STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on October 29, 2019 through October 30, 2019.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION 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. The findings are: Observation of resident room #7 on 10/29/19 at 8:52am revealed: -There were three empty portable oxygen tanks in the resident's room, between two night stands next to the beds. -The three empty portable oxygen tanks were standing upright in front of nine tanks that were in racks. -The three empty portable oxygen tanks were not	D 079		

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	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

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D 079	Continued From page 1 secure or in a rack. Interview with the personal care aide (PCA) on 10/29/19 at 8:54am revealed: -She was a new employee. -She had been working in the facility for three weeks. -She did not know the proper way empty or full portable oxygen tanks were to be stored. Interview with the Resident Care Director (RCD) on 10/29/19 at 8:54am revealed: -She called the medical supply company to pick up the empty tanks on 10/25/19. -The tanks were to be picked up on 10/28/19. -She did not have another place to store the empty portable oxygen tanks. -She was not aware the empty portable oxygen tanks had a potential to explode if they were stored on the floor. -She was aware the empty and full portable oxygen tanks were to be stored in racks. Telephone interview with a representative from a local medical supply company on 10/29/19 at 2:11pm revealed: -The company's technician was at the facility on 10/22/19 to deliver portable oxygen tanks. -They delivered oxygen to the facility when the facility called them. -The empty portable oxygen tanks were automatically picked up when the technician delivered new tanks. -When the technicians delivered the full portable oxygen tanks, the portable oxygen tanks were placed wherever the facility told the technician to leave them. -When oxygen equipment was ordered and delivered to a resident at a facility, racks and crates were not included unless it was requested	D 079		

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D 079	Continued From page 2 by the facility because they were billed separately. Interview with the resident who resided in room #7 on 10/30/19 at 9:11am revealed: -She used the cylinder portable oxygen tanks when she went out to appointments. -The empty and full portable oxygen tanks were kept in her room. -The empty and full portable oxygen tanks are normally stored in a rack. -The three empty portable oxygen tanks that were on the floor had been there for a week. Interview with a Medication Aide (MA) on 10/30/19 at 9:13am revealed: -She was not aware the portable oxygen tanks were sitting on the floor. -She was aware the portable oxygen tanks should have been stored in a rack and not on the floor. Observation on 10/30/19 at 9:30am revealed the three empty portable oxygen tanks had been removed from resident room #7. The facility failed to ensure empty portable oxygen tanks were stored securely in a storage rack away from electrical outlets, creating a potential for an unsecured cylinder to fall and/or be knocked over, damaging the valve, and rapidly releasing the high-pressure gas from the tank, which could potentially cause an explosion in the facility. The facility's failure was detrimental to the health and safety of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/29/19 for this violation.	D 079		

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	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 079	Continued From page 3 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 14, 2019.	D 079		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION 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. The findings are: Review of Resident #3's current FL-2 dated 06/03/19 revealed diagnoses included gastroesophageal reflux disease (GERD), heartburn, nausea, throat pain, insomnia, acute pain, chronic pain syndrome, hypertension, bipolar disorder, dementia, major depressive disorder, anxiety, and constipation. Review of Resident #3's Resident Care Notes (documentation by a medication aide) revealed: -On 10/14/19 "around 6:30am, I had to send the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 273	Continued From page 4	D 273		

resident [Resident #3] to the hospital emergency room".
-She has been bad off sick for two days or so, complaining of nausea, throwing up, diarrhea as well as complaining of severe pain on the right side of her stomach.
- She threw up all meds this morning that was given to her.
-"I checked her vitals and contacted the Resident Care Director (RCD) and she asked me to go ahead and send her out".

Review of a post hospital report revealed:
-Resident #3 was hospitalized from 10/14/19 to 10/16/19 with a diagnosis of abdominal pain.
-The resident's discharge medications included Percocet 10/325 (used to relieve moderate to severe pain), 3 times a day for five days to relieve abdominal pain; Loperamide 2mg (used to relieve diarrhea) every 8 hours as needed for diarrhea, and Xanax 0.25mg (used to relieve anxiety) every 12 hours as needed for sleep up to five days.
-There was no other information regarding the hospitalization in the resident's record.

Review of Resident #3's Resident Care Notes revealed:
-On 10/18/19 (1st shift) the "resident [Resident #3] had been constantly going to the bathroom, it started after 10am and having nausea as well as diarrhea. She has complained of weakness and I contacted the RCD. The RCD had already talked to the resident's [family member] and wanted the resident sent out to the emergency room (ER). We sent her out to the emergency room about 2:30pm or so".
-On 10/18/19 (2nd shift) "the resident has returned back to the facility from the hospital with a doctor's order for nausea medicine. Resident has been acting a lot better tonight".

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 273	Continued From page 5 Review of an "After Visit Summary" report from a local ER dated 10/18/19 revealed: -The reason for the ER visit was Resident #3's complaint of abdominal pain. -The resident was diagnosed with abdominal pain, non-intractable vomiting with nausea (vomiting that is difficult to control and does not lessen with time or treatment), and unspecified vomiting type. -The resident was treated with sublingual Fentanyl (used to treat severe pain), promethazine (used to treat nausea and vomiting) and an intravenous bolus of 0.9% sodium chloride (used to treat dehydration). -The resident was discharged from the ER with an order to follow-up with a local gastroenterologist (address and phone number of the gastroenterologist provided) in one week (around 10/25/19). The appointment was not scheduled by the ER. Telephone interview with the local gastroenterologist on 10/30/19 at 4:50pm revealed: -A referral for Resident #3 was never received at the office. -The hospital did not call in a referral and the facility did not contact the office to schedule an appointment for Resident #3 in October 2019. Observation on 10/30/19 at 3:55pm revealed Resident #3 was sitting in the TV room with her legs elevated on her oxygen concentrator. Interview with Resident #3 on 10/30/19 at 3:55pm revealed: -When sitting up, she elevated her legs to help relieve stomach discomfort. -She was transported to the hospital two times in	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 273	Continued From page 6	D 273		

October 2019 because she was having severe stomach pain, vomiting and diarrhea.
-She did not know if she had a referral to a "stomach doctor" since going to the hospital.
-She was not seen at a "specialist" office this month (October 2019).
-The facility staff transported her to medical appointments.

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.
-She was constipated due to the "twisted colon".
-After admission to the facility, in 2015, she was having stomach pain.
-Her primary care provider (PCP) at the facility sent her to a specialist for her stomach pain after admission but she did not know the date.
-She was currently not having stomach pain.

Review of a Resident Physician Order Request/Visit for Resident #3 dated 10/21/19 revealed:
-Resident #3's PCP made a follow-up (post-hospital) visit with the resident at the facility to assess abdominal pain and nausea.
-There was an order to follow-up with hospital scheduled "GI" visit.

Interview with Resident #3's PCP on 10/30/19 at 11:06am revealed:
-She was aware a referral to a gastroenterologist was made by the local ER medical provider on 10/18/19.
-She did not know if the facility staff had scheduled the appointment for the resident.
-She expected the facility staff to follow-up with any ordered referrals, including making medical

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CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 273	Continued From page 7	D 273		

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 aware 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, the RCD was to make appointments.
-The RCD received all post hospital 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 appointment was not made, but the resident

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	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

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CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 273	Continued From page 8 probably refused to go. -She was responsible for scheduling medical appointments for all of the residents and the appointments were documented on the transportation appointment calendar. Interview with the Transportation Director on 10/30/19 at 5:30pm revealed: - There was not an appointment on the October 2019 calendar for Resident #3. -He did not remember transporting the resident to a local gastroenterologist office in October 2019. -If the resident refused to go to an appointment, he would note it on the appointment calendar and report the refusal to the RCD The facility failed to schedule a follow-up appointment with a gastroenterologist as ordered by the ER for Resident #3 who had a history of bowel obstruction and was recently hospitalized twice for acute abdominal pain, nausea and intractable vomiting. This failure was detrimental to the health, safety, and welfare to the resident which constitutes a Type B Violation. The facility provided a Plan of Correction on 10/30/19 in accordance with G. S. 131D-24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 14, 2019.	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes:	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

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D 296	Continued From page 9 (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have matching therapeutic menus for food service guidance for 3 of 3 sampled residents (#1, #2, #3) with physician orders for Low Concentrated Sweets (LCS), a No Added Salt (NAS) diet (#1 and #2) and LCS diet, NAS diet, Chopped meats diet (#3). The findings are: 1. 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 a NAS, LCS diet. Interview with Resident #1 on 10/30/19 at 2:49pm revealed: -She ate whatever she wanted. -She was not a diabetic. Review of the resident diet list dated 10/24/18 revealed it had not been updated with the current physician's diet order for Resident #1. Review of the handwritten menu on 10/29/19 located on a message board in the dining room revealed: - The lunch meal consisted of 2-3 ounces of baked ham, ½ cup scalloped potatoes and ½ cup of baked apples. -The dinner meal consisted of 1 cup of spaghetti with meat sauce, ½ cup broccoli and cake (did	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 296	Continued From page 10	D 296		

not specify the amount to be served).
-The dinner meal did not specify whether the cake was non sugar free or sugar free.

Review of the facility's menus revealed there were no menus for therapeutic 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 sugar free.
- The lunch meal consisted of philly cheese steak sandwiches with 2-ounces of steak, ½ cup coleslaw, and a ½ cup of pears and raisins.
-The dinner meal consisted of 2-3 ounces of 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.
-The dinner meal did not specify whether the 2 small cookies were sugar free.

Review of the facility's menus revealed there were no menus for therapeutic diets.

Observation of the lunch meal on 10/30/19 at 12:00pm- 12:15pm revealed:
-Resident #1 was served a philly cheese steak sandwich, ½ cup of coleslaw, and a ½ cup of pears and raisins.
-Resident #1 ate 100 percent of her meal.

Review of the handwritten menu for a No Concentrated Sweets diet on 10/30/19 sent by the Registered Dietitian (RD) revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 11 -The menu was a list of sugar free desert substitutions for a regular diet. -The menu was signed by the RD. -There was no menu for an LCS and NAS diet. Refer to the interview with the medication aide (MA) on 10/3019 at 10:36am. Refer to the interview with the cook on 10/30/19 at 12:17pm. Refer to the interview with the personal care aide (PCA) on 10/30/19 at 12:20pm. Refer to the interview with the Administrator on 10/30/19 at 12:45pm. Refer to telephone interview with the RD on 10/31/19 at 9:19am. 2. Review of Resident #2's current FL-2 dated 02/20/19 revealed: - Diagnoses included schizophrenia, hypoglycemia, hypertension, diabetes mellitus II, vitamin D deficiency, gastrointestinal disorder and allergic rhinitis. -There was an order for fasting blood sugars every week on Wednesday. -There was an order for monthly weights. Review of the most recent diet order dated 07/29/19 for Resident #2 revealed a diet order for low concentrated sweets (LCS) and no added salt (NAS). Review of the facility's menus revealed there were no menus for therapeutic diets. Review of the resident diet list dated 10/24/18 revealed it had not been updated with the current	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 12 physician's diet order for the residents in the facility. Review of the handwritten menu on 10/29/19 located on a message board in the dining room revealed: - The lunch meal consisted of 2-3 ounces of baked ham, ½ cup of scalloped potatoes and ½ cup of baked apples. -The dinner meal consisted of 1 cup of spaghetti with meat sauce, ½ cup of broccoli and cake (did not specify the amount to be served). -The dinner meal did not specify whether the cake was non sugar free or sugar free. -There were no menus for therapeutic diets. Review of the menu handwritten 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. -The dinner meal did not specify whether the 2 small cookies were sugar free. Observation of the lunch meal on 10/30/19 at 12:00pm- 12:15pm revealed: -Resident #2 was served philly steak sandwiches, ½ cup of coleslaw, and a ½ cup of pears and	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 13	D 296		

raisins.
-Resident #2 ate 100 percent of her meal.

Review of the handwritten menu for NCS on 10/30/19 sent by the Registered Dietitian (RD) revealed:
-The menu was a list of sugar free desert substitutions for a regular diet.
-The menu was signed by the RD.
-There was no menu for an LCS and NAS diet.

Refer to the interview with the medication aide (MA) on 10/3019 at 10:36am.

Refer to the interview with the cook on 10/30/19 at 12:17pm.

Refer to the interview with the personal care aide (PCA) on 10/30/19 at 12:20pm.

Refer to the interview with the Administrator on 10/30/19 at 12:45pm.

Refer to telephone interview with the RD on 10/31/19 at 9:19am.

3. Review of Resident #3's current FL-2 dated 06/03/19 revealed diagnoses included constipation, gastrointestinal disorder, vitamin D deficiency, chronic obstruction pulmonary disease, major depressive disorder, nausea, hypertension, hypercholesterolemia, heartburn, and hyperlipidemia.

Review of the most recent diet order dated 07/29/19 for Resident #3 revealed a diet order for chopped meat, no added salt (NAS) and low concentrated sweets (LCS).

Review of the resident diet list dated 10/24/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 14 revealed it had not been updated with the current physician's diet order for the residents in the facility. Review of the facility's menus revealed there were no menus for therapeutic diets. Review of the handwritten menu on 10/29/19 in the dining room revealed: - The lunch meal consisted of 2-3 ounces of baked ham, ½ cup of scalloped potatoes and ½ cup of baked apples. -The dinner meal consisted of 1 cup spaghetti with meat sauce, ½ cup of broccoli and cake (did not specify the amount to be served). -The dinner meal did not specify whether the cake was sugar free. 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. -The dinner meal did not specify whether the 2 small cookies were sugar free. Observation of the lunch meal on 10/30/19 at 12:00pm- 12:15pm revealed:	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

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CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 296	Continued From page 15 -Resident #3 was served philly steak sandwiches with 2-ounce steak, ½ cup of coleslaw, and a ½ cup of pears and raisins. -Resident #3 ate 100 percent of her meal. Review of the handwritten menu for a No Concentrated Sweets on 10/30/19 sent by the Registered Dietitian (RD) revealed: -The menu was a list of sugar free desert substitutions for a regular diet. -The menu was signed by the RD. Refer to the interview with the medication aide (MA) on 10/3019 at 10:36am. Refer to the interview with the cook on 10/30/19 at 12:17pm. Refer to the interview with the personal care aide (PCA) on 10/30/19 at 12:20pm. Refer to the interview with the Administrator on 10/30/19 at 12:45pm. Refer to telephone interview with the RD on 10/31/19 at 9:19am. _____ Interview with the cook on 10/30/19 at 12:17pm revealed: -She had not been trained as a cook. -She had not had any food service training from the facility. -She shadowed the previous cook for one week when she first started. -She served all residents sugar free deserts and non-sweetened tea. -She did not add salt or sugar to any food when she was cooking. -She did not have any recipes to follow when	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 296	Continued From page 16	D 296		

preparing the meal for the facility.
-She did not have a therapeutic diet menu to follow to prepare the meals for the residents.
-She had not been given any specific instructions on how to prepare the residents' meals.

Interview with a Medication Aide (MA) on 10/30/19 at 10:36am revealed:
-The food was prepared in another building and brought over by the cook.
-The personal care aide (PCA) served the residents during meal times.

Interview with the PCA on 10/30/19 at 12:20pm revealed:
-The food for the residents came from another building in large containers.
-She plated the food for the residents and served them.
-She reviewed the residents' diet list on the refrigerator in the kitchen to determine which diet was to be served to the residents.

Interview with the Administrator on 10/30/2019 at 12:45pm revealed:
-She noticed when she first started working at the facility, the facility was serving the same menu every week.
-The registered dietitian (RD) sent menus to the facility for no concentrated sweets (NCS).
-She had not been able to meet with the RD to review the menus needed for the facility.
-There were no menus for a low concentrated sweets (LCS) and no added salt (NAS) diet.

Telephone interview with the RD on 10/31/19 at 9:19am revealed:
-She emailed the facility an NCS diet menu spreadsheet along with desert substitutions on 07/25/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 296	Continued From page 17 -She emailed the facility an NAS menu spreadsheet on 07/25/19. -She instructed the facility to review the NCS and NAS menu spreadsheet. -Once the facility approved the menu spreadsheet, she would sign the menu and include her license number. -The facility had not contacted her to follow-up on the status of the menus.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 3 residents sampled (#3) who had a physician's order for Low Concentrated Sweets (LCS), No Added Salt (NAS), and a chopped meat. The findings are: Review of Resident #3's current FL-2 dated 06/03/19 revealed diagnoses included constipation, gastrointestinal disorder, vitamin D deficiency, chronic obstruction pulmonary disease, major depressive disorder, nausea, hypertension, hypercholesterolemia, heartburn, and hyperlipidemia. Review of the most recent diet order dated	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 310	Continued From page 18 07/29/19 for Resident #3 revealed a diet order for chopped meat, NAS, LCS. Review of the resident diet list dated 10/24/18 posted in the facility's kitchen revealed Resident #3 was on a regular diet. Review of the facility's menus revealed there were no menus for therapeutic 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. -The dinner meal did not specify whether the 2 small cookies were sugar free. Observation of the lunch meal on 10/30/19 at 12:00pm- 12:15pm revealed: -Resident #3 was served a regular philly steak sandwich with 2-ounces of steak, ½ cup coleslaw, ½ cup of pears and raisins and pudding. -Resident #3 ate 100 percent of her meal. Review of the pudding label revealed the pudding was not sugar free.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 310	Continued From page 19 Interview with a personal care aide (PCA) on 10/30/19 at 12:00pm revealed: -The food for the residents came from another building in large containers. -She plated the food for the residents and served them. -She did not serve Resident #3 chopped meat today. -She thought it was the responsibility of the cook to make sure the resident's food was chopped. -She reviewed the residents' diet list on the refrigerator in the kitchen to determine which diet was to be served to the residents. -She was not aware Resident #3 was to be served chopped meat. -Resident #3 won the pudding in a game during activities. Interview with the cook on 10/30/19 at 12:17pm revealed: -She had not been trained as a cook. -She had not had any food service training from the facility. -She shadowed the previous cook for one week when she first started. -She did not have a therapeutic diet menu to follow to prepare the meals for the facility. -She did not have any recipes to follow when preparing the meal for the facility. -She had not been given any specific instructions on how to prepare the residents' meals. -She did not chop the pepper steak today because "it was tender enough and she did not see the need to chop it." Interview with the Administrator on 10/30/2019 at 12:45pm revealed: -She noticed when she first started working at the facility, the facility was serving the same menu every week.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 310	Continued From page 20 -The registered dietitian (RD) sent menus to the facility for no concentrated sweets (NCS). -She had not been able to meet with the RD to review the menus needed for Resident #3. -She did not have a menu for a chopped diet order. 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 07/25/19. -She emailed the facility an NAS menu spreadsheet on 07/25/19. -She instructed the facility to review the NCS and NAS menu spreadsheet. -Once the facility approved the menu spreadsheet, she would sign the menu and include her license number. -The facility had not contacted her to follow-up on the status of the menus. -She was not aware the facility needed a modified diet menu for chopped meats.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 358	Continued From page 21 Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 3 of 3 sampled residents (Residents #1, #2 and 3) which included including a medication used to treat major depressive disorder and neuropathic pain (#3); a medication used to treat gastroesophageal reflux disease (#2) and a medication used to treat depression and anxiety (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 02/20/19 revealed: - Diagnoses included major depressive disorder, anxiety disorder, insomnia, fibromyalgia, chronic pain syndrome, acute pain, generalized arthritis, bipolar disorder, gastroesophageal reflux disease (GERD), heart burn, throat pain, chronic obstructive pulmonary disease (COPD) and hypertension. -There was an order for Duloxetine HCL DR 20mg, two capsules one time a day (generic name for Cymbalta used to treat major depression and nerve pain from fibromyalgia). Review of a visit report from Resident #3's psychiatrist dated 08/09/19 revealed: -There was an order to discontinue Cymbalta 20mg. -There was an order to begin Cymbalta 60mg, one capsule daily for anxiety, depression, and chronic pain. Resident #3's August 2019 medication administration record (MAR) was not available for review.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 358	Continued From page 22 Review of Resident #3's September 2019 MAR revealed: -There was an entry for Cymbalta 20mg, 2 capsules (40mg) one time a day. - There was documentation the medication was administered at 8:00am every day from 09/01/19 to 09/30/19. Review of Resident #3's October 2019 MAR revealed: -There was an entry for Cymbalta 20mg, 2 capsules (40mg) one time a day. -There was documentation the medication was administered at 8:00am every day from 10/01/19 to 10/30/19. Review of Resident#'s medications available for administration revealed: - There were Cymbalta 20mg capsules packaged in the bubble packs. -There were two capsules in each bubble and 7 days of medication left. -The medication was dispensed on 10/02/19 and 60 capsules were dispensed. -Instructions on the bubble pack were Duloxetine HCL (Cymbalta) 20mg, 2 capsules (40mg) one time a day. Telephone interview with the facility's pharmacist on 10/30/19 at 4:20pm revealed: -Resident #3's current order (dated 7/02/19) was for Cymbalta 20mg, 2 capsules one time a day. -There was no subsequent order which changed the dose of the medication. -The medication was dispensed on 10/02/19 and 60 capsules were dispensed. Interview with Resident #3 on 10/30/19 at 4:45pm revealed; -About 2 months ago her mental health provider	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 358	Continued From page 23	D 358		

had talked to her about increasing the dose of Cymbalta to help relieve her pain from fibromyalgia and decrease depression.
-She did not know if the medication was changed.
-She continued to be depressed and continued to have pain.

Telephone interview with Resident #3's psychiatrist on 10/31/19 at 10:45am revealed:
-On 08/09/19 she visited the resident at the facility to make a quarterly supervisory visit and assess the resident's medication.
-The resident complained of increased nerve pain from fibromyalgia and she had symptoms of increased depression.
-She ordered Cymbalta to be increased to 60mg one time a day to decrease the resident's nerve pain and depression. The 20mg order was discontinued.
-The Cymbalta order had not been changed by her since 08/09/19.
-She expected the facility to start Cymbalta 60mg one time a day on 08/09/19.
-The facility staff did not contact her regarding clarification of the order.
-Another mental health provider (from the same mental health group) made regular monthly visits and may have changed the order.

Telephone interview with a mental health provider on 10/31/19 at 12:37pm revealed:
-She visited Resident #3 at the facility on 09/12/19.
-She noted the Resident had a current order for Cymbalta 60mg one time a day.
-She reviewed the resident's September 2019 MAR and noted the facility continued to administer Cymbalta 40mg one time a day.
-She brought this to the attention of the RCD and informed her of the 08/09/19 order which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 24	D 358		

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 RCD on 10/30/19 at 5:25pm.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 25 -There was an order for Omeprazole 20mg (used to treat GERD) every morning. Review of Resident #2's primary care provider's Consultation (PCP) Note dated 06/17/19 revealed: -The resident complained of increased cough and a burning sensation in her chest. -The resident stated the burning sensation was worse with acid food and symptoms began 2 hours after eating dinner at 6:00pm. -There was an order to "stop" Omeprazole 20mg one time a day and start Ranitidine Max Strength 150mg (used to treat GERD), one tablet, two times a day. 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 Resident #2's PCP's 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 was documented as administered twice a day from 08/01/19 - 08/31/19 at 8:00am and 8:00pm. Review of Resident #2's September 2019 MAR revealed: -Omeprazole 20mg was documented as administered every day from 09/01/19 - 09/30/19 at 7:30am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 26 -Ranitidine 150mg was documented as administered twice a day day from 09/01/19 - 09/30/19 at 8:00am and 8:00pm. Review of Resident #2's October 2019 MAR revealed: -Omeprazole 20mg was documented as administered every day from 10/01/19 - 10/31/19 at 7:30am. -Ranitidine 150mg was documented as administered twice a day from 10/01/19 - 10/31/19 at 8:00am and 8:00pm. Observation of Resident #2's medication on hand revealed: -Omeprazole 20 mg, 30 capsules, were dispensed on 10/01/19. There were 4 capsules on hand. -Ranitidine 150mg, 60 tablets, were dispensed on 10/18/19. There were 37 tablets on hand. Interview with the Administrator and the RCD on 10/30/19 at 9:50am revealed: - They were not aware Resident #2's Omeprazole was discontinued on 06/17/19 but continued to be administered every day. -They were not aware there was an order for Ranitidine which was being administered two times a day. -The RCD contacted Resident #2's PCP on 10/29/19 to clarify the order to discontinue the Omeprazole. Interview with Resident #2's PCP on 10/30/19 at 11:06am revealed: -She was not aware the resident was receiving both Ranitidine and Omeprazole. -On 6/17/19, Resident #2 reported she was having worsening GERD symptoms and the Omeprazole was stopped and Ranitidine 150mg	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 27	D 358		

two times a day was ordered.
-The facility staff should only be administering the Ranitidine 150mg in the morning and in the evening.
-She did not expect the resident to have interactions from recieving the medications, but may experience constipation or headaches from recieving both medications.
-The RCD contacted the PCP on 10/29/19 to clarify the Omeprazole order and was instructed to stop the medication.
-The PCP expected the facility to implement all orders and the Ranitidine should have been discontinued on 06/17/19.

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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	HAL051062	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 28 generic name for Lexapro). Review of a physician's order for Resident #1 dated 08/09/19 revealed: -Discontinue current Lexapro. -Begin Lexapro 10mg 1 ½ tablets (15mg) at bedtime for anxiety, depression and insomnia. Review of Resident #1's August 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Lexapro 10mg, take 1 and ½ tablets at bedtime dated 08/09/19. -There was documentation the medication had been administered at 8:00pm daily from 08/09/19-08/31/19. Review of Resident #1's September 2019 MAR revealed: -There was a handwritten entry for Lexapro 10mg tablets, take 1 and ½ tablets at bedtime dated 08/09/19. -There was documentation the medication had been administered at 8:00pm daily from 09/01-09/30/19. Review of Resident #1's October 2019 MAR revealed: -There was a handwritten entry for Lexapro 10mg, take 1 and ½ tablets at bedtime dated 08/09/19. -There was documentation the medication had been administered at 8:00pm daily from 10/01/19-10/29/19. 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.	D 358		

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D 358	Continued From page 29 Telephone interview with the Pharmacist on 10/30/19 at 4:27pm revealed Lexapro 10mg tablets were last dispensed on 10/18/19 for a 30-day supply. Interview with a Medication Aide (MA) on 10/29/19 at 3:29pm revealed: -It was the responsibility of the Resident Care Director (RCD) to assure medication orders were clarified and discontinued with the pharmacist. -She administered one tablet of Lexapro 10mg to Resident #1. -She had not administered one and a half tablet (15mg) of Lexapro to Resident #1. -She was not aware Resident #1's medication order had changed. Telephone interview with the primary care provider (PCP) on 10/30/19 at 12:27pm revealed: -Resident #1 was prescribed the dosage increase of Lexapro on 08/09/19 due to increased depression. -There was the possibility of negative outcome due to the staff's failure to assure Resident #1 received her medications as ordered which included continuation of depression symptoms. -She had not been notified by the facility staff, Resident #1 had not been receiving her current dosage order of 15 mg Lexapro. -She expected the facility to administer medications as ordered. Refer to interview with the Administrator and the RCD on 10/30/19. Interview with the Administrator and the RCD on 10/30/19 at 5:25pm revealed: -The RCD and the medication aides (MA) were responsible for processing new orders.	D 358		

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D 358	Continued From page 30 -The RCD or the MA should fax all new medication orders to the pharmacy as soon as received and the new medication order should be added to the current MAR by the RCD or the MA on duty. -The pharmacy should be contacted to confirm the new order was received. -The RCD was responsible for updating the residents' MARS when there were medication and treatment changes. -The new orders were documented in the staff communication book to cue the MAs of any medication changes or new orders. -The 2nd and 3rd shift MAs audited the MARS using the communication book. -The facility medical provider made rounds at the facility every Monday and all written orders were left with the RCD. _____ 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.	D 358		

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D912	Continued From page 31	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record 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)].	D912		

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D912	Continued From page 32 3. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 3 of 3 sampled residents (Residents #1, #2 and 3) which included including a medication used to treat major depressive disorder and neuropathic pain (#3); a medication used to treat gastroesophageal reflux disease (#2) and a medication used to treat depression and anxiety (#1). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type Unabated B)].	D912		