Division of Health Service Regulation

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 01/23/2020

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 January 23, 2020.	{D 000}		
{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: FOLLOW UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to assure referral and follow up for 1 of 3 sampled residents related to every 6-month dental appointments (#3). The findings are: Review of Resident #3's current FL-2 dated 07/01/19 revealed diagnoses included hypertension, asthma, incontinence, thyrotoxicosis with crisis, chondrocostal junction syndrome, depression and unspecified neurological disorder severe. Review of Resident #3's Assessment and Care	{D 273}	Monitored by RCC/ TRN - All Appointments will be made by TRN Dept./Guardian for the Resident or Family Member will Contact transportation to make sure there was no conflict of times. - Transportation will Review time for Appt. weekly on Monday and Friday - All Referrals will handed off to Transportation. He will Arrange all Appt.	2/6/2020

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2/6/2020

The Plan of Correction has been Reviewed and Accepted
DN 03/23/20

RECEIVED
MAR 20 2020
ADULT CARE LICENSURE SECTION
RALEIGH

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{D 273}	Continued From page 1 Plan dated 06/24/19 revealed: -The resident was oriented, and her memory was adequate. -The resident required extensive assistance from staff to cut up her food and required staff monitoring when eating. Telephone interview with Resident #3's Guardian on 01/23/20 at 12:05pm revealed: -The resident was not seen for any dental care in 2019. -The resident had a dental appointment in July 2019, but the resident was not seen by the dentist and was a "no show" for the appointment. -She contacted the facility on 01/23/20 and requested the facility to call and schedule a dental appointment for the resident. -The resident was scheduled for a dental appointment today, (01/23/20) at 10:30am. Interview with the Transporter on 01/23/20 at 2:47pm revealed: -He was not aware of a dental appointment for Resident #3 in July 2019 because he had just started working at the facility in July 2019, however, he would look back in the appointment calendar. -He transported Resident #3 today to a dental appointment and the resident was scheduled to return to have further dental work done. Interview with the receptionist for Resident #3's Dentist on 01/23/20 at 2:49pm revealed: -On 07/18/18, there was documentation a telephone call was made by the dentist office to the facility concerning an appointment for Resident #3, however, there was no answer at the facility when the call was made to schedule an appointment. -A July 2019 appointment for Resident #3 was not	{D 273}	*All Resident* -Once a month Chart Audit For Any Referrals, specialty Appointment from House Doctor (DMHC), Follow up from Hospital D/C & Summary -All Resident returning from the Hospital Chart will be Review when the PA on the Next Visit Day. At the Same Chart Audit to Assure All Referral Follow Are on Schedule with Trans. RCC & Tran will Monitor..	

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{D 273}	Continued From page 2	{D 273}		

showing in the scheduling system but if there was an appointment for Resident #3 the appointment could have been deleted from the scheduling system.

Interview with the Dental Hygienist for Resident #3's Dentist on 01/23/20 at 2:52pm revealed:
-The resident was last seen by the Dentist on 02/14/18.
-When Resident #3 was seen on 02/14/18 a dental cleaning was done, and the resident was found to have a heavy build-up on her teeth due to poor dental care at home, but did not have any dental cavities at that time.
-There was documentation a call was placed to the facility on 10/12/18 regarding the resident's need for an every 6-month dental cleaning but an appointment was not scheduled for the resident and there was no documentation what staff the dental office had spoken with at the facility.
-The resident was seen today (01/23/20) and was found to have 8 dental cavities which would require dental fillings.
-The resident was scheduled for an upcoming appointment on 02/06/20 to have 3 of the dental cavities filled.
-The resident's other 5 cavities would be treated at additional upcoming appointments because the resident's tooth cavities were all found on the resident's lower teeth and the local numbing agent required could not be done at one time because numbing of the whole lower jaw would be required.
- It was difficult to clean Resident #3's teeth.
-The resident would not relax her lips, tongue, or chin and would not open her mouth in a wide position which made it difficult to access her bottom teeth.
-She thought the resident might have dental anxiety.

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{D 273}	Continued From page 3	{D 273}		

-It was important for Resident #3 to have good home care, a diet low in sugar, and visiting the dentist regularly to maintain good oral care.
-If the resident had been seen by the dentist for her annual 6- month dental exams, the resident's dental cavities might not have occurred.
-The resident's dental cavities were "moderate" meaning the cavities were not superficial, were on multiple surfaces and the dental cavities "had been there a while".

Interview with the Resident Care Coordinator (RCC) on 01/23/20 at 3:16pm revealed:
-She was not aware of a July 2019 dental appointment for Resident #3 because she started working for the facility on 07/23/19.
-She called Resident #3's Dentist office this week on Tuesday, 01/21/20 to schedule the resident's appointment today (01/23/20) because the resident's Guardian called her and requested for a dental appointment to be done.
-She was responsible for telling the Transporter when residents had needed outside appointments.
-The Transporter was responsible for scheduling those appointments and documenting when the residents' appointments were and Transporting the residents to those appointments.
-The Transporter was responsible to bring all the residents' documentation including follow up appointments back to her from each appointment.
-She would also track residents' upcoming appointment needs on her desk top calendar.
-She was responsible for filing the residents' new provider documents from the follow-up appointments in the residents' record.
-She was not aware Resident #3 needed to be seen by the dentist until Resident #3's guardian called this week.

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{D 273}	Continued From page 4 Interview with Resident #3 on 01/23/20 at 12:51pm and at 6:00pm revealed: -She performed her own personal care and grooming and did not require assistance from staff. -The resident was told by the dentist office today, (01/23/20) that she had cavities in her teeth and had to have the cavities filled. -She did not have any tooth pain or any oral pain and did not know she had any cavities. A second interview with the Transporter on 01/23/20 at 3:20pm revealed he reviewed the July 2019 calendar and there was no documentation of a dentist appointment for Resident #3. Interview with the Administrator on 01/23/20 at 5:45pm revealed: -The RCC, Business Office Manager and herself were responsible for record audits to assure the residents' follow up needs were met. -The Transporter was responsible to assure the residents' appointments and referrals were scheduled. -She started working for the facility in June of 2019 and she was not aware Resident #3 had missed any dental appointments in July 2019 or that her every 6-month dental appointments were not kept.	{D 273}		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's	D 392	Monitored by RCC, BOM, ED -Random Chart Audits narcotics and Regular Meds. -Meds CARD will be checked front and back for puncture and holes -Both Med Tech coming on shift and leaving shift well	

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D 392	Continued From page 5 record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure an accurate accounting of the disposition of controlled substances for 1 of 3 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 01/14/20 revealed: -Diagnoses included insomnia, vitamin D deficiency, major depressive disorder, hypertension, gastroesophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), generalized arthritis, and hyperlipidemia. -There was an order for Percocet 10-325 take 1 tablet by mouth three times daily. (Percocet is a controlled substance, schedule II narcotic used to treat moderate to severe pain). Observation of Resident #2's medication on hand on 01/23/20 at 3:05 pm revealed: -There was one bubble card of Percocet 10-325mg available for administration with a dispense date of 11/27/19 for a quantity of 30 tablets dispensed and 30 tablets remained on the card. -There was a second bubble card of Percocet 10-325mg available for administration with a dispense date of 11/27/19 for a quantity of 30 tablets dispensed and 16 tablets remained in the card. -There was one white round tablet that looked different in the bubble pack of the Percocet. -The color of the tablet was white while others	D 392	look at the Med CARD. -MED Tech are initialing the pill slot when administering medication and signing the pill out to record the amount of pills on hand -when new Meds are delivered RCC will check all Meds In. To assure all Meds are account for, Med Count Sheet for Narcotics will be counted and handed off to the Med Tech. -Sign the packet of Control on the side of the pill that was removed: Sign + Date -Administrator - To do Chart Audit Mon + Tue -RCC - To do Chart Audit on Wed + Thur -Bim - To do Chart Audit on Fri Sat ; Sun, To Check Control Packs for	2/6/2020

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D 392	Continued From page 6	D 392	tampering and to make All pill are the same.	

were yellow.
-The size of the tablet was larger in size than the other tablets in the bubble pack of Percocet.
-There were 15 tablets that were Percocet and the 16th was not the same as the other 15 in the bubble pack.
-The 16th tablet had been punctured with no tape on the bubble pack.

Review of a Controlled Substance Logs (CSLs) for Resident #2's Percocet 10-325mg revealed:
-The current count was documented as 16.
-The count started at 30 doses 01/11/20 at 8:00 pm.
-The count ended at 16 doses on 01/16/20 at 8:00 am.

Review of pharmacy dispensing records for Resident #2 revealed Percocet was dispensed on 12/31/19 with a quantity of 90 tablets, 11/27/19 with a quantity of 90 tablets, and 10/30/19 with a quantity of 90 tablets.

Review of Resident #2's January 2020 medication administration record (MAR) revealed:
-There was an entry for Percocet 10-325 mg take 1 tablet three times a day scheduled to be administered 8:00am, 2:00pm, and 8:00pm.
-There were 48 doses (10-325 mg) of Percocet document as administered between 01/01/20 and 01/16/20 on the front and the back of the MAR.
-The dates between 01/17/20 and 01/23/20 were circled for the administration times of 8:00am, 2:00pm, and 8:00pm with documentation the resident was hospitalized.

Interview with Resident #2 on 01/23/20 at 4:11 pm revealed:
-She returned back to the facility today from being in the hospital.

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-She had arthritis and the Percocet were effective in relieving her pain.
-She had not noticed any discrepancies in the administration of the Percocet.
-She could not recall the color of the Percocet and did not recall any previous issues with the appearance or shapes of her Percocet tablets.

Interview with a Medication Aide (MA) on 01/23/20 at 4:37 pm revealed:
-She had not noticed any tampering or discrepancies with the narcotic counts.
-At the beginning of her shift, she counted the number of tablets in the bubble sheet for controls after the MA whose shift has ended called the number of remaining tablets in the bubble pack to her.
-She would remove the bubble pack from the rubber band (if there were multiple packs) and look for the number on the bubble pack identifying the number remaining in the pack.
-She missed this count because she did not pull the card completely out of the rubber band attached.
-She checked the tablets in the pack as well as the number.
-This was the first occurrence of tampering of discrepancies with the narcotic counts.
-If she saw a tablet in the bubble pack she would count it during the narcotic counts.

Interview with a second MA on 01/23/20 at 4:51 pm revealed:
-The controlled substance count was supposed to be counted each shift by ongoing and off going MAs.
-She had not experienced any tampering or discrepancies in the past with controlled medications.
-If staff pulled a medication from the bubble pack

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and a resident refused, they would tape the back of the bubble pack.
-The MA going off a shift for the day would report to the MA coming on the shift the total number of controlled substance tablets remaining, then the MA coming on the shift verified the number of controlled substance tablets by counting and looking at each bubble card.
-If there was a discrepancy she would contact the supervisor, but this was the first experience.
-During her control count she did not pull the bubble cards completely out of rubber band pack to visibly look at the bubble card.
-When controls were brought to the facility, the control sheets were labeled.

Interview with a third MA on 01/23/20 at 5:09 pm revealed:
-She had not had an issue with tampering or discrepancies regarding controlled substances.
-If there was an issue she would report the issues to the Resident Care Coordinator (RCC).
-It was each MAs' responsibility to count the number of controlled substance and document accordingly at the end of each shift.
-Staff were not supposed to take the key for their shift if there was a discrepancy with the controlled substances.
-There were concerns with staff in the past being in a hurry to go home and rush through the control count.

Interview with Resident Care Coordinator (RCC) on 01/23/20 at 5:30 pm revealed:
-She had not been notified by any MAs of any discrepancies in controlled substance counts.
-Staff were expected to do a thorough count of the controlled substances prior to their shift.
-The MA's were expected to not take the medication cart keys if there was a discrepancy

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with controls.
-Staff were expected to notify her or the Administrator if discrepancies were identified.
-This was the first incident regarding controls at the facility.
-She had not noticed any discrepancies or tampering with controls in the past.
-MAs were expected to look at each bubble pack to ensure accuracy of counting controls.
-She was not there in the mornings during the controlled substances count.
-She went solely on the documentation of the MAs to determine accurate documentation of the controlled substances.
-She did random checks on the medications carts and the last one was conducted on 01/17/20.
-No issues were identified during her last random medication cart check on 01/17/20.

Interview with a Pharmacist from the facility's contracted pharmacy on 01/23/20 at 4:40pm and 5:41pm revealed:
-The date the pharmacy filled the prescription was the same day it was delivered to the facility.
-He was contacted today (01/23/20) about the discrepancy found with Resident #2's Percocet 10-325mg and he immediately came to the facility.
-The facility had not returned any Percocet 10-325mg tablets for Resident #2 to the pharmacy.

Telephone interview with Resident #2's primary care provider (PCP) on 01/23/20 at 4:53pm revealed:
-Resident #2 was prescribed Percocet for osteoarthritis, fibromyalgia and chronic pain.
-Resident #2 had not verbalized any issues with uncontrolled pain.

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Interview with Administrator on 01/23/20 at 5:45 pm revealed:
-She worked until 9:00 pm last night (01/22/20) to check Resident #2's Percocet to ensure she had plenty available upon her return from the hospital.
-She took out all of Resident 2's medications and did not notice any discrepancies or evidence of tampering of controlled substances.
-The RCC counted the controlled substances with her also to ensure accuracy.
-She did not notice a different pill had been placed in the bubble pack.
-She made the facility's contracted pharmacist aware of her conducting a control count for Resident #2.
-The control count was not documented in the control log.
-The last control count identified on the control sheet for Resident #'2 Percocet was on 01/16/20.
-The RCC had a system for conducting audits for the medication carts.
-These audits were randomly done by RCC and was conducted last week on 01/17/20.
-The process was for the MA coming on shift to touch the control bubble pack and examine for tampering from front to back.
-The MAs were expected to review for perforations from front to back.