar disorder, hype heartburn, chronic pageneralized arthritis a	dementia, hypertension a, gastroesophageal reflux ficiency, chronic obstructive najor depressive disorder, ther seasonal allergies, ircholesterolemia, anxiety, in syndrome, throat pain, nd fibromyalgia.			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of	<u>of Health Service Regu</u>	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					_D	
		HAL051062	B. WING		R	
		HAL051062			07124	4/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
01.40010	0.155.1101150.11.4	101 ANNIE	PARKER CIRC	CLE		
CLASSIC	CARE HOMES # 1	SMITHFIE	LD, NC 27577			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ı	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
			1	DEFICIENCY)		
{D 273}	Continued From page	e 1	{D 273}			
, ,			'			
	late a decreate Decide					
		nt #2 on 07/23/19 at 11:29				
	revealed:	-t the level amount on a				
		at the local emergency une 2019 for an injury that				
	occurred to her leg.	ane 2019 for an injury triat				
	•	nind her roommate helping				
	her to propel her whe					
		tank that she was pushing				
	along with her.	tank that she was pashing				
	~	pped abruptly in front of her				
		nich caused her to bump her				
		n cylinder valve and injured				
	her right leg.					
		and required stitches for				
	the wound.	•				
	-She did not remembe	er a nurse coming out to see				
	her for the care of the	wound to her leg.				
	-The primary care pro	ovider (PCP) removed the				
	stitches at the facility.					
		s far as she knew without				
	any problems.					
	-She was currently re	•				
		therapy but because of leg				
	pain her therapy was	on hold.				
	Daview of an Aften Vie	oit Community from a local ED				
		sit Summary from a local ED				
	for Resident #2 dated					
	diagnosed with an op	en for a leg laceration and				
		return to the ED for suture				
		rom the injury or follow-up				
	with the PCP for remo					
	with the FCF IOI 181110	Jvai.				
	Review of a physician	n's order written by Resident				
		cian Visit Summary" dated				
		ere was an order to start				
	skilled nursing for righ					

Telephone interview with the Assistant Clinical

STATE FORM 6899 C4TS12 If continuation sheet 2 of 62

HAL051062 B. WING 07/24/2	/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
CLASSIC CARE HOMES # 1 101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(D 273) Continued From page 2 Director with Resident #2's home health agency on 07724/19 at 8:36am revealed: -The resident had received services from the agency off and on since 2018. -A referral came into the office on 06/17/19 for physical therapy, occupational therapy and speech therapy but skilled nursing was not included on the referral. -There had been no referrals made for skilled nursing for a right leg wound on or around 06/24/19. Telephone interview with Resident #2's PCP on 07/24/19 at 4:48pm revealed: -She was not aware skilled nursing was never contacted for the care of Resident #2's leg wound, but she removed the stitches from Resident #2's leg wound, but she removed the stitches from Resident #2's leg wound earlier this month (July 2019). -She would have expected the facility staff to have contacted a home health agency for skilled nursing services for monitoring and care of the resident's leg wound at the time the order was written. -It was the responsibility of the facility to contact with home health agencies when a referral order was given. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 5:20pm and 6:00pm revealed: -She was not aware of a referral for Resident #2 to receive skilled nursing services for Resident #2 sleg wound from June 2019. -She was responsible for processing residents' orders and referrals. -Resident #2 had stitches so she could not understand why the resident would have needed a nurse for wound care.	

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STATE FORM 6899 C4TS12 If continuation sheet 3 of 62

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL051062	B. WING		R 07/24/2019
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA		
CLASSIC	CARE HOMES # 1		PARKER CIRC D, NC 27577	CLE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
	07/24/19 at 6:00pm re-She was not aware on nursing for Resident 7-She expected for all processed and comple RCC. 2. Review of Residen 06/17/19 revealed dia hypertension, diabete leg syndrome (RLS), suprapubic catheter, 3-The resident was into	of referral order for skilled #2. residents' orders to be leted as ordered by the at #1's current FL-2 dated agnoses included anxiety, as mellitus type II, restless neurogenic bladder,			
	with bathing and dres -The resident was set -The resident had an Review of a hospital of the control of the co	ssing. mi-ambulatory. indwelling catheter. Visit Summary dated t#1 revealed there was a Prednisone 20 mg tablets ng) two times a day for three structive pulmonary disease is a medication used to on and help people recover 119 Medication d (MAR) for Resident #1 n entry for Prednisone nistered at 8:00am and ing days, 07/12/19, 07/13/19,			
	-The ED had a syster	m in place where the MAs ication administration and			

Division of Health Service Regulation

STATE FORM 6899 C4TS12 If continuation sheet 4 of 62

Division o	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					R	
		HAL051062	B. WING		1	4/2019
NAME OF D		CTREET AR	DDECC CITY CTA	TE 7/D CODE	<u> </u>	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
CLASSIC	CARE HOMES # 1		E PARKER CIR	CLE		
		SMITHFIE	LD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
{D 273}	Continued From page	; 4	{D 273}			
	-The ED terminated a when informed by and that the entire Prednisto Resident #1The MA observed the Prednisone was a however; she observed Prednisone, was still -The ED received a p for Resident #1 and the message from the MA-The primary care prothat Resident #1 did reprednisone, no additi provided. Telephone Interview on 07/24/19 on 04:48-She had not been not Resident #1 did not reordered PrednisoneThe PCP's expectation should have notified the receive the Prednisor all medications should orderedThere was the possill due to the facility's fair received the Prednisor continuation of breath shortness of breath on hospitalThe PCP was aware hospitalized from 07/0 exacerbation of COPI.	present in the blister pack. icture of the July 2019 MAR the Prednisone pack via text A. byider (PCP) was not notified not receive a dose of onal information was with the PCP for Resident #1 pm revealed: btified by the facility that exceive a 40 mg dose of her ons were the facility staff the ordered on 07/11/19 and d be administered as bility of negative outcomes fillure to assure Resident #1 one as ordered, including the ning problems such as r a re-admission to the that Resident #1 was 09/19-07/11/19 for an				
	4:30pm revealed:					

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-Her expectations were to assure the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL051062	B. WING		07/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	
TO WILL OF TH	TO VIDER OR OUT FEEL		E PARKER CIR		
CLASSIC	CARE HOMES # 1		LD, NC 27577		
0(1) 15	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	M (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(-,
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
{D 273}	Continued From page	e 5	{D 273}		
	administration of med	lications by staff in			
	accordance with PCF				
		the facility staff were to			
		right resident, right route,			
		quency, right site, right drug,			
	and right time.				
	-She also expected the	ne MAs to communicate any			
	medication changes v	with the RCC.			
D 296		(c)(7) Nutrition And Food	D 296		
	Service				
	104 NCAC 12E 000/	Nutrition And Food Service			
	(c) Menus in Adult Ca				
	• •	nave a matching therapeutic			
		sician-ordered therapeutic			
	diets for guidance of				
	3				
	This Rule is not met	Ţ.			
		ns, interviews and record			
	-	illed to have matching			
		r food service guidance for 2			
	•	ts with physician orders for a			
	-	nsistent carbohydrate diet			
	(#4).	trated sweets (NCS) diet			
	$(\pi + 1)$.				
	The findings are:				
	J				
		t #1's current FL-2 dated			
	06/17/19 revealed:				
		anxiety, hypertension,			
		e II, restless leg syndrome			
	· · · · · · · · · · · · · · · · · · ·	adder, suprapubic catheter,			
	and hip pain.				
		ermittently disoriented.			
	-ı nere was an order	for a low salt, diabetic diet.	1		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPLETED	
						
		HAL051062	B. WING		R 07/24/2019	
		HALUS 1002			07/24/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		E PARKER CIRC	CLE		
		SMITHFIE	LD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 296	Continued From page	e 6	D 296			
	Resident #1 dated 07 -There were diet instrand consistent carbot-Resident #1's hemogresult was elevated at 4-5.6%) which meant well controlled; it was healthy diet. (A hemodetermine the control levels over a 3 month -There was an order to dosage to 1000 mg two	uctions for a heart healthy hydrate diet. globin A1C laboratory (lab) t 8% (Reference range is her diabetes had not been important to maintain a globin A1C is a blood test to and average of blood sugar period).				
	a while" and all of a s -Staff checked her fin- "about every morning	but it wasn't on the book for udden diabetes "pops up". gerstick blood sugar (FSBS)				
	Resident#1 revealed: -There was a FSBS re -There was a FSBS re -There was a FSBS re	gar Monitoring document for esult of 130 on 07/02/19. esult of 153 on 07/09/19. esult of 121 on 07/16/19. esult of 137 on 07/23/19.				
	· ·	tic diet list posted in the aled Resident #1 was on an				
	posted in the dining re	"Week 1, Monday" form noom revealed: isted of 1 cup of chili with a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
,		152.1111.107.11.1011.110.1152.11	A. BUILDING: _	A. BUILDING:		
		HAL051062	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
CI ASSIC	CARE HOMES # 1	101 ANNI	E PARKER CIR	CLE		
		SMITHFIE	LD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPL	.ETE
D 296	Continued From page	e 7	D 296			
	cornbread muffin, 1 c tablespoons of dressi congealed salad with	up of side salad, 2 ng and pineapple in a				
	beans, one cornbread with dressing with 2 ½ dressing, ¾ cup pines	- 12:28pm revealed: ved one cup of chili with d muffin, one cup of salad ½ tablespoons of ranch apple in a red colored water and 16 ounces of tea.				
	aide (MA/PCA) that s meal on 07/22/19 at 1 -Resident #1 was a d diet. -The residents' meals building and brought	dication aide/personal care erved Resident #1 the lunch 12:24pm revealed: iabetic and on a diabetic were prepared in another over in large containers. lents' food prior to serving.				
	Tuesday" form posted revealed: -The lunch meal considered ham, ½ cup of of baked apples and a-The menu was not lated. Observation of the lung 07/23/19 at 12:23pm. Resident #1 was ser ½ cup of scalloped posted apples with cinnamor resident #1 ate apple.	sisted of 2-3 ounces of scalloped potatoes, ½ cup a roll. abeled for a specific diet. ach meal service on - 1230pm revealed: ved 2 round pieces of ham, otatoes, and ½ cup of baked an, unsweet tea and water. roximately 90% of her meal.				
	Interview with the coor revealed:	ok on 07/23/19 at 1:20pm				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		7202		R		
		HAL051062	B. WING		07/24/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		IE PARKER CIR ELD, NC 27577	CLE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 296	Continued From page	e 8	D 296	,		
	guide her when she vides Resident #1. -When she prepared serve no sweets, sugthat". Telephone interview vider (PCP) or revealed: -It was important for Fordered diet. -Resident #1 was on and if the diet was no was a potential the rebe elevated. -If the resident's blood because of a diet ord have potentially led to control the elevated by the side of the resident was a potentially led to control the elevated by the side of the resident's blood because of a diet ord have potentially led to control the elevated by the side of t	merapeutic diet menu to vas preparing meals for diabetic meals, she would ar free foods, "stuff like with Resident #1's primary on 07/24/19 at 4:48pm Resident #1 to follow the a diet to control diabetes t followed as ordered there esident's blood sugars would disugars were elevated er not followed then it could of medication adjustments to				
	Refer to the interview (ED) on 07/22/19 at 1					
	Refer to the interview at 12:52pm.	with the cook on 07/22/19				
	Refer to a second into 07/22/19 at 1:00pm.	erview with the cook on				
	Refer to the interview at 1:20pm.	with the cook on 07/23/19				
	Refer to the telephone Registered Dietician (10:25am.					

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DIVISION	or riealin Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED
				F	₹	
		HAL051062	B. WING			24/2019
NAME OF D	DOVIDED OD CUDDUED	OTDEET AD	DDECC CITY CTA	ATE ZID CODE	•	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	*		
CLASSIC	CARE HOMES # 1		E PARKER CIR	CLE		
			LD, NC 27577	_		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR		DATE
				DEFICIENCY)		
D 296	Continued From page	9	D 296			
	Refer to the interview	with the ED on 07/24/19 at				
	10:36am and 4:25pm					
	2. Review of Residen 02/20/19 revealed:	t #4's current FL-2 dated				
	-Diagnoses included	schizonhrenia				
		ension, diabetes mellitus				
		ciency, gastroesophageal				
	reflux disease, reflux	esophagitis and allergic				
	rhinitis.					
	-There was an order f sweets (NCS) diet.	ior a no concentrated				
	-There was an order t	to check fingerstick blood				
	sugars (FSBS) weekl	y.				
	Interview with Reside 12:22pm revealed:	nt #4 on 07/22/19 at				
	-She was a diabetic.					
		in and Insulin at one time				
		ake either one of those				
	medications. (Metforn					
	medications used for	diabetics to treat and				
	control high blood sug	• •				
		ic diet to control her blood				
	sugar levels.					
	Review of therapeutic	diet list posted in the				
	-	aled Resident #4 was on an				
	NCS diet.					
		' "Week 1, Monday" form				
	posted in the dining ro					
		sisted of 1 cup of chili with a				
	cornbread muffin, 1 c					
	I	ing and pineapple in a				
	congealed salad with	cool wrip. abeled for a specific diet.				
		ibolog for a specific dict.				
	Observation of the lur	nch meal service on				

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07/22/19 at 12:05pm revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		HAL051062	B. WING		07/24/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CI ASSIC	CARE HOMES # 1	101 ANNI	E PARKER CIRC	CLE		
		SMITHFIE	LD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 296	Continued From page	e 10	D 296			
	-Resident #4 was serbeans, one combread with dressing with 2 ½ dressing, ¾ cup pine gelatin, 12 ounces of unsweet teaResident #4 ate apprenal and ate 100 per served. Interview with the MA #4 the lunch meal on revealed: -She knew Resident a diabetic diet.	ved one cup of chili with d muffin, one cup of salad 2 tablespoons of ranch sapple in a red colored water and 16 ounces of roximately 95 percent of the cent of the gelatin and fruit VPCA that served Resident 07/22/19 at 12:24pm				
	building and brought -Staff plated the resid	were prepared in another over in large containers. lents' food prior to serving.				
	Tuesday" form posted revealed: -The lunch meal cons baked ham, ½ cup of of baked apples and	d in the dining room sisted of 2-3 ounces of scalloped potatoes, ½ cup				
	½ cup of scalloped po apples with cinnamor -Resident #4 ate all h slices of ham.	- 1230pm revealed: ved 2 round pieces of ham, ptatoes, and ½ cup of baked n, unsweet tea and water. er food except for the 2				
	form revealed there w resident's FSBS was	4's "Blood Sugar Monitoring" vas documentation the 135mg/dl on 07/03/19, and 144mg/dl on 07/24/19				

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, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING		R 07/24/2019		
NAME OF D		HAL051062		TE 7/0 000E	07/24/2019	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
CLASSIC	CARE HOMES # 1		ELD, NC 27577	<u></u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE	
D 296	Continued From page	e 11	D 296			
	revealed: -Resident #4 was a d -She did not have a th guide her when she w Resident #4 -When she prepared serve no sweets, sug that".	ok on 07/23/19 at 1:20pm iabetic. nerapeutic diet menu to vas preparing meals for diabetic meals, she would ar free foods, "stuff like				
	care provider (PCP) of revealed: -It was important for Fordered dietResident #4 was on and if the diet was no was a potential blood would be elevatedIf the resident's blood because an order was diabetic diet then it comedication adjustments.	Resident #4 to follow the a diet to control diabetes t followed as ordered there the resident's blood sugars d sugars were elevated s not followed for a specific ould have potentially led to ints to control the elevated ledication adjustments might				
	(ED) on 07/22/19 at 1	with the Executive Director 1:35am. with the cook on 07/22/19				
	Refer to a second into 07/22/19 at 1:00pm.	erview with the cook on				
	Refer to the interview at 1:20pm.	with the cook on 07/23/19				
	Refer to the telephone	e interview with the				

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Registered Dietician (RD) on 07/24/19 at

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING		R	,
HAL051062		B. WING		1	4/2019	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET AL		DRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		PARKER CIRC	CLE		
			LD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 296	Continued From page	e 12	D 296			
	10:25am.					
	Refer to the interview 10:36am and 4:25pm	with the ED on 07/24/19 at				
	07/22/19 at 11:35am -The facility currently menus prepared by a -She noticed when sh facility the foods on th menus every weekThe facility owner rec cycles for 3 weeks tha would be served durin serving size for each -She was planning to therapeutic diets from allow time to see which or disliked from the m purchasedShe had researched needed to be served	did not have any therapeutic registered dietician (RD). The first started working at the me menu were the same cently purchased menu at included what foods may each meal daily with the food to be served. The meet with the RD to request in the RD but was trying to ch foods the residents liked				
	revealed: -She had worked as t	the cook preparing the pproximately 2 weeks. en she cooked the				
	1:00pm revealed: -She did not have a the by in order to prepare	ven any specific instructions				

Division of Health Service Regulation

STATE FORM 6899 C4TS12 If continuation sheet 13 of 62

MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577 PROVIDERS PLAN OF CORRECTION PREFIX IS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG D 296 Continued From page 13 D 296 Continued From page 13 D 296 Continued From page 13 Interview with the cook on 07/23/19 at 1:20pm revealed: -She determined who was a diabetic and who was not when she prepared the residents' alganoses listed on the medication administration records (MARS)The Resident Care Coordinator (RCC) or the ED would let her know what dides the residents were ordered or when a diet changed; "whatever they tell Ime, that's what I do." -The ED had not given her any additional information on how to prepare therapeutic meals. Telephone interview with the RD on 07/24/19 at 10:25am revealed: -When she completed the menus for the previous ED, she thought there were no therapeutic diets for any of the residentsShe had spoken with the current ED yesterday, (07/23/19) who notified her that the facility needed a therapeutic diet for a NCS and a NAS dietShe sent the facility a rough draft copy of an NCS diet yesterday (07/23/19) to go by until she submitted a completed NCS menu spreadsheet.
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 ANNIE PARKER CIRCLE SUMMARY STATEMENT OF DEFICIENCIES WITHFIELD, NC. 27577 Oct. Interview In
CLASSIC CARE HOMES # 1 SUMMARY STATEMENT OF DEFICIENCIES MITHFIELD, NC 27577 CALL CALL
(A4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 296 Continued From page 13 Interview with the cook on 07/23/19 at 1:20pm revealed: -She determined who was a diabetic and who was not when she prepared the residents' meals by looking at the residents' diagnoses listed on the medication administration records (MARS)The Resident Care Coordinator (RCC) or the ED would let her know what diets the residents were ordered or when a diet changed; "whatever they tell me, that's what I do." -The ED had not given her any additional information on how to prepare therapeutic meals. Telephone interview with the RD on 07/24/19 at 10:25am revealed: -When she completed the menus for the previous ED, she thought there were no therapeutic diets for any of the residentsShe had spoken with the current ED yesterday, (07/23/19) who notified her that the facility needed a therapeutic for a NCS and a NAS dietShe sent the facility a rough draft copy of an NCS diet yesterday (07/23/19) to go by until she
CX4] ID PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDERS PLAN OF CORRECTION CACH DEFICIENCY
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 296 Continued From page 13 Interview with the cook on 07/23/19 at 1:20pm revealed: -She determined who was a diabetic and who was not when she prepared the residents' meals by looking at the residents' diagnoses listed on the medication administration records (MARS). -The Resident Care Coordinator (RCC) or the ED would let her know what diets the residents were ordered or when a diet changed; "whatever they tell me, that's what I do." -The ED had not given her any additional information on how to prepare therapeutic meals. Telephone interview with the RD on 07/24/19 at 10:25am revealed: -When she completed the menus for the previous ED, she thought there were no therapeutic diets for any of the residents. -She had spoken with the current ED yesterday, (077/23/19) who notified her that the facility needed a therapeutic diet for a NCS and a NAS diet. -She sent the facility a rough draft copy of an NCS diet yesterday (07/23/19) to go by until she
Interview with the cook on 07/23/19 at 1:20pm revealed: -She determined who was a diabetic and who was not when she prepared the residents' meals by looking at the residents' diagnoses listed on the medication administration records (MARS). -The Resident Care Coordinator (RCC) or the ED would let her know what diets the residents were ordered or when a diet changed; "whatever they tell me, that's what I do." -The ED had not given her any additional information on how to prepare therapeutic meals. Telephone interview with the RD on 07/24/19 at 10:25am revealed: -When she completed the menus for the previous ED, she thought there were no therapeutic diets for any of the residents. -She had spoken with the current ED yesterday, (07/23/19) who notified her that the facility needed a therapeutic diet for a NCS and a NAS diet. -She sent the facility a rough draft copy of an NCS diet yesterday (07/23/19) to go by until she
revealed: -She determined who was a diabetic and who was not when she prepared the residents' meals by looking at the residents' diagnoses listed on the medication administration records (MARS)The Resident Care Coordinator (RCC) or the ED would let her know what diets the residents were ordered or when a diet changed; "whatever they tell me, that's what I do." -The ED had not given her any additional information on how to prepare therapeutic meals. Telephone interview with the RD on 07/24/19 at 10:25am revealed: -When she completed the menus for the previous ED, she thought there were no therapeutic diets for any of the residentsShe had spoken with the current ED yesterday, (07/23/19) who notified her that the facility needed a therapeutic diet for a NCS and a NAS dietShe sent the facility a rough draft copy of an NCS diet yesterday (07/23/19) to go by until she
-She had concerns when too much starches were served to residents every dayShe had concerns when too many sweets and foods high in sugar content were served to residents which could raise the residents' blood sugar and make them more insulin resistant Salt intake was important for health reasons because increased salt intake could affect a resident by causing too much fluid which could lead to affecting the resident's heart and kidneys. Interview with the ED on 07/24/19 at 10:36am and 4:25pm revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL051062		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		B. WING		0.7	R / 24/2019	
NAME OF D				TE 71D 00DE	1 07	124/2019
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STAT E PARKER CIRC			
CLASSIC	CARE HOMES # 1		ELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 296	the diet orderedShe was aware a the required for each diet -She had obtained a the RD for an NCS di to follow and had met therapeutic diet menu-She was planning to diets for all the reside	apeutic diet that a eet was needed by a RD for erapeutic menu by a RD was coffered at the facility. therapeutic diet menu from et for the cook on 07/23/19 the with the cook about the u received from the RD. have the PCP review the ents.	D 296			
{D 310}	Service 10A NCAC 13F .0904 (e) Therapeutic Diets (4) All therapeutic die supplements and thic served as ordered by This Rule is not met Based on observation reviews, the facility fa diets were served as sampled who was dia mellitus type 2 and ha no concentrated swee The findings are: Review of Resident # 02/20/19 revealed: -Diagnoses included hypoglycemia. hypert type 2, vitamin D defi	ns, interviews and record illed to assure therapeutic ordered for 1 of 3 residents agnosed with diabetes ad a physician's orders for a lets (NCS) diet (#4).	{D 310}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL051062		B. WING		R
		HAL051062	b. WINO		07/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CLASSIC CARE HOMES # 1		PARKER CIRC	CLE		
	SMITHFIEL		_D, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
{D 310}	Continued From page	: 15	{D 310}		
	sugars (FSBS) weekl				
	Interview with Reside 12:22pm revealed: -She was a diabetic.	nt #4 on 07/22/19 at			
	-She was on Metform	in and Insulin at one time			
	•	ake either one of those			
	medications. (Metformin and insulin are medications used for diabetics to treat and				
	control high blood sugars).				
	-She was on a diabet sugar levels.	ic diet to control her blood			
		diet list posted in the aled Resident #4 was on an			
	posted in the dining re- The lunch meal cons cornbread muffin, 1 c tablespoons of dressi	isted of 1 cup of chili, a up of side salad, 2 ng and pineapple in a cool whip (no serving size			
	beans, one cornbread with dressing with 2 ½ dressing, ¾ cup pines gelatin, 12 ounces of unsweet tea. -Resident #4 ate appr	revealed: ved one cup of chili with d muffin, one cup of salad ½ tablespoons of ranch			

served.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	DENTILICATION NUMBER.		A. BUILDING: _		COWIFLET	ED
HAL051062		B. WING		R 07/24/	2019	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET AI		DRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		E PARKER CIR	CLE		
	SMITHFIEI		LD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{D 310}	Continued From page	e 16	{D 310}			
	Interview with Reside 12:22pm revealed sh because it made her	e could not drink sweet tea				
	10:36am revealed the					
	aide (MA/PCA) that s meal on 07/22/19 at 1 -She knew Resident 3 diabetic diet. -The residents' meals building and brought	#4 was a diabetic and on a s were prepared in another over in large containers and ted the residents' food prior				
	revealed: -She had worked as t residents' meals for a -The residents were s flavored gelatin today mealShe had already disp	the cook preparing the approximately 2 weeks. Served cherry or strawberry (07/22/19) for the lunch coosed of the box of gelatin act" kind in a different flavor lunch meal today,				
	the lunch meal on 07There were no artific fructose corn syrupIn the labeled ingred listed ingredient.	or the gelatin served during /22/19 revealed: cial sweeteners and no high ients, sugar was the first of sugar in a ½ cup serving.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE S COMPLI		
	HAL051062		B. WING		R 07/2	4/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
CLASSIC CARE HOMES # 1		E PARKER CIR	CLE			
OLAGOIO	SMITHFIEL		LD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 310}	Continued From page	e 17	{D 310}			
	1:00pm revealed: -She thought no high labeled information or there was no added s serve to a diabetic resultation of the serve to a diabetic resultation. She did not notice suingredient in the gelation during the lunch meal she thought the labe gelatin box meant the she had not noticed that sugar was the firsultation. She did not have a the by in order to prepare she had not been given guidelines from the prepare the residents. A NCS diet meant she the food. Review of the Review Tuesday" form posted revealed: -The lunch meal considered ham, ½ cup of of baked apples and and another the she that the food. Observation of the lunch for the lunch meal considered apples and another the she food.	ingar was the first labeled in served to the residents' on 07/22/19. Ided information on the gelatin was sugar free. In the ingredients section in the ingredient listed. In the residents meals. In the residents meals. It is well as the would not add sugar to the would not add sugar to the would not add sugar to the interest of 2-3 ounces of scalloped potatoes, ½ cup a roll. In the dining room the would not specific diet. The meal service on the service on the scalloped potatoes, and of baked apples with				

Division of Health Service Regulation

Review of Resident #4's "Blood Sugar Monitoring"

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Division c	<u>of Health Service Regu</u>	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					R	,
		HAL051062	B. WING		1	4/2019
		11/42001002			0112	4/2013
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
CLASSIC CARE HOMES # 1		E PARKER CIRC	CLE			
CLASSIC	SMITHFIEL		LD, NC 27577			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	KEGULATURT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DAIL
			+ +			
{D 310}	Continued From page	e 18	{D 310}			
	form revealed there v	vas documentation the				
		135mg/dl on 07/03/19,				ı
		9 and 144mg/dl on 07/24/19.				ı
		7 and 1				
	Interview with the coo	ok on 07/23/19 at 1:20pm				
	revealed:					ı .
	-Resident #4 was a d	iabetic.				ı
		Resident #4's meals, she				ı .
		ts, sugar free foods, "stuff				ı
	like that".					ı
		posed of the can of apples				ı
		esidents' lunch meal today.				
		anned in light syrup would be				ı
		ident #4, but she would not				
	•	ruits canned in heavy syrup.				ı
		was a diabetic and who				ı
	I	epared the residents' meals dents' diagnoses listed on				ı
		nistration records (MARS).				1
		Coordinator (RCC) or the ED				1
		hat diets the residents were				1
		et changed; "whatever they				1
	tell me, that's what I o					1
		en her any information on				1
		re for residents on a NCS				1
	diet.					I
						I
		with the Registered Dietician				1
	(RD) on 07/24/19 at 1					1
		d the menus for the previous				1
		e were no therapeutic diets				1
	for any of the residen					1
		n the current ED yesterday,				1
	(07/23/19) who notifie	ed her that the facility diet for a NCS and a NAS				1
	diet.	diet for a NCS and a NAS				1
		a rough draft copy of an				1
	_	07/23/19) to go by until she				1
	,	ed NCS menu spreadsheet.				1
Į.	, oabiiiittea a complete	a 1100 mona oproadonoci.				ı

-She had concerns when too much starches were

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL051062		B. WING		R 07/24/2019
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 0772-472013
CLASSIC CARE HOMES # 1		PARKER CIRC	CLE		
		SMITHFIEL	.D, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 310}	Continued From page	2 19	{D 310}		
	served to residents even She had concerns whoods high in sugar concerns which could sugar and make them. Telephone interview who care provider (PCP) or revealed: Resident #4 was on and if the diet was now was a potential blood would be elevated. If the resident's blood because an order was diabetic diet then it comedication adjustments.	hen too many sweets and ontent were served to raise the residents' blood in more insulin resistant. with Resident #4's primary on 07/24/19 at 4:48pm a diet to control diabetes it followed as ordered there the resident's blood sugars in diagrams were elevated is not followed for a specific buld have potentially led to ents to control the elevated edication adjustments might			
	and 4:25pm revealed -She was aware when therapeutic diet that a was needed by a RD -She was aware a the required for each diet -She had obtained a the RD for an NCS di	n a PCP ordered a therapeutic spreadsheet for the diet ordered. erapeutic menu by a RD was			
{D 358}	10A NCAC 13F .1004 Administration	e(a) Medication	{D 358}		
	(a) An adult care hor preparation and admi	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL051062 B. V		B. WING		R 07/24/2019
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
CLASSIC	CARE HOMES # 1		PARKER CIRC	CLE	
			.D, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	20	{D 358}		
	which are maintained	ance with: ned prescribing practitioner in the resident's record; and on and the facility's policies			
	This Rule is not met a	as evidenced by:			
	reviews, the facility fa medications as ordered the facility's policies for (#1, #2, #3) including #3); narcotics and a s	ed and in accordance with or 3 of 3 residents sampled errors with inhalers (#1, #2,			
	The findings are:				
	06/03/19 revealed dia hypertension constipa gastroesophageal refl deficiency, chronic ob (COPD), major depre- nausea, other season disorder, hypercholes	ux disease, vitamin D structive pulmonary disease ssive disorder, acute pain, al allergies, bipolar terolemia, anxiety, in syndrome, throat pain,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		1141 054000	B WING		R	
		HAL051062	b. WING		07/24	1/2019
		DRESS, CITY, STA				
CLASSIC	CARE HOMES # 1		E PARKER CIRO LD, NC 27577	CLE		
240.45	OUR MARRY OTATEMENT OF RESIDIENCIES		<u> </u>	DDOVIDED'S DI ANI OF CORDECTION		0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	21	{D 358}			
{U 358}	Interview with the Exe 07/23/19 at 9:40am re- The resident had bee rehabilitation center. The resident was addrehabilitation center the analysis of Resident 06/03/19 revealed an inhale daily. (Spiriva i used to control and proposed to control and	ecutive Director (ED) on evealed: en an inpatient at a local mitted to the facility from the ne first of June 2019. It #2's current FL-2 dated order for Spiriva 18mcg s an inhaled medication revent symptoms of of breath caused by ongoing COPD). e Summary from a local #2 revealed: mitted from 06/14/19 to arge diagnosis was left lower wed. mitted with acute on chronic boxygen in the blood) and and ry failure (a condition that brough the body, which en gets in and less carbon andary to acute chronic y disease exacerbation er lobe gram negative on Release form for #04/19 from a local evealed: Dispense" 30 day supply of	{U 358}			
	-Spiriva 18mcg was n listed.	ot one of the medications member signed the form on				
	06/04/19.	-				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPL	ETED	
			B. WING		F	
		HAL051062	b. WING		07/2	24/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
CLASSIC	CARE HOMES # 1		E PARKER CIR	CLE		
			LD, NC 27577		_	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 22	{D 358}			
	Review of Resident #	2's June 2019 medication				
	administration record					
		itten entry for Spiriva 18mcg				
		e contents of one capsule once daily with a scheduled				
	administration time of	•				
	-There was no docum	•				
		5/19, 06/06/19, 06/08/19,				
		and 06/13/19 at 8:00am.				
	-There was a posted note over the administration dates for Spiriva from 06/24/19-06/31/19 with a					
	handwritten entry "awaiting verification, don't					
	sign" at 8:00am.					
		round the medication aides'				
	(MAS') initials for the a	administration of Spiriva on				
		tation on the back of the				
		s "on order" on 06/11/19 at				
		r documentation regarding				
	the missed doses of Spiriva.					
	Review of Resident #	2's dispensing records				
		23/19 from the facility's				
		revealed there was a				
	filled on 07/01/19 and	supply of Spiriva 18 mcg				
		7 677 927 10.				
		ent #2's medications on				
		10:40am revealed Sprivia				
	_	with a pharmacy dispensing 9 for a total of 30 doses.				
	Interview with Reside 11:09am revealed:	nt #2 on 07/23/19 at				
	-She wore oxygen at	all times.				
		eathe at times especially				
	when doing tasks.					
	-Shortness of breathe	e was "just one" of her				1

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biggest problems.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAI 054063				R	
	HAL051062		B. WING		1	4/2019
NAME OF PROVIDER OR SUPPLIER STREET AD			DRESS, CITY, STA	TE, ZIP CODE		
CLASSIC CARE HOMES # 1		PARKER CIRC	CLE			
			LD, NC 27577	DDOWNERIO DI ANI OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ALEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	23	{D 358}			
	(RCC) on 07/23/19 at 5:20pm revealed: -The posted note over for Spiriva from 06/24 handwritten entry "aw sign" at 8:00am was executive Director (E-She could not explair placed over the the disprivation not to be admistered for the could not explair documentation Residual administered for the could not be admistered for the could not be administered (PCP) or revealed: -She had not been not revealed: -There was ordered COPDHer expectations we have notified her that received Sprivia and be administered as ordered as of the could be administered as ordered and the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medication included breathing provided to the staff's failureceived her medi	vaiting verification, don't done by the previous D). In why there was a note ates for Resident #2's inistered. In why there was no ent #2's Sprivia was not dates in June 2019 because as the RCC in June 2019. With Resident #2's primary on 07/24/19 on 04:48 pm Diffied by the facility staff that eccive doses of her Sprivia to control the resident's The facility staff should Resident #2 had not that all medications should redered. Dility of negative outcomes are to assure Resident #2 ions as ordered which oblems, exacerbation of the hospitalizations. Il staff interview.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _	A. BUILDING:	
		HAL051062	B. WING		R 07/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		101 ANNI	E PARKER CIRC	CLE	
CLASSIC	CARE HOMES # 1		LD, NC 27577		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
{D 358}	Continued From page	24	{D 358}		
	Refer to the interview at 3:16pm and on 07/	with the RCC on 07/23/19 24/19 at 5:20pm.			
	Refer to the interview 4:30pm.	with the ED on 07/24/19 at			
	06/03/19 revealed an with Lidocaine 4% ap shoulder, right knee, to 10:00am and remove				
	the medications listed -Salonpas Patch with with "#3" written besid	/04/19 from a local evealed: 'Dispense" 30 day supply of I. Lidocaine 4% was listed			
	administration record -There was a handwripatch with Lidocaine a shoulder, right knee, is remove at 8:00pm with administration time of 8:00pm to removeThere was no docum removed on 06/09/19 -There was a circle at (MAs') initials for Salo 4% on 06/08/19 at 8:00am, 06/11/19	atten entry for Salonpas 4% apply one patch to right right hip daily at 8:00am and th a scheduled 8:00am to apply and entation Salonpas was at 8:00pm. Found the medication aides' enpas patch with Lidocaine enpatch with Lidocaine enpatch at 8:00pm, 06/10/19 06/12/19 at 8:00am and 8:00am, 06/20/19 at 8:00pm,			

Division of Health Service Regulation

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		HAL051062	B. WING		R 07/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CLASSIC	CARE HOMES # 1		PARKER CIRC	CLE	
			.D, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	25	{D 358}		
	dates for Salonpas pa 06/24/19-06/31/19 wit "awaiting verification, 8:00pm. -There was document MAR for that the Salo 8:00pm was "not avail 8:00pm "not available 8:00pm "not available 8:00pm "not available 8:00pm "not available 06/25/19 at 8:00pm a available, not given", available and an entry available".	tation on the back of the inpas patch on 06/26/19 at lable, not given", 06/11/19 at in, not done", 06/12/19 at in, not done", 06/20/19 at in, not given", 06/20/19 at in, not given", 06/21/19, and 06/19/19 at 8:00pm "not ithat Salonpas was not in on 06/13/19 "L. patch, not			
	Review of Resident #2's July 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Salonpas patch with Lidocaine 4% apply one patch to right shoulder, right knee, right hip daily at 10:00am and remove at 10:00pmThere was no documentation Salonpas was administered from 07/01/19 - 07/22/19 at 10:00am and removed at 10:00pm.				
	patch on nowThe pain patch was r Review of Resident # dated 06/01/19 - 07/2	r pain every day and had a removed at night. 2's dispensing records 3/19 from the facility's			
	contracted pharmacy quantity of a 30 day s patch filled on 06/05/	upply Salonpas Lidocaine			

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Observation of Resident #2's medications on

STATE FORM 6899 C4TS12 If continuation sheet 26 of 62

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL051062	B. WING		07/24/2019	
		HALUS 1002			U//24/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
21 1 2 2 1 2		101 ANNI	E PARKER CIRC	CLE		
CLASSIC	CARE HOMES # 1	SMITHFIE	LD, NC 27577			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)	$\neg \neg$
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLE	ETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE DATE	·
				DEL TOLETO I		\longrightarrow
{D 358}	Continued From page	e 26	{D 358}			
	hand on 07/23/19 at 1	10:40am revealed Salonpas				
	Lidocaine 4% patch w	vas available with a				
	dispensing label date	ed 07/02/19 with a quantity of				
	30 dispensed.					
	Interview with the Re	sident Care Coordinator				
	(RCC) on 07/23/19 at	t 3:16pm revealed:				
	-She was not sure wh					
		lent #2's Salonpas had not				
		ut she knew the resident got				
	the patch today.	-				
		er the administration dates				
	Tell Tell	/24/19-06/30/19 with a				
	•	vaiting verification, don't				
	sign" at 8:00am was					
	Executive Director (E					
		n why the note was placed				
	there not to administe	•				
	Tolonhono interview v	with Resident #2's primary				
	I	on 07/24/19 on 04:48 pm				
	all medications as ord	ed facility staff to administer				
		Jereu.				
	Refer to a confidentia	ıl staff interview.				
	Refer to a interview w	vith the medication aide (MA)				
	on 07/23/19 at 10:30a	* ,				
	Refer to the interview	with the RCC on 07/23/19				
	at 3:16pm and on 07/	/24/19 at 5:20pm.				
		with the ED on 07/24/19 at				
	4:30pm.					
	c. Review of Residen	t #2's current FL-2 dated				
		order for Nystop 100,000				
		oply to abdominal fold and				
		imes a day. (Nystop is a				
		ication used to treat fungal				

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STATEMENT	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL051062	B. WING		R 07/24/2019
NAME OF D	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIR CODE	,
NAIVIE OF PI	ROVIDER OR SUPPLIER				
CLASSIC CARE HOMES # 1			ULE		
		SMITHFIEL	D, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	e 27	{D 358}		
	skin infections).				
	administration record -There was a handwr powder 100,000 units abdominal folds and u day with a scheduled 8:00am, 2:00pm and -There was no docum was administered on 2:00pm, 06/07/19, 06 06/12/19 at 2:00pm, 06 06/24/19 at 2:00pmThere was a circle at (MAs) initials for the a 6/23/19 - 06/24/19, 06 8:00pm.	itten entry for Nystop apply to areas under under breasts three times a administration time of 8:00pm. nentation Nystop powder 06/05/19 at 8:00am and /08/19, 06/10/19 and 06/13/19 at 2:00pm and /22/19, 06/23/19 and round the medication aides' administration of Nystop on 6/29/19 and 06/30/19 at			
		2's dispensing records			
		3/19 from the facility's			
	contracted pharmacy				
		upply of Nystop Powder on 06/04/19 and 07/02/19.			
	100,000 annugin inieu	on coron to and orrozrio.			
	hand on 07/23/19 at 2 powder was available	of 07/02/19 for a total of 30			
	care provider (PCP) of	vith Resident #2's primary on 07/24/19 on 04:48 pm d facility staff to administer dered.			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION (X3) DATE SURV NG:		
		HAL051062	B. WING		07	R 7/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CI VESIC	CARE HOMES # 1	101 ANN	IE PARKER CIRCL	E		
CLASSIC	CARE HOWES # 1	SMITHFI	ELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 28	{D 358}			
	Refer to a confidentia	al staff interview.				
	Refer to a interview v on 07/23/19 at 10:30	vith the medication aide (MA) am.				
		with the Resident Care n 07/23/19 at 3:16pm and on				
	Refer to the interview (ED) on 07/24/19 at 4	with the Executive Director 4:30pm.				
	06/03/19 revealed an	nt #2's current FL-2 dated n order for Lyrica 100mg one a day. (Lyrica is a pain reat nerve pain and				
	the medications listed	6/04/19 from a local revealed: "Dispense" 30 day supply of d. ocumented with "#31"				
	administration record -There was a handwr one capsule three tim administration time o 8:00pmThere was no docun administered on 06/0 8:00am and 2:00pm,	ritten entry for Lyrica 100mg hes a day with a scheduled f 8:00am, 2:00pm and hentation Lyrica was 16/19 at 2:00pm, 06/09/19 at and 06/12/19 at 2:00pm. hentation regarding the				
		#2's July 2019 MAR revealed: ritten entry for Lyrica 100mg				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL051062	B. WING		07/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CLASSIC	CARE HOMES # 1		PARKER CIR	CLE	
			_D, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	29	{D 358}		
	one capsule three timadministration time of 8:00pm. -There was no docum administered on 07/142:00pm. -There was no docum missed doses of Lyricon Review of Resident # dated 06/01/19 - 07/2 contracted pharmacy quantity of a 30 day son 07/02/19. Observation of Resident was available with a part date of 07/02/19 for a tablets remaining. Interview with Reside 10:55am revealed: -She took pain medications were taken as needed. She had pain due to painThe pain medications her pain some. Telephone interview was care provider (PCP) of the second provider (PCP) of	les a day with a scheduled 8:00am, 2:00pm and hentation Lyrica was 4/19 at 8:00am and at hentation regarding the factor of the facility's revealed there was a supply of Lyrica 100mg filled hent #2's medications on 10:40am revealed Lyrica charmacy dispensing label total of 90 doses with 89 ht #2 on 07/22/19 at ations that were scheduled ome pain medications that d. "Fibromylagia" and arthritic is she tool helped to control with Resident #2's primary on 07/24/19 on 04:48 pm d facility staff to administer dered.			
	Refer to a interview w	vith the medication aide (MA)			

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on 07/23/19 at 10:30am.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUF	
			A. BOILDING		R	
		HAL051062	B. WING		07/24/	/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1	101 ANNI	E PARKER CIR	CLE		
			LD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	÷ 30	{D 358}			
		with the Resident Care n 07/23/19 at 3:16pm an on				
	Refer to the interview (ED) on 07/24/19 at 4	with the Executive Director :30pm.				
	06/03/19 revealed an					
	the medications listed	/04/19 from a local evealed: 'Dispense" 30 day supply of I. documented with "#30"				
	administration record -There was a handwr mg take one tablet da administration time of -There was documen administered from on	itten entry for Protonix 40 hily with a scheduled 8:00am. tation Protonix 40 mg was 06/05/19 through 06/30/19 06/15/19 - 06/19/19 due to				
	-There was a handwr mg take one tablet da administration time of -There was no docum was administered on	8:00am. nentation Protonix 40 mg				

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missed dose of Protonix.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		
		HAL051062	B. WING		07	R // 24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	·	
CI ASSIC	CARE HOMES # 1	101 ANN	IIE PARKER CIRC	LE		
CLASSIC	CARL HOWLS # 1	SMITHFI	ELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 31	{D 358}			
	dated 06/01/19 - 07/2 contracted pharmacy quantity of a 30 day s filled on 07/02/19. Observation of Resident on 07/23/19 at 2 was available with a p	2's dispensing records 3/19 from the facility's revealed there was a supply of Protonix 40 mg ent #2's medications on 10:40am revealed Protonix charmacy dispensing label				
	with 16 tablets remain	dated 07/02/19 for a total of 30 doses dispensed with 16 tablets remaining. Telephone interview with Resident #2's primary				
	care provider (PCP) of	on 07/24/19 on 04:48 pm d facility staff to administer				
	Refer to a confidentia	I staff interview.				
	Refer to a interview w on 07/23/19 at 10:30a	vith the medication aide (MA) am.				
		with the Resident Care n 07/23/19 at 3:16pm and on				
	Refer to the interview (ED) on 07/24/19 at 4	with the Executive Director :30pm.				
	06/03/19 revealed an	#2's current FL-2 dated order for Fluticasone use stril daily. (Fluticasone is a seasonal allergies).				
	Review of a Medication Resident #2 dated 06 rehabilitation center real-There was an entry the medications listed	i/04/19 from a local evealed: 'Dispense" 30 day supply of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		TED
					R	.
		HAL051062	B. WING			4/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			PARKER CIRC			
CLASSIC	CARE HOMES # 1		D, NC 27577			
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 32	{D 358}			
	bottle" handwritten be	was documented with "1 eside the medication. member signed the form on				
	hospital for Resident	e Summary from a local #2 dated 06/19/19 revealed ne use one spray in each				
	hospital for Resident	e Summary from a local #2 dated 07/19/19 revealed isted with the discharge				
	administration record -There was a handwri mcg use one spray in scheduled administra -There was no docum administered on 06/10 -There was a circle ar (MAs) initials for the a 50 mcg on 06/11/19 a -There was a posted dates for Fluticasone 06/24/19-06/31/19 wit "awaiting verification, -There was document MAR that Fluticasone on 06/11/19 at 8:00ar	each nostril daily with a tion time of 8:00am. The tion fluticasone was 10/19 at 8:00am. The tion time of 8:00am. The tion fluticasone was 10/19 at 8:00am. The tion of fluticasone was 10/19 at 8:00am. The tion of the administration 150 mcg from 150 mcg				
	dated 06/01/19 - 07/2	2's dispensing records 4/19 from the facility's revealed Fluticasone 50 spensed.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		HAL051062	B. WING			4/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		PARKER CIRC	CLE		
			.D, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	33	{D 358}			
	hand on 07/23/19 at 7 Fluticasone 50 mcg w	/as not available.				
	(RCC) on 07/23/19 at -The posted note ove for Fluticasone 50 mo with a handwritten en don't sign" at 8:00am Executive Director (E	r the administration dates of from 06/24/19 - 06/30/19 try "awaiting verification, was done by the previous D). n why the note was placed				
	10:36am revealed: -Resident #2's primar the resident on 07/22 an order for no medic -She would clarify to	see if Resident #2 should casone 50 mcg use one				
	from the RCC with a Resident #2's PCP da	ent to Resident #2's PCP response back from ated 07/24/19 revealed the ed to be on Fluticasone.				
	(RCC) on 07/24/19 at responsible to review discharge summary a prescribing practitione or questions regardin discharge summary.	the residents' hospital ind contacted the er if there were any changes g a medication listed on the				
	Refer to a confidentia	I staff interview.				
	Refer to a interview won 07/23/19 at 10:30a	vith the medication aide (MA)				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL051062	B. WING		R 07/24/2019
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 0772-472013
		101 ANNIE	PARKER CIRC	CLE	
CLASSIC	CARE HOMES # 1	SMITHFIEL	D, NC 27577		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	e 34	{D 358}		
		with the Resident Care n 07/23/19 at 3:16pm an on			
	Refer to the interview (ED) on 07/24/19 at 4	with the Executive Director :30pm.			
	•	ation order for Resident #2 led an order for Colace 100 ce is a stool softener).			
		e Summary from a local #2 dated 06/19/19 revealed 00 mg twice daily.			
	by a prescribing pract	discharge summary signed titioner dated 07/19/19 ng was not listed with the s.			
	administration record -There was a handwr mg twice daily with a time of 8:00am and 8 -There was a circle at (MAs) initials for the a 100mg on 06/11/19, 0 06/22/19 - 06/24/19 a 06/26/19 and 06/28/1 -There was no docum	atten entry for Colace 100 scheduled administration :00pm. Tound the medication aides administration of Colace :06/12/19 at 8:00pm, t 8:00am, 06/25/19 - 9 at 8:00am and 8:00pm. The nentation Colace 100mg was 1/19- 06/13/19, 06/27/19			
	-There was documen MAR that Colace was on 06/11/19, 06/12/19 06/28/19.	tation on the back of the not "available, not given" 0, 06/25/19, 06/26/19 and documentation regarding			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL051062	B. WING		R 07/2	4/2019
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 0772	4/2019
CLASSIC	CARE HOMES # 1		PARKER CIRC	CLE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 35	{D 358}			
	Review of Resident # dated 06/01/19 - 07/2 contracted pharmacy had not been dispensed to be provided in the pr	2's dispensing records 4/19 from the facility's revealed Colace 100mg red. ent #2's medications on 10:40am revealed Colace able. sident Care Coordinator 10:36am revealed: y care provider (PCP) saw /19 for a follow up and wrote ration changes. see if Resident #2 should ce 100 mg twice daily. ent to Resident #2's PCP response back from reded 07/24/19 revealed the red to be on "Colace". sident Care Coordinator 10:36am she was the residents' hospital and contacted the er if there were any changes g a medication listed on the I staff interview. with the medication aide (MA) am.				
		with the Resident Care n 07/23/19 at 3:16pm an on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL051062	B. WING		R 07/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE	
CLASSIC	CARE HOMES # 1		PARKER CIRCLD, NC 27577	CLE	
0(0.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTI	ON OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
{D 358}	Continued From page	e 36	{D 358}		
	Refer to the interview with the Executive Director (ED) on 07/24/19 at 4:30pm.				
	06/03/19 revealed an 1.25mg every week of	t #2's current FL-2 dated order for Vitamin D2 n Fridays, then stop on 2 is a vitamin supplement).			
	the medications listed -Vitamin D2 1.25mg (documented with "#4 medication.	/04/19 from a local evealed: 'Dispense" 30 day supply of I.			
	hospital for Resident	e Summary from a local #2 dated 06/19/19 revealed 02 1.25mg 50,000 units			
	hospital for Resident	e Summary from a local #2 dated 07/19/19 revealed sted with the discharge			
	administration record -There was a handwr 1.25mg (50,000 units on Friday with a sche 8:00amThere was documen had been administere circle around the med on 06/28/19.	2's June 2019 medication (MAR) revealed: itten entry for Vitamin D2) one by mouth once a week duled administration time of tation Vitamin D2 1.25mg ed on 06/07/19, 06/21/19, a dication aide's (MA's) initials tation the resident was in			

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STATE FORM 6899 C4TS12 If continuation sheet 37 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL051062	B. WING		07	R / /24/2019
	ROVIDER OR SUPPLIER CARE HOMES # 1	101 ANI	ADDRESS, CITY, STAT NIE PARKER CIRC IELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{D 358}	administration record no entry for Vitamin E once a week. Review of Resident # dated 06/01/19 - 07/2 contracted pharmacy 1.25mg (50,000 units) Observation of Resident and on 07/23/19 at 2 D2 1.25mg (50,000 units) Interview with the Resident #2's primar the resident on 07/22 an order for no medically an order for no medically an order for no medically weekly. Review of an email set from the RCC with an Resident #2's PCP dates are sident was supposed. Interview with the Resident was supposed. Interview with the Resident was supposed.	2's July 2019 medication (MAR) revealed there was 02 1.25mg (50,000 units) 2's dispensing records 4/19 from the facility's revealed Vitamin D2) had not been dispensed. ent #2's medications on 10:40am revealed Vitamin nits) was not available. sident Care Coordinator 10:36am revealed: y care provider (PCP) saw /19 for a follow up and wrote lation changes. see if Resident #2 should nin D2 1.25mg (50,000 ent to Resident #2's PCP response back from lated 07/24/19 revealed the led to be on "Vitamin D". sident Care Coordinator 10:36am she was the residents' hospital and contacted the er if there were any changes g a medication listed on the	{D 358}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7.112 7 27.11	or dorate of the transfer of t	IDENTIFICATION NO.	A. BUILDING: _	A. BUILDING:		_0
		HAL051062	B. WING		R 07/24/2	2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		PARKER CIRC D, NC 27577	CLE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 38	{D 358}			
	Refer to a interview with the medication aide (MA) on 07/23/19 at 10:30am.					
		with the Resident Care n 07/23/19 at 3:16pm an on				
	Refer to the interview (ED) on 07/24/19 at 4	with the Executive Director :30pm.				
	06/03/19 revealed an Micronized 1 gram tal	ke one tablet daily d is a medication used to				
	Review of a Medication Release form for Resident #2 dated 06/04/19 from a local rehabilitation center revealed: -There was an entry "Dispense" 30 day supply of the medications listedColestipol Micronized 1gm was documented with "#14" handwritten beside the medicationResident #2's family member signed the form on 06/04/19.					
	hospital for Resident	e Summary from a local #2 dated 06/19/19 revealed ol Micronized 1gm daily.				
	by a prescribing pract	discharge summary signed titioner dated 07/19/19 licronized was not listed with tions,				
	administration record -There was a handwr	itten entry for Colestipol tablet daily with a scheduled				

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STATE FORM 6899 C4TS12 If continuation sheet 39 of 62

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL051062	B. WING		07	R //24/2019
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	, ,	72 11 20 10
			IE PARKER CIRCL	•		
CLASSIC	CARE HOMES # 1	SMITHFI	ELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page	39	{D 358}			
	dates for Colestipol N 06/24/19-06/30/19 with	note over the administration licronized 1gm from th a handwritten entry don't sign" at 8:00am.				
	administration record	2's July 2019 medication (MAR) revealed there was tipol Micronized 1gm one				
		•				
		ent #2's medications on 10:40am revealed Colestipol not available.				
	(RCC) on 07/23/19 at -The posted note ove for Colestipol Microni: 06/24/19-06/30/19 wi "awaiting verification, done by the previous	r the administration dates zed 1gm from th a handwritten entry don't sign" at 8:00am was Executive Director (ED). n why the note was placed				
	revealed: -Resident #2's primar the resident on 07/22 an order for no medic	see if Resident #2 should				
	from the RCC with a	ent to Resident #2's PCP response back from ated 07/24/19 revealed the				

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STATE FORM 6899 C4TS12 If continuation sheet 40 of 62

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					_R	
		HAL051062	B. WING		1	4/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE	•	
TO THE OT 1	NOVIBER OR OUT FEEL		PARKER CIRC			
CLASSIC	CARE HOMES # 1		D, NC 27577	JEE .		
	OLIMANA DV OT		·	PROMPERIO PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 40	{D 358}			
	resident was supposed to be on "Colestipol".					
		•				
		sident Care Coordinator				
	(RCC) on 07/24/19 at					
		the residents' hospital				
	discharge summary a	and contacted the er if there were any changes				
		g a medication listed on the				
	discharge summary.	g a medication listed on the				
	Refer to a confidentia	I staff interview.				
	Refer to a interview won 07/23/19 at 10:30a	vith the medication aide (MA) am.				
		with the Resident Care n 07/23/19 at 3:16pm an on				
	Refer to the interview (ED) on 07/24/19 at 4	with the Executive Director :30pm.				
	06/17/19 revealed dia	hip pain, and chronic				
	06/17/19 with the atta administration record for Incruse Ellipta 62. once daily in the morr	(MAR) revealed an order 5 mcg inhaler; inhale 1 puff ning. (Incruse Ellipta helps eathe better by relaxing ').				
	I	/25/19 revealed an order for				

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Incruse Ellipta 62.5 mcg inhaler; inhale 1 puff

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
						R
		HAL051062	B. WING		07	//24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
CLASSIC	CARE HOMES # 1	101 ANNI	E PARKER CIRCL	.E		
		SMITHFIE	ELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 41	{D 358}			
	once daily in the more	ning.				
		ade to the Executive 2/19, 07/23/19 and 07/24/19 019 MAR was not available				
	Review of Resident #1's June 2019 MAR revealed: -There was a computer printed entry for Incruse					
	Ellipta 62.5 mcg inhaler; inhale 1 puff once daily in the morning with a scheduled administration time of 8:00am.					
	(MA's) initials for Incr	round the medication aide's use Ellipta 62.5 mcg on 6/19/19, 06/27/19, and				
	-There was documen June 2019 MAR that was on order on 06/1	tation on the back of the the Incruse Ellipta 62.5 mcg 1/19, 06/16/19, 06/18/19 and ion was "on order", and				
	06/15/19 and 06/171 -There was no further	9 "not available, not given". r documentation regarding ncruse Ellipta 62.5 mcg.				
	Review of Resident #1's dispensing records dated 05/01/-07/24/19 from the facility's contracted pharmacy revealed Incruse Ellipta with a quantity a 30 day supply filled on 05/28/19 and 06/27/19.					
	hand on 07/23/19 at 7 Ellipta inhaler was av	ent #1's medications on 10:06 am revealed Incruse ailable with a pharmacy of 06/27/19 for a total of 30				
	(RCC) on 07/24/19 at	sident Care Coordinator : 05:20pm revealed she did I's primary care provider				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
					!	R
		HAL051062	B. WING		07/	24/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		101 ANNI	E PARKER CIR	CLE		
CLASSIC	CARE HOMES # 1	SMITHFIE	ELD, NC 27577			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHI		COMPLETE DATE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APF DEFICIENCY)	ROPRIATE	DATE
{D 358}	Continued From page	e 42	{D 358}			
	(PCP) that she had m	nissed 8 days of her inhaler				
	(Incruse) in June 201	9 because she did not work				
	at the facility at that ti	me.				
	Tolophono intonviou v	vith Resident #1's primary				
	-	on 07/24/19 on 04:48 pm				
	revealed:	511 6172 17 18 611 6 11 16 pm				
	-She had not been no	otified by the facility staff that				
		eceive 8 days of her Incruse				
	(inhaler).					
	•	re the facility staff should				
	have notified her that					
	should be administered	aler) and that all medications				
		scribed Incruse Ellipta to				
	treat the resident's Co	· · · · · · · · · · · · · · · · · · ·				
		bility of negative outcomes				
	•	re to assure Resident #1				
	received her medicati	ions as ordered which				
		xacerbation of the resident's				
	COPD and hospitaliza	ation.				
	Intensions with the ED	on 07/24/10 of 4:20nm				
	revealed:	on 07/24/19 at 4:30pm				
		esident #1's PCP that she				
	· · · · · · · · · · · · · · · · · ·	her Incruse (inhaler), no				
	additional information					
		sure the administration of				
	medications by staff in	n the PCP's orders.				
	Refer to a confidentia	ll staff interview.				
	Refer to an interview	with the medication aide				
	(MA) on 07/23/19 at 1	10:30am.				
	Refer to the interview	with the RCC on 07/23/19				
	at 03:16pm and 07/24					
	Refer to the interview	with the ED on 07/24/19 at				
		110 LD 311 311 L 11 10 Ut	1	1		1

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04:30pm.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL051062 B. WING		R 07/24/2019	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 0772472019
	CARE HOMES # 1		PARKER CIRC		
CLASSIC	CARE HOWES # 1	SMITHFIEL	D, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	2 43	{D 358}		
	Department (ED) Pro revealed Resident #1 cough and wheezing. Review of a hospital I	t #1's Hospital Emergency vider Note dated 07/09/19 's chief compliant was Discharge Summary for			
	Resident #1 dated 07/11/19 revealed: -The resident was admitted on 07/09/19 and discharged on 07/11/19.				
	admitted with chronic disease (COPD) exact -There was an order to 2 tablets (40 mg total)	tation the resident was obstructive pulmonary cerbation. for Prednisone 20 mg, take) twice daily for 3 days. ication used to decrease			
	administration record -There was a handwr mg tablets take two ta day for three days wit administration time of	itten entry for Prednisone 20 ablets (40mg) two times a th a scheduled 8:00am and 8:00pm umented as administered at on the following days,			
	07/24/19 at 4:30pm re -The ED was made at 10:59pm of Resident Prednisone doses who observed another MA was administered on however; she observed Prednisone, was still	ware on 07/14/19 at #1 not receiving 1 of 6 wen a medication aide (MA) document the Prednisone the July 2019 MAR; ed the medication, present in the blister pack. tified of the situation; no			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL051062	B. WING		07/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CLASSIC	CARE HOMES # 1		PARKER CIRC	CLE	
	OUR MARK OT		.D, NC 27577		.,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	e 44	{D 358}		
{D 358}	Interview with the Res (RCC) on 07/24/19 at -She was aware Resi Prednisone 40 mg or -The RCC did not not (PCP) that Resident # doses of her Prednisone Telephone Interview v07/24/19 on 4:48pm r -She had not been not Resident #1 did not reordered PrednisoneHer expectations we have notified her that received Prednisone should be administered fix what she did not kingly the resident #1's faillure received her medicating resident #1's failure Prednisone could have breathing problems si exacerbation of COPI hospital. -She was aware that hospitalized from 07/0 exacerbation of COPI Refer to a confidential	sident Care Coordinator 5:20 pm revealed: dent #1 missed one dose of dered on 07/11/19. ify the primary care provider #1 did not receive 1 of 6 one ordered on 07/11/19. with Resident #1's PCP on evealed: otified by the facility staff eceive a 40 mg dose of her are the facility staff should Resident #1 had not and that all medications ed as ordered and could not now. oility of negative outcomes are to assure Resident #1 ons as ordered. to receive one dose of ace caused a continuation of uch as shortness of breath, D or a re-admission to the Resident #1 was 09/19-07/11/19 for an D. I staff interview.	{D 358}		
	10:30am.	with the BCC on 07/23/19 at			
	3:16pm and on 07/24	·			
	Refer to the interview 4:30pm.	with the ED on 07/24/19 at			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION (X3)			
7440 1 1544	or connection	BEITTI 19/11/31/11/31/11/31/11/31/31	A. BUILDING:			PLETED
		HAL051062	B. WING		07	R 7/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	. ZIP CODE	•	
			IE PARKER CIRCL			
CLASSIC	CARE HOMES # 1		ELD, NC 27577	. -		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 45	{D 358}			
	O6/17/19 revealed: -There was a handwr (medication administration section of to the FL-2There was an order take one tablet two tin a medication used for disorders and social at Review of a hospital A Resident #1 dated 07 #1 to stop taking Clora Review of Resident #1 -There was a comput Clonazepam 0.5 mg mouth two times a da-Clonazepam was do	for Clonazepam 0.5 mg tabs mes a day. (Clonazepam is the treatment of panic anxiety disorder). After-Visit Summary for 7/11/19 revealed for Resident mazepam 0.5 mg tablet. It's July 2019 MAR revealed: er printed entry for tabs take one tablet by				
	hand on 07/23/19 at of Clonazepam tablets v					
	(RCC) on 07/24/19 at -If the RCC received summary, the dischart to the pharmacy and with the primary care electronically signed summaryShe could not provid #1's Clonazepam was	a hospital discharge rge summary would be sent orders would be clarified provider (PCP) who the hospital discharge e rationale why Resident				

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Division of	<u>of Health Service Regul</u>	lation			
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
	l				R
		HAL051062	B. WING		07/24/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	ſE, ZIP CODE	
CI 466IC	CARE HOMES # 1	101 ANNI	E PARKER CIRC	LE	
CLASSIC	CARE HOWES # 1	SMITHFIE	LD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	÷ 46	{D 358}		
	hospital After-Visit Summary order dated 07/11/19 on the July 2019 MAR.				
	07/24/19 on 4:48pm r -Her expectations wer administer all medicar -She was not aware to been discontinued on Summary dated 07/12 -She re-ordered Resir restarted on 07/24/19	re the facility staff should tions as ordered. that the Clonazepam had the hospital After-Visit 1/19. dent #1's Clonazepam to be			
	07/24/19 at 4:30pm re why Resident #1's Clo transcribed correctly f	ecutive Director (ED) on evealed she was not sure onazepam did not get from the hospital After-Visit 1/19 on the July 2019 MAR.			
	Refer to a confidentia	I staff interview.			
	Refer to an interview 10:30am.	with the MA on 07/23/19 at			
	Refer to an interview 3:16pm and on 07/24.	with the RCC on 07/23/19 at			
	Refer to the interview 4:30pm.	with the ED on 07/24/19 at			
	07/01/19 revealed: -Diagnoses included I incontinence, thyrotox chondrocostal junction unspecified neurologi-There was an order f twice daily. (Advair is	n syndrome, depression and			

lung airways).

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
		HAL051062	B. WING		07	R 7/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	•	
			IE PARKER CIRCL			
CLASSIC	CARE HOMES # 1		ELD, NC 27577	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 47	{D 358}			
	one puff twice daily Based on requests m Director (ED) on 07/2 Resident #3's May 20	n order for Advair 250-50, ade to the Executive 2/19, 07/23/19 and 07/24/19				
	250-50, one puff twick times daily and rinse scheduled administra 5:00pm. -There was a circle at (MAs) initials for the a 250-50 on 06/11/19 fron 06/13/19 and 06/1 -There was documen MAR that Advair was 06/11/19 at 8:00am, 0 available, not given", available, not given", available, not given", with no documented to 06/14/19 at 5:00pm "I	er printed entry for Advair e daily, inhale one puff two mouth after use with a tion time of 8:00am and round the medication aides' administration of Advair fom 8:00am through 5:00p 4/19 at 5:00pm. tation on the back of the "on order, not given" on 06/11/19 at 8:00am "not 06/12/19 at 8:00pm "not another entry for 06/12/19 time "not available", and not available, not given".				
	-There was a handwr one puff twice daily, i daily with an administ 5:00pm. -There was a circle al	3's July 2019 MAR revealed: itten entry for Advair 250-50, nhale one puff two times tration time of 8:00am and round the medication aides' administration of Advair				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		_	
		HAL051062	B. WING		R 07/2	4/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		PARKER CIRC D, NC 27577	CLE		
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
{D 358}	Continued From page	e 48	{D 358}			
{D 358}	250-50 on 07/02/19 at 8:00am through 07 -There was documen MAR on 07/02/19 at 8 available, not given available"There was no further the missed doses of A Review of Resident #dated 05/01/19 - 07/2 contracted pharmacy a quantity of a 30 day and 06/30/19. Observation of Resident Advair 250-50 was of dispensing label date dosesThere was a handwr staff on the box "oper Interview with the Resident #3 (PCP) that she had minhaler in June 2019 at 19-10-10-10-10-10-10-10-10-10-10-10-10-10-	t 5:00pm and from 07/03/19 //04/19 at 5:00pm. tation on the back of the 8:00pm Advair was "not and 07/03/19 at 8:00am "not r documentation regarding Advair 250-50. 3's dispensing records 4/19 from the facility's revealed Advair 250-50 with r supply filled on 05/30/19 ent #3's medications on 10:24am revealed: n hand with a pharmacy of 06/30/19 for a total of 60 itten entry not signed by a ned 07/05/19". sident Care Coordinator 105:20pm revealed she did 3's primary care provider hissed doses of her Advair	{D 358}			
	care provider (PCP) of revealed: -She had not been not Resident #3 did not re AdvairResident #3 was pre	with Resident #3's primary on 07/24/19 on 04:48pm of on 07/24/19 on 04:48pm of on 07/24/19 on 04:48pm of one of on				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _			
		HAL051062	B. WING		R 07/24/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
רו אפפור	CARE HOMES # 1	101 ANNIE	PARKER CIRC	CLE		
CLASSIC	CARE HOMES # 1	SMITHFIEL	.D, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	e 49	{D 358}			
(2 333)	-Resident #3 could exif she missed doses of -She would have expense.	sperience difficulty breathing	(2 333)			
	Refer to a confidentia	I staff interview.				
	Refer to an interview (MA) on 07/23/19 at 1	with the medication aide 10:30am.				
	Refer to the interview with the RCC on 07/23/19 at 3:16pm and on 07/24/19 at 5:20pm.					
	Refer to the interview (ED) on 07/24/19 at 4	with the Executive Director :30pm.				
	-There had been time problems processing residents, but the start the problem wasThe staff knew some medications had not ladminister to the resident and the Executive Dirmedications were not pharmacy because the	peen in the facility recently to				
	residents' medication: -She notified the RCC doses of a medicatior -She did not documer RCC about the need be ordered.	revealed: nsible for ordering the s from the pharmacy. C when there were 2 or 3				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_		R	
		HAL051062	B. WING		07/24	/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
רו אפפור	CARE HOMES # 1	101 ANNIE	PARKER CIRC	CLE		
CLASSIC	CARE HOWES # 1	SMITHFIEL	.D, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	÷ 50	{D 358}			
	hand, but this was where worked at previous fare. She contacted the Refeat. -All MAs were responsimmediately after medicated to a resident by placify the medication was an -MAs were responsibility of medications were an -All medication aides on the back of the medication was not gresident refused. -A circle around the inwas not given and the on the back of the MAR.	sible to document dications were administered and their initials on the date dministered. He to sign the residents' MAR dministered. Were required to document edication administration				
	revealed: -There was no curren system in place relate reconciliation that incoresidents' medication (MARs) to assure the administered as order-The current process was when a new order would fax the new method pharmacyThe RCC would continew medication was a placing a phone call the system of the results of the relation of the results of the relation of the relat	administration records medications had been red. for medication reconciliation er was received the RCC edication order to the firm if the faxed order for a received by the pharmacy by				

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related to medications in order to track the

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	or riealth Service Regu		T		T	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COIVII L	LILD
					F	₹
		HAL051062	B. WING		1	24/2019
NAME OF D		CTDEET AD	DDECC CITY CTA	TE 7/D CODE	<u>-</u>	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
CLASSIC	CARE HOMES # 1		PARKER CIR	CLE		
		SMITHFIE	LD, NC 27577			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAG		,	IAG	DEFICIENCY)		
(D 250)	Continued From none	- 54	(D 250)			
{D 358}	Continued From page	2 5 1	{D 358}			
	implementation.					
	-Once the new medic	ation was available				
	in-house, the RCC wo	ould add the new medication				
	to the MAR.					
	-The RCC confirmed	the MAs also wrote new				
		ARs and she would review				
	when she returned to					
		pare the MARs to the				
		nary care physician (PCP)'s				
	•	ng medication reconciliation				
	on a monthly basis.	and an an active deafter the				
		orders received after the				
	the RCC.	ed, the MA would call or text				
		ermine the priority of the				
		dication was urgent, she				
		and/or text message to the				
		dication was non-urgent,				
	•	nedication order via fax to				
		she arrived to work in the				
	morning.					
	0	medication carts around the				
	9th of each month.					
	-The residents' sched	uled medications were sent				
	from the pharmacy or	n a cycle fill except creams,				
	inhalers, eyedrops an	d narcotics.				
	-Staff had not reporte	d to her that any of the				
	residents' medication	s were not available to				
		id noticed a MA had not				
	signed when a reside					
		mately 1 1/2 weeks ago.				
		red to verbally report the				
	•	for daily (QD) medications				
		oses were left; for twice a				
	-	s notification when 14 doses				
		nes a day (TID) medications				
		doses were remaining.				
		ten policy of the notification				
		re was a low supply of				
	medications; the MAs	were given this policy				1

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BOILDING		
	HAL051062	B. WING		R 07/24/2019
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
CLASSIC CARE HOMES # 1		E PARKER CIRC	CLE	
		ELD, NC 27577		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{D 358} Continued From page	e 52	{D 358}		
verballyFor any new PCP or in the RCC's box and following dayWhen there were nee the responsibility of the changes to the MAR. when she was out of -When a medication of the MAs' initials would be the revealed: -Her expectations for medications as order PCP's ordersHer expectations for follow these 7 steps: right reason, right free and right timeShe also expected the the RCC when medication changes will read medication or hours it would be the address which would responsibility to proceed the the responsibility to proceed for 3 of 3 same resident diagnosed we pulmonary (COPD) do an inhaler used to co and shortness of bread 06/05/19-06/13/19 ar hospitalization for CO	ders, they should be placed a would be addressed the the addressed the the action of the work of the ED was her backup the office. Was not given to a resident of the becircled on the MAR. On 07/24/19 at 4:30pm The staff were to administer the facility staff were to right resident, right route, quency, right site, right drug, the MAs to communicate with the extensions were running low. If the on hold until the the were clarified with the PCP, ders came through after the MA's responsibility to include notifying the RCC, ders came through during all the the RCC's the sess. Indiminister medications as a mpled residents resulting in a with chronic obstructive lisease missing 6 doses of our of symptoms of wheezing ath caused by COPD from and required an acute	(D 330)		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLE	
		HAL051062	B. WING		07/2	4/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	1 0772	4/2013
			PARKER CIRC			
CLASSIC	CARE HOMES # 1	SMITHFIE	LD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
{D 358}	from the hospital with not receiving an inhal resident not receiving treat asthma and previous failure of the facility to ordered was detriment welfare of the resident B Violation. The facility provided a accordance with G.S. this violation. CORRECTION DATE	d after she was discharged a COPD exacerbation and er for COPD (#1); and a an ordered inhaler used to went flare-ups (#3). The administer medications as intal to the health, safety and its, which constitutes a Type a plan of protection in 131D-34 on 07/24/19 for	{D 358}			
{D 367}	(j) The resident's me record (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa administered; (4) instructions for ad or treatment; (5) reason or justifica medications or treatm documenting the result (6) date and time of a (7) documentation of medications or treatm omission, including residuals.	Medication Administration dication administration e accurate and include the cation or treatment order; ge or quantity of medication ministering the medication tion for the administration of tents as needed (PRN) and alting effect on the resident; dministration; any omission of tents and the reason for the	{D 367}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '		(X3) DATE SURVEY COMPLETED	
			7.1. 20.122		R
		HAL051062	B. WING		07/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	
CI ASSIC	CARE HOMES # 1	101 ANN	IE PARKER CIRC	LE	
CLASSIC	CARE HOMES # 1	SMITHFII	ELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
{D 367}	Continued From page	e 54	{D 367}		
	signature equivalent t	atment. If initials are used, a to those initials is to be ntained with the medication (MAR).			
	interviews, the facility medication administra	ns, record reviews and failed to assure the ation records were accurate sidents (#2) related to a r, pain reliever and a			
	The findings are:				
	06/03/19 revealed dia hypertension constipa gastroesophageal ref deficiency, chronic ob disease, major depre- nausea, other seasor disorder, hypercholes	lux disease, vitamin D ostructive pulmonary ssive disorder, acute pain, nal allergies, bipolar sterolemia, anxiety, in syndrome, throat pain,			
	06/03/19 revealed the 100, 000 units/gram p fold and under breast is a topical antibiotic p fungal skin infections	t #2's current FL-2 dated ere was an order for Nystop bowder apply to abdominal s three times a day. (Nystop medication used to treat). 2's June 2019 medication			

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DIVISION	i Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						_
			D. MINO		F	
		HAL051062	B. WING		07/2	24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ATE ZIP CODE		
			E PARKER CIR	,		
CLASSIC	CARE HOMES # 1			CLE		
		SMITHFI	ELD, NC 27577	T		T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
TAG	REGULATORI ORI	100 IDENTIFY THE INTERNATION	TAG	DEFICIENCY)	WAIL	
{D 367}	Continued From page	e 55	{D 367}			
	administration record	(MAP) rayaalad:				
	administration record	•				
	-There was a handwr					
	•	apply to areas under				
		under breasts three times a				
	_	administration time of				
	8:00am, 2:00pm and	•				
		tation Nystop powder had				
		06/31/19 at 8:00am and				
	2:00pm.					
	-There were 30 days					
	_	ure on the MAR equivalent				
	to the initials of the st	aff who documented the				
	administration for the	resident's Nystop on				
	06/31/19.					
	Refer to the interview	with the medication aide				
	(MA) on 07/23/19 at 1	10:30am.				
	,					
	Refer to the interview	with the Resident Care				
		n 07/24/19 at 05:20 pm.				
	Refer to the interview	with the Executive Director				
	(ED) on 07/24/19 at 4					
	(23) 311 3172 11 13 46 1					
	h Review of Residen	t #2's current FL-2 dated				
		ere was an order for Lyrica				
		nree times a day. (Lyrica is a				
		to treat nerve pain and				
	Fibromyalgia).	to treat herve pain and				
	Fibroffiyalgia).					
	Davious of Booldont	#2's June 2019 medication				
	administration record					
		itten entry for Lyrica 100mg				
		les a day with a scheduled				
	administration time of	8:00am, 2:00pm and				
	8:00pm.					
		tation Lyrica 100mg had				
		06/31/19 at 2:00pm, and				
	06/31/19 at 8:00am.					
	-There were 30 days	in June 2019.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
					R	
		HAL051062	B. WING		1	4/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		E PARKER CIRO LD, NC 27577	CLE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 367}	Continued From page -There was no signate to the initials of the standinistration for the 06/31/19. Refer to the interview (MA) on 07/23/19 at 1 Refer to the interview Coordinator (RCC) or Refer to the interview (ED) on 07/24/19 at 4 c. Review of Resident 06/03/19 there was at one daily. (Protonix is used to treat certain signoidlems). Review of Resident # administration record -There was a handwriming take one tablet da administration time of -There was document been administered on -There were 30 days -There was no signate	e 56 The on the MAR equivalent aff who documented the resident's Lyrica on with the medication aide 0:30am. with the Resident Care 107/24/19 at 05:20 pm. with the Executive Director 1:30pm. If #2's current FL-2 dated 1:40 order for Protonix 40 mg 1:40 a medication used to treat 1:40 tomach and esophagus 2's June 2019 medication (MAR) revealed 1:40 illy with a scheduled 1:40 illy with a sche	TAG {D 367}		KATE	DATE
	06/31/19. Refer to the interview (MA) on 07/23/19 at 1 Refer to the interview	with the medication aide 0:30am. with the Resident Care 07/24/19 at 05:20 pm.				

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Refer to the interview with the Executive Director

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HAL051062 B. WING O7/24/2019 NAME OF PROVIDER OR SUPPLIER CLASSIC CARE HOMES # 1 STREET ADDRESS, CITY, STATE, ZIP CODE 101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CLASSIC CARE HOMES # 1 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577				_		R	
CLASSIC CARE HOMES # 1 101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577			HAL051062	B. WING			Э
CLASSIC CARE HOMES # 1 SMITHFIELD, NC 27577	NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	CLASSIC	CARE HOMES # 1			CLE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COM	PLETE
(D 367) Continued From page 57 (ED) on 07/24/19 at 4:30pm. Interview with the medication aide (MA) on 07/23/19 at 10:30am revealed: -All MAs were responsible to document immediately after medications were administered to a resident by placing their initials on the date the medication was administeredMAs were responsible to sign the residents' medication administration record (MAR) if medication administration record (MAR) if medication swere administeredAll medication aides were required to document on the back of the MAR when there was reason a medication was not given, in the hospital or the resident refusedA circle around the initials meant the medication was not given and there should be documentation on the back of the MAR for the reason not given, but at times she would forget to document on the back of the MAR. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 05:20 pm revealed: -Her expectations for the MAs were to document administration of a medication with their initials, and to include their signature and initials at the bottom of the MARIf a medication was not given, she expected this to be documented on the MARShe confirmed the MARs were not reviewed for accuracy due to starting her new position recently. Interview with the Executive Director (ED) on 07/24/19 at 4:30pm revealed: -Her expectations for staff were to administer medications as ordered by hospital orders and primary care provider's (PCP's) ordersHer expectations for the facility staff were to	{D 367}	Interview with the me 07/23/19 at 10:30am -All MAs were responsimmediately after med to a resident by placing the medication was a -MAs were responsib medication administrated medication administrated medication was not gresident refusedA circle around the information was not given and the on the back of the MA but at times she woul back of the MAR. Interview with the Reserview with the MARIf a medication was not given and to include their side bottom of the MARIf a medication was not given and to include their side to be documented on -She confirmed the Maccuracy due to starting recently. Interview with the Executations for medications as ordered primary care provider	dication aide (MA) on revealed: asible to document dications were administered ing their initials on the date diministered. Ile to sign the residents' action record (MAR) if ministered. were required to document AR when there was reason a liven, in the hospital or the initials meant the medication are should be document and for the reason not given, deforget to document on the initials meant the medication are should be documentation are should be documentation are should be document on the initials meant the medication are should be document on the initials at the most given, she expected this in the MAR. If and initials at the most given, she expected this in the MAR. If and initials are not reviewed for ling her new position in the position in the staff were to administer end by hospital orders and its (PCP's) orders.	{D 367}	DELIVOT)		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL051062	B. WING		0.7	R
					07	/24/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STATE E PARKER CIRO			
CLASSIC	CARE HOMES # 1		ELD, NC 27577)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{D 367}	and right time. -The MAs should not administration of a megiven the medication -If a medication was report to be documented on -She confirmed the Maccuracy due to startirecently.	be documenting the edication unless the MA had to the resident. not given, she expected this the MAR with the reason. IARs were not reviewed for ng her new position	{D 367}			
{D912}	G.S. 131D-21 Declar Every resident shall h 2. To receive care an adequate, appropriate	laration of Residents' Rights ration of Residents' Rights rave the following rights: ad services which are a, and in compliance with state laws and rules and	{D912}			
	interviews, the facility resident had the right services which are accompliance with rules to medication adminis food service. The findings are: Based on observation reviews, the facility facility facility resident.	ns, record reviews, and failed to assure every to receive care and lequate, appropriate, and in and regulations as related etration and nutrition and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING: COMPLE				
		HAL051062	B. WING		07	R //24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CI ASSIC	CARE HOMES # 1	101 ANN	IIE PARKER CIRCL	E		
OLAGGIO	OARE HOMEO# 1	SMITHF	ELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{D912}	(#1, #2, #3) including #3); narcotics and a s relievers, an antifung (#2). [Refer to Tag 03	or 3 of 3 residents sampled errors with inhalers (#1, #2,	{D912}			
{D935}	Training and Compet G.S. § 131D-4.5B (b)	Adult Care Home aining and Competency	{D935}			
	(b) Beginning Octobe home is prohibited from any unsupervised methat individual has promedication aide during an adult care home of the following: (1) A five-hour training Department that incluing all of the following: a. The key principles administration. b. The federal Centern Prevention guidelines applicable, safe inject procedures for monitobleeding occurs or the exists. (2) A clinical skills even NCAC 13F .0503 and (3) Within 60 days from individual must have a. An additional 10-hodeveloped by the Deliver individual must have as the strength of the strength o	er 1, 2013, an adult care of allowing staff to perform edication aide duties unless eviously worked as a gethe previous 24 months in a successfully completed all gethe previous and instruction of medication es for Disease Control and so on infection control and, if tion practices and pring or testing in which the potential for bleeding aluation consistent with 10A in 10A NCAC 13G .0503. The date of hire, the completed the following:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
			A. BOILDING.							
		HAL051062	B. WING		R 07/24/2019					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
CLASSIC CARE HOMES # 1										
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)						
{D935}	Continued From page 60		{D935}							
	Prevention guidelines applicable, safe inject procedures for monito bleeding occurs or the exists. b. An examination de by the Division of Hea	s of Disease Control and on infection control and, if								
	facility failed to assure sampled (Staff A) hire completed at least 5 I Medication Aide traini medications.	ews and interviews the e 1 of 3 Medication Aides								
	-Staff's A date of hire -There was documentstate written medicatitien. There was documented Administration Clinical Validation Checklist durantee was no documented and the compression of the compression	tation Staff A passed the on exam on 01/31/12. tation of a Medication al Skills Competency lated 03/07/19. mentation of verification of as a MA within the last 24 mployment at the facility. tation of the completion of								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
			D WING		R						
		HAL051062	B. WING		07/24/2019	•					
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
CLASSIC CARE HOMES # 1											
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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	'E ACTION SHOULD BE COMPLETE D TO THE APPROPRIATE DATE						
{D935}	Continued From page 61		{D935}								
	Administration Training Course for Adult Care Homes for Staff A on 07/11/19. Review of a resident's June 2019 medication administration record (MAR) revealed Staff A documented administering medication on 06/11/19 and 06/26/19. Review of the same resident's July 2019 MAR revealed Staff A documented administering medication on 07/01/19, 07/03/19, and 07/05/19-07/10/19.										
	revealed: -She had worked at the 4 monthsShe had been working care aide (PCA) since employment at the fact she had previous MargacilitiesShe had recently contraining course this margary she had administered residents since she since	cility. A experience at other mpleted a 15 hour MA onth (July 2019). d medications to the tarted working at the facility.									
	7/24/19 at 05:00pm re- -All the documentatio qualifications should I -She believed Staff A MA at another facility -She was not aware t	n of Staff A's MA pe in her personnel record. had worked previously as a hat Staff A had not ur Medication Training until									

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