Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION (X3) DAT UILDING:	
					R
		HAL051062	B. WING		10/30/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
CLASSIC	CARE HOMES # 1		IIE PARKER CIRCL ELD, NC 27577	E	
(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 000	Initial Comments		D 000		
		sure Section conducted a october 29, 2019 through			
D 079	10A NCAC 13F .0306 Furnishings	(a)(5) Housekeeping and	D 079		
	10A NCAC 13F .0306 Furnishings (a) Adult care homes (5) be maintained in a orderly manner, free of hazards; This Rule shall apply facilities.	shall an uncluttered, clean and of all obstructions and			
	This Rule is not met a	as evidenced by:			
	failed to assure the fa evidenced by the store	is and interviews, the facility cility was free of hazards as age of three empty portable ured in racks or crates, in a			
	The findings are:				
	8:52am revealed: -There were three em the resident's room, b next to the bedsThe three empty port standing upright in fro racks.	nt room #7 on 10/29/19 at  pty portable oxygen tanks in etween two night stands  able oxygen tanks were nt of nine tanks that were in  able oxygen tanks were not			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SU COMPLE	
			_		R	
		HAL051062	B. WING		1	/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		
	CLIMMADY CT		·	DDOVIDED'S DI ANI OF CORRECTION		0.5
(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 079	Continued From page	e 1	D 079			
	secure or in a rack.					
	10/29/19 at 8:54am re -She was a new empl -She had been workin weeks.	loyee.  ng in the facility for three e proper way empty or full				
	on 10/29/19 at 8:54ar -She called the medic up the empty tanks of -The tanks were to be -She did not have and empty portable oxyge -She was not aware t tanks had a potential stored on the floor.	cal supply company to pick in 10/25/19. The picked up on 10/28/19. The picked up on 10/28/19. The picked up on to store the entanks. The empty portable oxygen to explode if they were				
	local medical supply of 2:11pm revealed: -The company's techn 10/22/19 to deliver portable of automatically picked of delivered new tanksWhen the technician oxygen tanks, the porplaced wherever the fleave themWhen oxygen equipmed delivered to a resident	en to the facility when the				

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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 10/30/2019	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	10/30/2019	
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 APPROPR DEFICIENCY)	BE COMPLETE	
D 079	Continued From page	2	D 079			
	by the facility because	e they were billed separately.				
	#7 on 10/30/19 at 9:1 -She used the cylinde when she went out to -The empty and full posept in her roomThe empty and full posept in a rationally stored in a rational full posept in the floor had been shown in the floor had	er portable oxygen tanks appointments. ortable oxygen tanks were ortable oxygen tanks are ack. table oxygen tanks that were there for a week. cation Aide (MA) on evealed: the portable oxygen tanks or. oortable oxygen tanks should				
	Observation on 10/30	rack and not on the floor.  /19 at 9:30am revealed the oxygen tanks had been at room #7.				
	rack away from electr potential for an unsect be knocked over, dan releasing the high-pre which could potentiall facility. The facility's the health and safety constitutes a Type B	ored securely in a storage ical outlets, creating a sured cylinder to fall and/or naging the valve, and rapidly essure gas from the tank, y cause an explosion in the failure was detrimental to of the residents which violation.				
	The facility provided a accordance with G.S. this violation.	a plan of protection in 131D-34 on 10/29/19 for				

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Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL051062	B. WING		10	R 0/30/2019
	ROVIDER OR SUPPLIER  CARE HOMES # 1	101 ANN	ADDRESS, CITY, STATE NIE PARKER CIRCL IELD, 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 ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 079	Continued From page CORRECTION DATE VIOLATION SHALL N 14, 2019.		D 079			
D 273	1 ' '		D 273			
	reviews the facility fail appointment for 1 of 3 (Residents #3) regard gastroenterologist. The Review of Resident # 06/03/19 revealed diagastroesophageal refineartburn, nausea, the pain, chronic pain synbipolar disorder, demidisorder, anxiety, and Review of Resident #	ns, interviews and record iled to schedule an 3 sampled residents ding a referral to a ne findings are:  3's current FL-2 dated agnoses included flux disease (GERD), proat pain, insomnia, acute ndrome, hypertension, entia, major depressive disconstipation.				
	(documentation by a	medication aide) revealed:				

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	FOF DEFICIENCIES OF CORRECTION	COMPLETE		(X3) DATE SURVEY	
ANDILAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING:	BUILDING:	
		HAL051062	B. WING		R 10/30/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	
		101 ANN	IE PARKER CIRC	LE	
CLASSIC	CARE HOMES # 1		ELD, NC 27577		
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	)N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 273	Continued From page	e 4	D 273		
	room"She has been bad of complaining of nause well as complaining of side of her stomach.	I to the hospital emergency  If sick for two days or so, a, throwing up, diarrhea as If severe pain on the right  ds this morning that was			
	given to her.				
		and contacted the Resident			
	Care Director (RCD) and she asked me to go				
	ahead and send her	out".			
	10/16/19 with a diagn -The resident's discha Percocet 10/325 (use severe pain), 3 times abdominal pain; Lope diarrhea) every 8 hou and Xanax 0.25mg (u 12 hours as needed f	spitalized from 10/14/19 to nosis of abdominal pain. arge medications included and to relieve moderate to a day for five days to relieve eramide 2mg (used to relieve ars as needed for diarrhea, used to relieve anxiety) every for sleep up to five days.			
	revealed: -On 10/18/19 (1st shi #3] had been constar started after 10am an diarrhea. She has coi contacted the RCD. T to the resident's [fami resident sent out to th	3's Resident Care Notes  ft) the "resident [Resident ntly going to the bathroom, it d having nausea as well as mplained of weakness and I he RCD had already talked ly member] and wanted the ne emergency room (ER). e emergency room about			
	returned back to the f	acility from the hospital with ausea medicine. Resident			

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	n rieaitii Service Regu		1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
						n
			D WING			R
		HAL051062	B. WING		10/	30/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	JE ZIP CODE		
TO WILL OF TH	NOVIDER OR OUT FIER		, ,	•		
CLASSIC	CARE HOMES # 1		E PARKER CIR	ULE		
		SMITHFI	ELD, NC 27577			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T		DATE
				DEFICIENC	·Y)	
D 273	273 Continued From page 5		D 273			
D 213	Continued From page	9 5	02/3			
	Review of an "After V	isit Summary" report from a				
	local ER dated 10/18/	· · · · · · · · · · · · · · · · · · ·				
		R visit was Resident #3's				
	complaint of abdomin	· · · · · · · · · · · · · · · · · · ·				
		ignosed with abdominal				
	pain, non-intractable	vomiting with nausea				
	(vomiting that is diffic	ult to control and does not				
	lessen with time or tre	eatment), and unspecified				
	vomiting type.	,,				
	-The resident was treated with sublingual					
	Fentanyl (used to treat severe pain),					
	•	o treat nausea and vomiting)				
	and an intravenous be					
	chloride (used to treat	- · · · · · · · · · · · · · · · · · · ·				
	-The resident was dis	charged from the ER with				
	an order to follow-up	with a local				
	gastroenterologist (ac	ddress and phone number of				
		t provided) in one week				
		ne appointment was not				
	scheduled by the ER.					
	Schoduled by the Liv.					
	Talambana intensiass.	ا ما ما الماني				
	Telephone interview v					
	gastroenterologist on	10/30/19 at 4:50pm				
	revealed:					
	<ul> <li>-A referral for Resider</li> </ul>	nt #3 was never received at				
	the office.					
	-The hospital did not	call in a referral and the				
		t the office to schedule an				
	-	dent #3 in October 2019.				
		2010.				
	Observation on 10/20	)/19 at 3:55pm revealed				
		ng in the TV room with her				
	legs elevated on her	oxygen concentrator.				
	Interview with Reside	nt #3 on 10/30/19 at 3:55pm				
	revealed:					
	-When sitting up. she	elevated her legs to help				
	relieve stomach disco					
		to the hospital two times in				
	-one was transported	to the hospital two tilles ill	1			1

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BOILDING.			R
		HAL051062	B. WING		l l	/30/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		E PARKER CIRC LD, NC 27577	CLE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE
D 273	Continued From page	e 6	D 273			
	stomach pain, vomitir -She did not know if s "stomach doctor" sind -She was not seen at month (October 2019 -The facility staff trans appointments.	she had a referral to a see going to the hospital. a "specialist" office this ). sported her to medical				
	A second interview with Resident #3 on 10/30/19 at 4:15pm revealed: -She went to the doctor due to a "twisted colon" before she was admitted to the facility in May 2019.					
	-After admission to th having stomach pain.					
	sent her to a specialis admission but she did	vider (PCP) at the facility st for her stomach pain after d not know the date. ot having stomach pain.				
	revealed: -Resident #3's PCP n (post-hospital) visit w to assess abdominal -There was an order	ident #3 dated 10/21/19  nade a follow-up  ith the resident at the facility				
	11:06am revealed: -She was aware a ref was made by the loca 10/18/19She did not know if t scheduled the appoint-She expected the factorial statement of the second statemen	nt #3's PCP on 10/30/19 at ferral to a gastroenterologist at ER medical provider on the facility staff had attent for the resident. Colity staff to follow-up with a including making medical				

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STATE FORM 6899 6MEI11 If continuation sheet 7 of 33

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HAL051062  B. WING		CTION IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
HAL051062     B. WING			_		R
		HAL051062	B. WING		10/30/2019
404 ANNIE DADIZED CIDCI E	IE OF PROVIDER OR SUPPLII	OR SUPPLIER STREET	ADDRESS, CITY, STAT	TE, ZIP CODE	
CLASSIC CARE HOMES # 1	ASSIC CARE HOMES # 1		NIE PARKER CIRC	CLE	
SMITHFIELD, NC 27577	TOOIO OAKE HOMEO# 1	SMITH	FIELD, NC 27577		
	REFIX (EACH DEF	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETE
appointments.  She was at the facility and assessed the resident on 10/21/19. After reviewing the ER discharge orders/referral, she wrote an order confirming the referral to a gastroenterologist.  Resident #3 had a history of gastric problems and the resident reported she had a history of bowel obstruction.  Interview with the Administrator on 10/30/19 at 5:25pm revealed:  She was not aware Resident #3 had a gastroenterology referral from the local ER and her PCP.  She was ware the resident was sent to the hospital two times in October 2019 because of stomach pain, vomiting and diarrhea.  She did not know whether an appointment was scheduled with the local gastroenterologist on the 10/18/19 ER "After Care Summary" or if the resident was transported to the appointment.  All discharge summaries from hospitalizations or ER visits should be given to the medication aide immediately upon the resident's return to the facility to review for orders.  The RCD also reviewed discharge summaries and followed up on all referrals.  She expected the RCD to review all hospital/ER summaries and if there were any medical referrals and informed the Transportation Director of the referral and appointment.  Interview with the RCD on 10/30/19 at 5:30pm revealed:  She did not know why the gastroenterologist appointment was not made.  There was no documentation explaining why the	appointmentsShe was at the on 10/21/19. Af orders/referral, referral to a gast-Resident #3 hat and the resident bowel obstruction.  Interview with the 5:25pm revealether PCPShe was not an gastroenterology her PCPShe was aware hospital two times stomach pain, where we will be the stomach pain, which is should be should be the stomach pain, which is should be should be supposed to the stomach pain, which is should be should	After reviewing the ER discharge (referral, she wrote an order confirming the I to a gastroenterologist. ent #3 had a history of gastric problems a resident reported she had a history of obstruction.  We with the Administrator on 10/30/19 at a revealed:  Was not aware Resident #3 had a senterology referral from the local ER and CP.  Was aware the resident was sent to the all two times in October 2019 because of ch pain, vomiting and diarrhea.  Id not know whether an appointment was called with the local gastroenterologist on the 19 ER "After Care Summary" or if the not was transported to the appointment. Scharge summaries from hospitalizations or its should be given to the medication aide liately upon the resident's return to the to review for orders.  ICD also reviewed discharge summaries allowed up on all referrals.  ECD also reviewed discharge summaries and if there were any medical ls, the RCD was to make appointments.  ECD received all post hospital referrals and end the Transportation Director of the I and appointment.  Be with the RCD on 10/30/19 at 5:30pm end:  Id not know why the gastroenterologist them the was not made.	D 273		

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE  A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL051062	B. WING		R 10/30/2019
	ROVIDER OR SUPPLIER  CARE HOMES # 1	101 ANN	DDRESS, CITY, STATI IE PARKER CIRC 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 273	appointments for all of appointments were do transportation appointments were do transportation appointments with the Tra 10/30/19 at 5:30pm re - There was not an appointment with a local gastroenterologif the resident refuse he would note it on the report the refusal to the transpointment with a gast by the ER for Resider bowel obstruction and twice for acute abdomintractable vomiting. To the health, safety, a which constitutes a Tymp. The facility provided a 10/30/19 in accordance CORRECTION DATE.	for scheduling medical f the residents and the coumented on the timent calendar.  Insportation Director on evealed: Insportation Director on eventual e	D 273		
D 296	Service	(c)(7) Nutrition And Food	D 296		
	10A NCAC 13F .0904 (c) Menus in Adult Ca	Nutrition And Food Service are Homes:			

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	r of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	CLIDVEV
	FOF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				LETED
			A. BUILDING: _			
			5 14/110			R
		HAL051062	B. WING		10	/30/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		101 ANN	E PARKER CIRC	CLE		
CLASSIC	CARE HOMES # 1		ELD, NC 27577	<del></del>		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CO	ADDECTION .	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
				DEFICIENCY		
D 296	Continued From page	e 9	D 296			
	(7) The facility shall be					
		nave a matching therapeutic				
	diets for guidance of	sician-ordered therapeutic				
	diets for guidance of	iood service stair.				
	This Rule is not met	as evidenced by:				
		ns, interviews and record				
		illed to have matching				
	therapeutic menus fo	r food service guidance for 3				
	of 3 sampled resident	ts (#1, #2, #3) with physician				
	orders for Low Conce	entrated Sweets (LCS), a No				
	Added Salt (NAS) die	et (#1 and #2) and LCS diet,				
	NAS diet, Chopped m	neats diet (#3).				
	The findings are:					
		t #1's current FL-2 dated				
	08/05/19 revealed:	abrania abatruatian				
	-Diagnoses included	yperlipidemia, cerebral				
		peripheral vascular disc.				
	-There was an order	•				
	There was an order	ior a rate, 200 diet.				
	Interview with Reside	nt #1 on 10/30/19 at 2:49pm				
	revealed:	·				
	-She ate whatever sh	e wanted.				
	-She was not a diabe	tic.				
		nt diet list dated 10/24/18				
		een updated with the current				
	physician's diet order	TOT RESIDENT #1.				
	Deview of the handw	ritten menu on 10/29/19				
		e board in the dining room				
	revealed:	c board in the diffing footif				
		sisted of 2-3 ounces of				
		calloped potatoes and ½ cup				
	of baked apples.					
		sisted of 1 cup of spaghetti				
		up broccoli and cake (did				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		E SURVEY PLETED				
			A. BUILDING:			_
		HAL051062	B. WING		10	R 0/ <b>30/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
			NIE PARKER CIRCL			
CLASSIC	CARE HOMES # 1		IELD, 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 ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 296	Continued From page	e 10	D 296			
	cake was non sugar f	not specify whether the ree or sugar free.				
	were no menus for the	s menus revealed there erapeutic diets.				
	located on a message revealed:  -The breakfast menu yogurt (did not specifize the preakfast menu syrup was sugar free the lunch meal con sandwiches with 2-ou coleslaw, and a ½ cu the dinner meal con barbeque chicken, ½ of broccoli, cauliflower and 2 small cookies.  -The dinner menu did cornbread to be served.	did not specify whether the sisted of philly cheese steak inces of steak, ½ cup p of pears and raisins. sisted of 2-3 ounces of cup of potato salad, ½ cup er and carrots, cornbread. I not specify the amount of ed. not specify whether the 2				
	Review of the facility' were no menus for th	s menus revealed there erapeutic diets.				
	12:00pm- 12:15pm re-Resident #1 was ser sandwich, ½ cup of c pears and raisinsResident #1 ate 100 Review of the handw	ved a philly cheese steak oleslaw, and a ½ cup of percent of her meal.  ritten menu for a No a diet on 10/30/19 sent by				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
			A. BOILDING.			D
		HAL051062	B. WING		10	R 9/ <b>30/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CI ASSIC	CARE HOMES # 1	101 ANN	IIE PARKER CIRCL	E		
CLASSIC	CARE HOWES # 1	SMITHFI	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 ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 296	Continued From page	e 11	D 296			
	-The menu was a list substitutions for a reg -The menu was signe -There was no menu	jular diet.				
	Refer to the interview (MA) on 10/3019 at 1	with the medication aide 0:36am.				
	Refer to the interview at 12:17pm.	with the cook on 10/30/19				
	Refer to the interview with the personal care a (PCA) on 10/30/19 at 12:20pm.					
	Refer to the interview 10/30/19 at 12:45pm.	with the Administrator on				
	Refer to telephone int 10/31/19 at 9:19am.	terview with the RD on				
	02/20/19 revealed: - Diagnoses included hypoglycemia, hypert vitamin D deficiency, allergic rhinitis.	ension, diabetes mellitus II, gastrointestinal disorder and for fasting blood sugars esday.				
		ecent diet order dated t #2 revealed a diet order for eets (LCS) and no added salt				
	Review of the facility's were no menus for th	s menus revealed there erapeutic diets.				
		nt diet list dated 10/24/18 een updated with the current				

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	′
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		1141 054000	B. WING		R	_
		HAL051062	D: Willo		10/30/201	9
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		101 ANNI	E PARKER CIR	CLE		
CLASSIC	CARE HOMES # 1		LD, NC 27577			
	OLIMANA DV OT		<del></del>	DDOV/DEDIO DI ANI OF CODDECTIO		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) MPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
D 296	Continued From page 12		D 296			
D 290	Continued From page 12		D 290			
	physician's diet order	for the residents in the				
	facility.					
	Review of the handwi	ritten menu on 10/29/19				
	located on a message	e board in the dining room				
	revealed:					
		sisted of 2-3 ounces of				
	•	scalloped potatoes and ½				
	cup of baked apples.					
		sisted of 1 cup of spaghetti				
		up of broccoli and cake (did				
	not specify the amour	· ·				
		not specify whether the				
	cake was non sugar f					
	-There were no menu	is for therapeutic diets.				
	Review of the menu h	nandwritten on 10/30/19				
	located on a message	e board in the dining room				
	revealed:	· ·				
	-The breakfast menu	consisted of 2 pancakes,				
	yogurt (did not specify	y the amount to be served),				
	½ cup of peaches and	d 2T syrup				
	-The breakfast menu	did not specify whether the				
	syrup was non sugar	free or sugar free.				
		sisted of philly cheese steak				
		ınces of steak, ½ cup of				
		p of pears and raisins.				
	-The dinner meal con					
		cup of potato salad, ½ cup				
	·	er and carrots, cornbread				
	and 2 small cookies.					
		I not specify the amount of				
	cornbread to be serve					
		not specify whether the 2				
	small cookies were su	ugar tree.				
	Observation of the live	ach mool on 10/20/10 of				
		nch meal on 10/30/19 at				
	12:00pm- 12:15pm re					
	-resident #∠ was ser	ved philly steak sandwiches,				

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½ cup of coleslaw, and a ½ cup of pears and

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL051062	B. WING		10	R 0/30/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CLASSIC	CARE HOMES # 1		NIE PARKER CIRCL	E		
	I		IELD, 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 T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 296	Review of the handw 10/30/19 sent by the revealed: -The menu was a list substitutions for a regarder are and the menu was signed. There was no menusured management of the interview (MA) on 10/3019 at a selection of the interview (MA) on 10/3019 at a selection of the interview (PCA) on 10/30/19 at 12:45pm.  Refer to the interview 10/30/19 at 12:45pm.  Refer to telephone in 10/31/19 at 9:19am.  3. Review of Reside 06/03/19 revealed diconstipation, gastroir deficiency, chronic of disease, major depression, hypertension, hypertension, hypertension, hypertension, hypertension, hypertension of the most of 107/29/19 for Resider of 107/29/19 for	oritten menu for NCS on Registered Dietitian (RD) to of sugar free desert gular diet. ed by the RD. for an LCS and NAS diet.  or with the medication aide 10:36am.  or with the personal care aide to 12:20pm.  or with the Administrator on the terview with the RD on the testinal disorder, vitamin D bestruction pulmonary essive disorder, nausea, cholesterolemia, heartburn, the terview and to the terview of the terview of the terview with the RD on the testinal disorder, vitamin D bestruction pulmonary essive disorder, nausea, cholesterolemia, heartburn, the terview of the torder dated at #3 revealed a diet order for dided salt (NAS) and low	D 296			
	Review of the reside	nt diet list dated 10/24/18				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL051062	B. WING		10	R 0/ <b>30/2019</b>
	ROVIDER OR SUPPLIER  CARE HOMES # 1	101 ANN	DDRESS, CITY, STATE IIE PARKER CIRCL 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 ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 296	revealed it had not be physician's diet order facility.  Review of the facility' were no menus for th Review of the handw the dining room revea - The lunch meal con baked ham, ½ cup of cup of baked applesThe dinner meal con with meat sauce, ½ conot specify the amounthe dinner meal did cake was sugar free.  Review of the handw located on a message revealed: -The breakfast menu yogurt (did not specify 2 cup of peaches and 1 - The breakfast menu syrup was non sugar - The lunch meal con sandwiches with 2-ou coleslaw, and a ½ cular - The dinner meal con barbeque chicken, ½ of broccoli, cauliflowed and 2 small cookiesThe dinner menu did combread to be served - The dinner meal did small cookies were strong the single strong and the served - The dinner meal did small cookies were strong the single strong the sing	een updated with the current for the residents in the smenus revealed there erapeutic diets.  ritten menu on 10/29/19 in aled: sisted of 2-3 ounces of scalloped potatoes and ½ sisted of 1 cup spaghetti up of broccoli and cake (did not to be served). not specify whether the ritten menu on 10/30/19 e board in the dining room consisted of 2 pancakes, y the amount to be served), d 2T syrup did not specify whether the free or sugar free. sisted of philly cheese steak inces of steak, ½ cup of p of pears and raisins. sisted of 2-3 ounces cup of potato salad, ½ cup er and carrots, cornbread I not specify the amount of ed. not specify whether the 2 ugar free.	D 296			

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_	
		HAL051062	B. WING		R 10/30/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		PARKER CIRC D, NC 27577	CLE		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 296	Continued From page	e 15	D 296			
	-Resident #3 was ser	ved philly steak sandwiches ½ cup of coleslaw, and a ½ ins.				
	Review of the handwr Concentrated Sweets Registered Dietitian (I -The menu was a list substitutions for a reg -The menu was signe	s on 10/30/19 sent by the RD) revealed: of sugar free desert gular diet.				
	Refer to the interview (MA) on 10/3019 at 1	with the medication aide 0:36am.				
	Refer to the interview at 12:17pm.	with the cook on 10/30/19				
	Refer to the interview (PCA) on 10/30/19 at	with the personal care aide 12:20pm.				
	Refer to the interview 10/30/19 at 12:45pm.	with the Administrator on				
	Refer to telephone int 10/31/19 at 9:19am.	terview with the RD on				
	Interview with the cocrevealed:	ok on 10/30/19 at 12:17pm				
	the facility.	/ food service training from				
	-She shadowed the previous cook for one week when she first startedShe served all residents sugar free deserts and					
	she was cooking.	or sugar to any food when y recipes to follow when				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
			D 14/11/0		F	
		HAL051062	B. WING		10/3	0/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		E PARKER CIRC	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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 296	Continued From page 16		D 296			
	preparing the meal formula of the meal	r the facility. herapeutic diet menu to meals for the residents. ven any specific instructions e residents' meals.  cation Aide (MA) on revealed: ed in another building and book. de (PCA) served the times.  A on 10/30/19 at 12:20pm dents came from another ainers. for the residents and served sidents' diet list on the hen to determine which diet				
	12:45pm revealed: -She noticed when sh facility, the facility was every weekThe registered dietitifacility for no concentraction of the shad not been about the menus need the sweets (LCS) and no the sweets (LCS) and no the shad not been about the menus need the sweets (LCS) and no the sweets (LCS) and no the shad not been about the same than the s	le to meet with the RD to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL051062	B. WING		R <b>10/30/2019</b>
	ROVIDER OR SUPPLIER	101 ANN	DDRESS, CITY, STA E PARKER CIRC 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 CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 296	NAS menu spreadshe -Once the facility appr spreadsheet, she wou include her license nu	lity an NAS menu 5/19. cility to review the NCS and eet. roved the menu uld sign the menu and umber. ontacted her to follow-up on	D 296		
D 310	Service  10A NCAC 13F .0904 (e) Therapeutic Diets (4) All therapeutic diesupplements and thic	Nutrition and Food  Nutrition and Food Service in Adult Care Homes: ets, including nutritional kened liquids, shall be the resident's physician.	D 310		
	reviews, the facility fa diets were served as sampled (#3) who had Concentrated Sweets (NAS), and a chopped	ns, interviews and record iled to assure therapeutic ordered for 1 of 3 residents d a physician's order for Low (LCS), No Added Salt			
	06/03/19 revealed dia constipation, gastroin deficiency, chronic ob disease, major depres	testinal disorder, vitamin D struction pulmonary ssive disorder, nausea, nolesterolemia, heartburn,			

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DIVISION	n nealth Service Regu	alion				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ובט
					R	
		HAL051062	B. WING		10/3	0/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
01.40010	04 DE 110ME0 # 4	101 ANNIE	PARKER CIRC	CLE		
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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 310	Continued From page	: 18	D 310			
	07/29/19 for Resident chopped meat, NAS,	#3 revealed a diet order for LCS.				
		t diet list dated 10/24/18 kitchen revealed Resident iet.				
	Review of the facility's were no menus for the	s menus revealed there erapeutic diets.				
	Review of the handwritten menu on 10/30/19 located on a message board in the dining room revealed:  -The breakfast menu consisted of 2 pancakes, yogurt (did not specify the amount to be served), ½ cup of peaches and 2T syrup  -The breakfast menu did not specify whether the syrup was non sugar free or sugar free.  - The lunch meal consisted of philly cheese steak sandwiches with 2-ounces of steak, ½ cup of coleslaw, and a ½ cup of pears and raisins.  -The dinner meal consisted of 2-3 ounces barbeque chicken, ½ cup of potato salad, ½ cup of broccoli, cauliflower and carrots, cornbread and 2 small cookies.  -The dinner menu did not specify the amount of cornbread to be served.					
	Observation of the lur 12:00pm- 12:15pm re -Resident #3 was sen sandwich with 2-ound ½ cup of pears and ra -Resident #3 ate 100	nch meal on 10/30/19 at vealed: ved a regular philly steak es of steak, ½ cup coleslaw, aisins and pudding.				

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DIVISION C	Division of Health Service Regulation					
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMF	PLETED
						<b>D</b>
			B. WING		l l	R
		HAL051062	B. WING		10	/30/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE. ZIP CODE		
			IE PARKER CIRC			
CLASSIC	CARE HOMES # 1			,LE		
		SMITHFIE	ELD, NC 27577			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF		COMPLETE DATE
IAG		,	IAG	DEFICIENCY)		
			1			1
D 310	Continued From page	e 19	D 310			
	Interview with a personal care aide (PCA) on 10/30/19 at 12:00pm revealed:					
	-The food for the residents came from another					
				İ		
	building in large conta			Í		
	<u> </u>	for the residents and served		Í		
	them.	11 -t #0 -bad mont		İ		
		esident #3 chopped meat		İ		
	today.	9 Hit. of the early		Í		
		he responsibility of the cook		İ		
		dent's food was chopped.		İ		
		sidents' diet list on the		İ		
	_	chen to determine which diet		İ		
	was to be served to the			İ		
		Resident #3 was to be		İ		
	served chopped mea			Í		
		e pudding in a game during		İ		
	activities.			Í		
				İ		
		ok on 10/30/19 at 12:17pm		İ		
	revealed:			İ		
	-She had not been tra			Í		
		y food service training from		İ		
	the facility.			Í		
	-She shadowed the p	revious cook for one week		İ		
	when she first started			İ		
		herapeutic diet menu to		İ		
	follow to prepare the	meals for the facility.		İ		
	-She did not have any	y recipes to follow when		İ		
	preparing the meal fo	or the facility.		İ		
	-She had not been give	ven any specific instructions		Í		
	on how to prepare the	e residents' meals.		İ		
	-She did not chop the	pepper steak today				
	because "it was tende	er enough and she did not				
	see the need to chop					
	Interview with the Adr	ministrator on 10/30/2019 at				
	12:45pm revealed:					
		ne first started working at the				
		s serving the same menu				

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every week.

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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		10/30/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	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 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	20	D 310		
	facility for no concent -She had not been ab review the menus nee -She did not have a n order.	ole to meet with the RD to eded for Resident #3. nenu for a chopped diet			
	Telephone interview with the RD on 10/31/19 at 9:19am revealed: -She emailed the facility a no concentrated sweets (NCS) diet menu spreadsheet along with desert substitutions on 07/25/19She emailed the facility an NAS menu spreadsheet on 07/25/19She instructed the facility to review the NCS and NAS menu spreadsheetOnce the facility approved the menu spreadsheet, she would sign the menu and include her license numberThe facility had not contacted her to follow-up on the status of the menusShe was not aware the facility needed a modified diet menu for chopped meats.				
D 358	(a) An adult care hor preparation and admi prescription and nonby staff are in accorda (1) orders by a licens which are maintained	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by:	D 358		

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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 <b>10/30/2019</b>	
	ROVIDER OR SUPPLIER	101 ANNIE	DRESS, CITY, STA PARKER CIRC 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 358	8 Continued From page 21		D 358			
	Based on these finding Violation was not abased on observation reviews, the facility far were administered as residents (Residents included including a major depressive disco (#3); a medication usureflux disease (#2) and depression and anxied anxiety disorder, insorpain syndrome, acute bipolar disorder, gaste (GERD), heart burn, to obstructive pulmonary hypertension.  -There was an order to 20mg, two capsules on ame for Cymbalta usudepression and nerved Review of a visit report psychiatrist dated 08/10-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	ags, the previous Type B ted.  as, interviews, and record iled to assure medications ordered for 3 of 3 sampled #1, #2 and 3) which nedication used to treat order and neuropathic pain ed to treat gastroesophageal and a medication used to treat ty (#1). The findings are:  at #3's current FL-2 dated  major depressive disorder, mnia, fibromyalgia, chronic pain, generalized arthritis, roesophageal reflux disease chroat pain, chronic y disease (COPD) and  for Duloxetine HCL DR one time a day (generic sed to treat major pain from fibromyalgia).  art from Resident #3's 09/19 revealed:  art odiscontinue Cymbalta  art begin Cymbalta 60mg, anxiety, depression, and				
	review.	(IVIAK) Was not available for				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		D	
	HAL051062 B. WING			R <b>10/30/2019</b>		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		PARKER CIRC D, NC 27577	CLE		
0/0.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	1 0/5	_
(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 APPROPF DEFICIENCY)	BE COMPLETE	Ē
D 358	Continued From page 22		D 358			
	revealed: -There was an entry f capsules (40mg) one - There was documer					
	revealed: -There was an entry f capsules (40mg) one -There was document					
	administration reveals - There were Cymbals in the bubble packsThere were two caps days of medication le -The medication was 60 capsules were dis -Instructions on the be	ta 20mg capsules packaged sules in each bubble and 7 ft. dispensed on 10/02/19 and				
	on 10/30/19 at 4:20pr -Resident #3's curren for Cymbalta 20mg, 2 -There was no subset the dose of the medic -The medication was 60 capsules were dis	t order (dated 7/02/19) was capsules one time a day. quent order which changed ation. dispensed on 10/02/19 and				
	revealed; -About 2 months ago	her mental health provider				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (			
			A. BUILDING:			_
		HAL051062	B. WING	10	R 9/ <b>30/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
		101 ANN	IE PARKER CIRCL	E		
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 T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	D 358 Continued From page 23		D 358			
	Cymbalta to help relie fibromyalgia and deci -She did not know if t	The state of the s				
	-On 08/09/19 she visi facility to make a qua assess the resident's -The resident compla from fibromyalgia and increased depression -She ordered Cymbal one time a day to decipain and depression. discontinuedThe Cymbalta order her since 08/09/19She expected the facone time a day on 08The facility staff did relarification of the ord -Another mental health	at 10:45am revealed: ted the resident at the reterly supervisory visit and medication. ined of increased nerve pain d she had symptoms of tata to be increased to 60mg crease the resident's nerve The 20mg order was had not been changed by cility to start Cymbalta 60mg //09/19. not contact her regarding fer. th provider (from the same made regular monthly visits				
	on 10/31/19 at 12:37p -She visited Resident 09/12/19. -She noted the Resid Cymbalta 60mg one t -She reviewed the res MAR and noted the fa administer Cymbalta	#3 at the facility on  ent had a current order for  time a day.  sident's September 2019  acility continued to  40mg one time a day.  he attention of the RCD and				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  101 ANNIE PARKER CIRCLE SMITHFIELD, NC. 27577  SMITHFIELD, NC. 27577  SMITHFIELD, NC. 27577  SMITHFIELD, NC. 27577  AGA  Continued From page 24  increased the Cymbalta to 60mg one time a dayThe RCD informed her she would 'fix this' the same day so the resident was one the resident's accordance of the medication because she reported increased nerve pain from the fibromyalgia, increased depression and increased administre the resident's medications as ordered.  -She expected the facility to contact the mental health provider if there was a need for order clarification or if they had any questions about medication changes  Interview with the Administrator and the RCD on 10/30/19 at 5:25pm revealed neither the Administrator or the RCD were aware Resident #3's Cymbalta dosage had not been changed in August 2019.  Interview with the 1st shift medication aide revealed: -She was not aware Resident #3's Cymbalta order had been changed in August 2019.  Interview with the 1st shift medication orders to the pharmacy, but if she was not available, the MAs faxed the orders and updated the MAR.  Refer to interview with the Administrator and the RCD on 10/30/19 at 5:25pm.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  CLASSIC CARE HOMES # 1  SUMMARY STATEMENT OF DEFICIENCIES  SMITHFIELD, NC 27577   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  SMITHFIELD, NC 27577  D 358  Continued From page 24  Increased the Cymbalta to 60mg one time a day, -The RCD informed her she would "fix this' the same day so the resident would start the medication because she reported increased nerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia, increased depression and increased anerve pain from the fibromyalgia depres			HAL051062	B. WING	B. WING		
CALL SINC CARE HOMES # 1	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
(A4)ID PREEEX TAG  SUMMARY STATEMENT OF DEFICIENCY  REGULATORY OR LSC IDENTIFYING INFORMATION)  D 1D PREEEX TAG  CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 24  increased the Cymbalta to 60mg one time a dayThe RCD informed her she would 'fix this' the same day so the resident would start the Cymbalta 60mgThe resident needed the increased dose of the medication because she reported increased depression and increased anxietyShe expected the facility to administer the resident's medications as orderedShe expected the facility to contact the mental health provider if there was a need for order clarification or if they had any questions about medication changes  Interview with the Administrator and the RCD on 10/30/19 at 5:25pm revealed neither the Administrator nor the RCD were aware Resident #3's Cymbalta dosage had not been changed in August 2019.  Interview with the 1st shift medication aide revealed: -She was not aware Resident #3's Cymbalta order had been changedThe resident was administered Cymbalta, two 20mg capsules every day at 8:00amThe RCD usually faxed medication orders to the pharmacy, but if she was not available, the MAs faxed the orders and updated the MAR.  Refer to interview with the Administrator and the	01.40010	0405 110450 # 4	101 ANN	E PARKER CIRC	LE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 24  Increased the Cymbalta to 60mg one time a day.  -The RCD informed her she would "fix this" the same day so the resident would start the Cymbalta foom;  -The resident needed the increased dose of the medication because she reported increased nerve pain from the fibromyalgia, increased depression and increased anxiety.  -She expected the facility to contact the mental health provider if there was a need for order clarification or if they had any questions about medication changes  Interview with the Administrator and the RCD on 10/30/19 at 5:25pm revealed neither the Administrator nor the RCD were aware Resident #3's Cymbalta dosage had not been changed in August 2019.  Interview with the 1st shift medication aide revealed:  -She was not aware Resident #3's Cymbalta order had been changed.  -The resident was administered Cymbalta, two 20mg capsules every day at 8:00am.  -The RCD usually faxed medication orders to the pharmacy, but if she was not available, the MAs faxed the orders and updated the MAR.  Refer to interview with the Administrator and the	CLASSIC	CARE HOMES # 1	SMITHFI	ELD, NC 27577			
increased the Cymbalta to 60mg one time a day.  -The RCD informed her she would "fix this' the same day so the resident would start the Cymbalta 60mg.  -The resident needed the increased dose of the medication because she reported increased nerve pain from the fibromyalgia, increased depression and increased anxiety.  -She expected the facility to administer the resident's medications as ordered.  -She expected the facility to contact the mental health provider if there was a need for order clarification or if they had any questions about medication changes  Interview with the Administrator and the RCD on 10/30/19 at 5:25pm revealed neither the Administrator nor the RCD were aware Resident #3's Cymbalta dosage had not been changed in August 2019.  Interview with the 1st shift medication aide revealed:  -She was not aware Resident #3's Cymbalta order had been changed.  -The resident was administered Cymbalta, two 20mg capsules every day at 8:00am.  -The RCD usually faxed medication orders to the pharmacy, but if she was not available, the MAs faxed the orders and updated the MAR.  Refer to interview with the Administrator and the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLETE
2. Review of Resident #2's current FL-2 dated 02/20/19 revealed: -Diagnoses of gastroesophageal reflux disease (GERD), reflux esophagitis, schizophrenia, hypoglycemia, hypertension and diabetes mellitus.	D 358	increased the Cymba -The RCD informed h same day so the resid Cymbalta 60mgThe resident needed medication because s nerve pain from the fi depression and increa -She expected the face resident's medications -She expected the face health provider if ther clarification or if they medication changes  Interview with the Adr 10/30/19 at 5:25pm re Administrator nor the #3's Cymbalta dosage August 2019.  Interview with the 1st revealed: -She was not aware order had been change -The resident was add 20mg capsules every -The RCD usually fax pharmacy, but if she w faxed the orders and  Refer to interview with RCD on 10/30/19 at 5  2. Review of Residen 02/20/19 revealed: -Diagnoses of gastroe (GERD), reflux esoph hypoglycemia, hypert	Ita to 60mg one time a day. er she would "fix this' the dent would start the  the increased dose of the she reported increased bromyalgia, increased ased anxiety. cility to administer the s as ordered. cility to contact the mental e was a need for order had any questions about  ministrator and the RCD on evealed neither the RCD were aware Resident e had not been changed in  shift medication aide  Resident #3's Cymbalta ged. ministered Cymbalta, two day at 8:00am. ed medication orders to the was not available, the MAs updated the MAR.  In the Administrator and the 6:25pm.  It #2's current FL-2 dated esophageal reflux disease lagitis, schizophrenia,	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_	
HAL051062		B. WING		R <b>10/30/2019</b>		
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1	101 ANNIE	PARKER CIRC	CLE		
SMITHFIEL			LD, 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 APPROPR DEFICIENCY)	BE COMPLET	E
D 358	Continued From page	25	D 358			
	-There was an order for Omeprazole 20mg (used to treat GERD) every morning.					
	Review of Resident # Consultation (PCP) N revealed:	2's primary care provider's ote dated 06/17/19				
	-The resident complain a burning sensation in	ined of increased cough and n her chest.				
	worse with acid food	he burning sensation was and symptoms began 2				
		to "stop" Omeprazole 20mg				
	•	art Ranitidine Max Strength GERD), one tablet, two				
	Review of Resident #2's PCP's Consultation Note dated 06/24/19 revealed there was an order to continue Ranitidine Max Strength 150mg, one tablet, two times a day.					
	Review of two of Resi					
	Consultation Notes dated 07/08/19 and 07/22/19 revealed there were ordesr to continue Ranitidine Max Strength 150mg, one tablet, two times a day.					
Review of Resident #2's August 2019 MAR revealed:						
	-Omeprazole 20mg was documented as administered every day from 08/01/19 - 08/31/19 at 7:30am.					
	-Ranitidine 150mg wa administered twice a 08/31/19 at 8:00am a	day from 08/01/19 -				
	Review of Resident # revealed:	2's September 2019 MAR				
	-Omeprazole 20mg w administered every da	as documented as ay from 09/01/19 - 09/30/19				

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at 7:30am.

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					_	
			B. WING		R	
		HAL051062	D. WIITO		10/3	0/2019
NAME OF PROVIDER OR SUP	PLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		101 ANNIF	E PARKER CIRC	CLE		
CLASSIC CARE HOMES # 1		LD, NC 27577				
(VA) ID SU	MMARY ST	FATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	N.	(X5)
(>\.)\.2		CY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
	ATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 358 Continued Fi	rom page	e 26	D 358			_
	. •					
		as documented as				ı
• • • • • • • • • • • • • • • • • • •		day day from 09/01/19 -				ı .
09/30/19 at 8	3:00am a	and 8:00pm.				
Davious of B	: dont +	401- O-t-har 2040 MAD				
revealed:	3810erit #	#2's October 2019 MAR				ı
	20ma v	vas documented as				ı .
1 -	•	lay from 10/01/19 - 10/31/19				ı
at 7:30am.	1 CVCi y G	ay 110111 1070 1710 1070 1710				ı
	50mg wa	as documented as				ı
l	•	day from 10/01/19 -				ı
10/31/19 at 8						ı
10/01/10 0.0	J.00aiii 3	та о.оорт.				
Observation	of Resid	lent #2's medication on hand				
revealed:						ı
	•	30 capsules, were				ı
·	n 10/01/1	19. There were 4 capsules				ı
on hand.						ı
	•	0 tablets, were dispensed on				ı
10/18/19. Th	ere were	e 37 tablets on hand.				ı
		ministrator and the RCD on				ı
10/30/19 at 9						ı
		re Resident #2's Omeprazole				1
		06/17/19 but continued to be				1
administered						1
		e there was an order for				1
		s being administered two				1
times a day.		Resident #2's PCP on				1
						I
l	10/29/19 to clarify the order to discontinue the Omeprazole.					1
Oneprazole	•					I
Interview wit	h Reside	ent #2's PCP on 10/30/19 at				1
11:06am rev		71. 112 01 01 01 10/00/10 dt				1
		the resident was receiving				I
both Ranitidi						I
		nt #2 reported she was				I
		ERD symptoms and the				1
		pped and Ranitidine 150mg				1

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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		HAL051062	B. WING		R 10/30/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 27	D 358			
	two times a day was of a The facility staff should revening.  She did not expect the interactions from recide may experience constructed recieving both medication. The RCD contacted clarify the Omeprazol to stop the medication. The PCP expected the staff should recipie to stop the medication.	ordered.  Ild only be administering the he morning and in the he resident to have eving the medications, but tipation or headaches from ations.  The PCP on 10/29/19 to e order and was instructed n.  The facility to implement all dine should have been				
	Telephone interview with the facility's pharmacist on 10/30/19 at 4:20pm revealed:  -Resident #2's Omeprazole 20mg was dispensed every month (30 tablets) including July 2019, August 2019, and October 2019.  -The facility staff faxed a discontinue order for Omeprazole on 10/29/19.  -An order for the resident's Ranitidine 150mg was received on 06/17/19 and 60 tablets were dispensed every month.  -Ranitidine was last dispensed on 10/18/19 (60 tablets).  Refer to interview with the Administrator and the RCD on 10/30/19 at 5:25pm.  3. Review of Resident #1's current FL-2 dated 08/05/19 revealed:  -Diagnoses included chronic obstruction pulmonary disease, hyperlipidemia, cerebral arteriosclerosis, and peripheral vascular disc.  -There was an order for Lexapro 10mg tablets take 1 and ½ at bedtime. (Lexapro is used to treat depression and anxiety).  -There was an order for Escitalopram 10 mg tablets, take one at bedtime. (Escitalopram is the					

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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	
			_		R	
		HAL051062	B. WING		10/30/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	28	D 358			
	generic name for Lex	apro).				
	dated 08/09/19 revealusion - Discontinue current I - Begin Lexapro 10mg bedtime for anxiety, decreased a series of Resident # administration record - There was a handwr 10mg, take 1 and ½ to 8/09/19.  -There was document been administered at 08/09/19-08/31/19.  Review of Resident #	Lexapro. 1 1 ½ tablets (15mg) at lepression and insomnia. 1's August 2019 medication (MAR) revealed: litten entry for Lexapro ablets at bedtime dated				
	revealed: -There was a handwritten entry for Lexapro 10mg tablets, take 1 and ½ tablets at bedtime dated 08/09/19There was documentation the medication had been administered at 8:00pm daily from 09/01-09/30/19.					
	revealed: -There was a handwr 10mg, take 1 and ½ t 08/09/19There was documen	1's October 2019 MAR itten entry for Lexapro ablets at bedtime dated tation the medication had 8:00pm daily from 10/01/19-				
	Observation of Resident #1's medications on hand on 10/29/19 at 2:41pm revealed:  -The medication pouch read Lexapro 10mg tablet, take one tablet once daily at bedtime.  -There was a 30-day supply of Lexapro on hand.					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. BOILBING	The Bolesmon		,	
HAL051062		B. WING		R 10/30/2019			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
01.40010	CARE HOMES #4	101 ANN	IIE PARKER CIRCI	.E			
CLASSIC	CARE HOMES # 1	SMITHFI	ELD, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE	
D 358	Continued From page	29	D 358				
	10/30/19 at 4:27pm retablets were last disp 30-day supply. Interview with a Medi 10/29/19 at 3:29pm relit was the responsibil Director (RCD) to associarified and discontining the same administered on Resident #1.  She had not administered on Resident #1.  She had not administered on Resident #1.  Telephone interview with provider (PCP) on 10.  Resident #1 was preof Lexapro on 08/09/2 depression.  There was the possidue to the staff's failureceived her medication included continuation. She had not been not Resident #1 had not lead sage order of 15 medications as ordered Refer to interview with RCD on 10/30/19.  Interview with the Adri 10/30/19 at 5:25pm retails.	evealed: lity of the Resident Care sure medication orders were nued with the pharmacist. le tablet of Lexapro 10mg to  tered one and a half tablet Resident #1. Resident #1's medication  with the primary care /30/19 at 12:27pm revealed: scribed the dosage increase 19 due to increased  bility of negative outcome re to assure Resident #1 ons as ordered which of depression symptoms. biffied by the facility staff, been receiving her current g Lexapro. cility to administer ed.  In the Administrator and the  ministrator and the RCD on					

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responsible for processing new orders.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
				R	
HAL051062		B. WING		10/30/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		101 ANNIE	PARKER CIRC	CLE	
CLASSIC CARE HOMES # 1			D, NC 27577		
		1	DDOV/DEDIC DLAN OF CODDECTION		
(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)	BE COMPLETE
D 358	Continued From page	e 30	D 358		
	received and the new added to the current I on duty.  -The pharmacy shoul the new order was responsed to the CD was responsed to the communication book medication changes of the 2nd and 3rd shift using the communication process.	the pharmacy as soon as medication order should be MAR by the RCD or the MA do be contacted to confirm ceived. Insible for updating the enthere were medication es. In documented in the staff to cue the MAs of any or new orders. If MAs audited the MARS			
	The facility failed to administer medications as ordered for 3 of 3 sampled residents resulting in a resident (#3) who had a history of major depressive disorder, fibromyalgia, chronic pain syndrome not receiving ordered dose of medication to relieve symptoms; a resident (#2) receiving a reflux medication for 4 months after it was discontinued; and a resident (#1) not receiving the correct dose of medication to treat depression for more than three months. The failure of the facility to administer medications as ordered was detrimental to the health, safety and welfare of the residents, which constitutes an Unabated Type B Violation.  The facility provided a Plan of Correction on 10/30/19 in accordance with G. S. 131D-24.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. 501251110.	R		
HAL051062		HAL051062	B. WING		10/30/2019	
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	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D912	Continued From page	31	D912			
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912			
	G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:  2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.					
	This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to Housekeeping and Furnishings, Health Care and Medication Administration.					
	The findings are:  1. Based on observations and interviews, the facility failed to assure the facility was free of hazards as evidenced by the storage of three empty portable oxygen tanks not secured in racks or crates, in a resident's room. [Refer to Tag D079 10A NCAC 13F 0306(5) Housekeeping and Furnishings (Type B Violation)].  2. Based on observations, interviews and record reviews the facility failed to schedule an appointment for 1 of 3 sampled residents (Residents #3) regarding a referral to a gastroenterologist.[Refer to Tag D273 10A NCAC 13F .0902(b) Health Care(Type B Violation)].					

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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		10/30/2019			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CLASSIC	CLASSIC CARE HOMES # 1  SMITHFIELD, NC 27577							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE			
D912	3. Based on observat reviews, the facility fa were administered as residents (Residents included including a najor depressive disc (#3); a medication use reflux disease (#2) and	ions, interviews, and record iled to assure medications ordered for 3 of 3 sampled #1, #2 and 3) which nedication used to treat order and neuropathic pain ed to treat gastroesophageal d a medication used to treat ty (#1). [Refer to Tag D358, (a) Medication	D912					

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