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
	HAL051064	A. BUILDING: ______ B. WING ______	R 06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 2	103 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 an annual and follow-up survey on 06/21/23 - 06/22/23.	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: Based on interviews and record reviews, the facility failed to ensure health care coordination for 1 of 3 sampled residents (#2) related to failing to obtain labwork to check thyroid hormone levels after a change was made with the resident's medication used to treat underactive thyroid disease. The findings are: Review of Resident #2's current FL-2 dated 04/19/23 revealed: -Diagnoses included thyroid disease. -There was an order for Levothyroxine 200mcg take 1 tablet daily. (Levothyroxine is used to treat underactive thyroid disease.) Review of Resident #2's labwork dated 01/11/23 revealed: -The resident's diagnoses included hypothyroidism (underactive thyroid disease). -The resident's TSH (thyroid stimulating hormone) level was 22.65 with a reference range of 0.40 - 4.50 mIU/L. (TSH is used to monitor thyroid functioning.) -The resident's TSH level was out of the normal range.	D 273		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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D 273	Continued From page 1 Review of Resident #2's primary care provider (PCP) visit dated 02/28/23 revealed: -The PCP increased the resident's Levothyroxine dosage to 225mcg once a day due to an elevated TSH level. -There was an order to recheck the TSH level in 6 weeks. Review of Resident #2's PCP visit dated 04/26/23 revealed there was an order for a TSH level. Review of Resident #2's labwork dated March 2023 - June 2023 revealed there was no documentation of a TSH level being checked since 01/11/23. Interview with Resident #2 on 06/22/23 at 9:37am revealed: -Someone usually came to the facility about every 3 weeks to draw blood for labs. -He was not sure what kind of labwork was being checked. -He did not know if he had missed any labwork appointments. -He thought he was taking medication for his thyroid but he was not sure if any labs for his thyroid had been checked. -He denied any symptoms of underactive or overactive thyroid. Interview with the Administrator on 06/22/23 at 6:33pm revealed: -There was a lab company that came to the facility to draw blood for labwork for the residents. -The labs were ordered through the facility's contracted PCP group. -There was no system at the facility to make sure labwork was completed as ordered. -She relied on the PCP group and their lab	D 273		

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D 273	Continued From page 2 company to complete the labwork for residents. Telephone interview with Resident #2's PCP on 06/22/23 at 4:36pm revealed: -She changed Resident #2's Levothyroxine dosage due to the resident having abnormal lab values for his thyroid lab panel. -She kept having to reorder thyroid labwork for Resident #2 because she was not seeing any documentation or results in the resident's record to indicate it was done. -She needed to make sure the resident responded appropriately to the dose adjustment. -If the resident's thyroid levels were not maintained at a normal level, he could experience symptoms such as insomnia, constipation, irregular heartbeat, temperature intolerance, and skin or nail changes. -Lab orders were usually sent to the facility and the lab provider that serviced the facility so the facility would be aware of any labs that had been ordered.	D 273		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by:	D 315		

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D 315	Continued From page 3 Based on observations, interviews, and record review, the facility failed to implement an activity program that promoted active involvement by the residents. The findings are: Review of the facility's resident list provided by the facility on 06/21/23 revealed there were currently 10 residents residing in the facility. Interview with a resident on 06/21/23 at 9:05am revealed there was not much to do at the facility. Interview with a second resident on 06/21/23 at 9:11am revealed: -The facility did not offer activities to the residents. -He got bored at the facility. -If activities were offered, he thought he would participate in activities depending on the activities offered. Interview with a third resident on 06/22/23 at 2:10pm revealed: -There had not been much activities done since the Activity Director (AD) had been on leave. -He would be glad when the AD returned to work. -He liked to play bingo, listen to music, and bowl. -It would be nice for staff to conduct some activities. Observation of the facility on 06/21/23 at 8:46am revealed: -There was an activity calendar posted on the wall in the hallway dated June 2023. -The activity for Monday, 06/19/23, was listed as "no meeting this week I will be out till the 26th sorry". -The activity for Tuesday, 06/20/23, was listed as	D 315		

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"day of movies and coloring, pages in tv room".
-The activity for Wednesday, 06/21/23, was "crossword puzzle day, pages are on activity shelf".
-The activity for Thursday, 06/22/23, was listed as "if you are up to it go outside and do some walking exercise".
-There were no times listed for the activities on 06/19/23 - 06/22/23.

Observations of the residents and staff on 06/21/23 and 06/22/23 throughout the survey revealed:
-No group activities were offered to the residents either day.
-The residents were observed either outside smoking, in the tv room, sitting in the dining room or hallway, or in their bedrooms lying in bed and sleeping at times.

Interview with the Administrator on 06/22/23 at 7:02pm revealed:
-The facility's AD had been out on leave last week and this week.
-She did not know when the AD would be returning to work at the facility.
-The AD was responsible for making and posting the activity calendar and ensuring activities were implemented.
-When the AD was working, the AD conducted activities in a sister facility next door.
-The AD would come to this facility to conduct activities for the residents that did not go to the sister facility to participate in activities.
-She did not know who would conduct activities in the absence of the AD.
-There was no plan in place to oversee activities while the AD had been out on leave.
-She had not seen any activities being conducted at the facility while the AD had been on leave.

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D 338	10A NCAC 13F .0909 Resident Rights	D 338		

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to treat a resident (#4) with respect and dignity related to the tone in which staff spoke to the resident.

The findings are:

Review of Resident #4's current FL-2 dated 05/10/23 revealed:
-Diagnoses included mild mental retardation, right above the knee amputation, and history of depression.
-The resident was assessed as constantly disoriented.
-The resident required the use of a wheelchair for mobility.
-The resident was incontinent of bowel and bladder.

Observations of Resident #4 on 06/21/23 at 9:55am revealed:
-Resident #4 was seated in his wheelchair in the hall outside the laundry room door.
-The Maintenance/Personal Care Aide (M/PCA) was standing in the hallway near Resident #4.
-A loud exchange of communication occurred from the M/PCA as he spoke to Resident #4.
-The M/PCA was telling Resident #4 in a loud voice not to go in the laundry room.
-Resident #4 was talking in a loud voice back at the M/PCA.

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-After several loud verbal exchanges about the resident going in the laundry room, the M/PCA walked away from the resident while laughing and smiling while looking at Resident #4.
-Resident #4 then self-propelled his wheelchair away from the laundry room and down the hallway toward the common area.
-A medication aide (MA) walked down the hall where the incident occurred and she was smiling and laughing while looking at Resident #4.

Interview with Resident #4 on 06/21/23 at 4:35pm revealed:
-Some staff would raise their voice when talking to residents.
-The resident would not name any staff who raised their voices when talking to residents.
-The resident did not like the way the M/PCA talked to and treated him.
-His feelings were hurt, he felt mad, and he did not have a good feeling when the M/PCA talked to him with a raised voice.
-The M/PCA had talked to him with a raised voice before today, 06/21/23.
-He had not reported the M/PCA's behavior to anyone.

Confidential interview with a second resident revealed:
-The M/PCA was nice to him.
-The M/PCA would "tell them off" if he saw that a resident was "not nice".
-The M/PCA talked loud, and "some might think he's intimidating".

Confidential interview with a third resident revealed:
-The M/PCA "keeps things in check".
-The M/PCA played with Resident #4.
-Other residents laughed when the M/PCA would

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play with Resident #4.

Interview with the M/PCA on 06/22/23 at 9:09am revealed:
-His job duties included assisting male residents with personal care.
-Resident #4 fought and cursed at staff when the resident was offered/provided personal care.
-Yesterday, 06/21/23, he caught Resident #4 in the laundry room and he asked the resident what he was doing in there.
-Resident #4 told the M/PCA that he could go in the laundry room if he wanted to.
-Resident #4 was "beefing with me".
-He told the resident, "you ain't going in this room".
-Resident #4 cursed at the M/PCA and said he was going in the room.
-He (M/PCA) "might be a little loud sometimes."
-They both were loud during the exchange in the hallway on 06/21/23.
-They were not arguing, he was "just playing really".
-He was laughing during the incident with Resident #4 on 06/21/23 because he knew Resident #4 was going to curse him out.

Interview with the Administrator on 06/21/23 at 10:00am revealed:
-She overheard the M/PCA's interaction with Resident #4 that morning, 06/21/23.
-It sounded like the M/PCA was "fussing" in a raised voice at Resident #4 for trying to go in the laundry room.
-After hearing the incident, she pulled the M/PCA to the side and told the M/PCA that he could not talk to Resident #4 like that in a raised voice.
-She observed the M/PCA and the MA laughing about the incident.
-It was disrespectful, and she told both staff that it

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was not a laughing matter.
-No resident's had voiced concerns about the way staff spoke to them prior to this incident.
-She had not observed any issues with the way staff spoke to residents prior to this incident.

D 344 10A NCAC 13F .1002(a) Medication Orders D 344

10A NCAC 13F .1002 Medication Orders
(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure clarification or verification of medication and treatment orders for 2 of 3 residents (#1, #3) sampled including orders for fingerstick blood sugar checks (#1) and an antidepressant (#3).

The findings are:

1. Review of Resident #1's current FL-2 dated 01/12/23 revealed:
-Diagnoses included hypertension, type 2 diabetes, hyperlipidemia, coronary artery disease, chronic kidney disease, chronic back pain, and

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depression.
-There was a physician's order for Novolog Flexpen Insulin (a rapid-acting insulin that helps lower blood sugar in adults with diabetes) inject up to 28 units under the skin three times a day 10 minutes before a meal per sliding scale as directed by the physician.
-There was a physician's order for Tresiba Flex Touch Insulin (a long acting insulin that helps control blood sugars in adults with diabetes) inject 32 units under the skin daily at bedtime.

Review of subsequent physician's orders for Resident #1 dated 04/26/23 revealed:
-There was a physician's order to discontinue the Novolog flexpen.
-There was a physician's order to discontinue Tresiba 32 units and start Tresiba 22 units twice daily.
-There were no physician's instructions changing the frequency for fingerstick blood sugar (FSBS) checks for Resident #1.
-There was no physician's order discontinuing fingerstick blood sugar checks for Resident #1.

Review of May 2023 blood sugar monitoring records for Resident #1 revealed:
-There were no FSBS readings documented for three times a day for Resident #1 beginning 05/26/23.
-There were FSBS readings documented one time a day at breakfast from 05/26/23 through 04/31/23 ranging from 177 to 351.

Review of June 2023 blood sugar monitoring records for Resident #1 revealed:
-There were no FSBS readings documented for three times a day for Resident #1.
-There were FSBS readings documented one time a day at breakfast from 06/01/23 through

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06/21/23 ranging from 150 to 332.

Interview with the Administrator on 06/22/23 at 12:45pm revealed:
-FSBS readings should be documented on the blood sugar monitoring sheet attached to the medication administration records (MARs).
-The Resident Care Coordinator (RCC) was responsible for filing the MARs and blood sugar monitoring sheets in the resident record.

Interview with the RCC on 06/22/23 at 12:57pm revealed:
-The blood sugar monitoring sheets for Resident #1 should be attached to the resident's MARs.
-She was looking for the order from the Primary Care Provider clarifying and changing FSBS checks from three times a day to daily.

Second interview with the RCC on 06/22/23 at 1:40pm revealed:
-Resident #1's FSBS's were being checked one time a day.
-FSBS checks for Resident #1 were three times a day when the resident was prescribed sliding scale insulin.
-She had requested clarification of the frequency of FSBS checks for Resident #1 when the sliding scale insulin was discontinued.
-She was concerned Resident #1's blood sugar may be too high or too low.
-She decided herself to check it one time a day until the PCP clarified the frequency for FSBS checks.
-She started checking Resident #1's FSBS one time a day after the Novolog sliding scale was discontinued.
-She did not remember the exact date when she started checking Resident #1's FSBS one time a day.

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-She talked to the PCP today and received an order for FSBS checks two times a day.

Interview with Resident #1 on 06/22/23 at 2:20pm revealed:
-His FSBS was being checked once in the morning and once at night, and then stated he could not remember if staff was checking his FSBS at night but were checking it every morning.
-The medication aides were checking his FSBS three times a day.

Telephone interview with Resident #1's Primary Care Provider on 06/22/23 at 4:30pm revealed:
-The Administrator bought to her attention today that there was no frequency for FSBS checks ordered when the Novolog sliding scale was discontinued.
-She sent a physician's order to the facility today (06/22/23) for FSBS checks two times a day with parameters to hold Resident #1's insulin if the FSBS was 90 or less and notify the PCP if the FSBS was greater than 500.
-The facility should have continued checking Resident #1's FSBS three times a day.
-She was concerned about Resident #1's blood glucose spiking.
-No one at the facility had ever mentioned an issue regarding FSBS checks before today (06/22/23).
-If Resident #1 had a spike in his blood glucose, the resident could have altered mental status, increased thirst, blood pressure affected, and diabetic ketoacidosis.
-She was not aware of Resident #1 having any medical issues because of a spike in his blood glucose.

2. Review of Resident #3's current FL-2 dated

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04/12/23 revealed diagnoses included schizophrenia, major depressive disorder, hypothyroidism, gastroesophageal reflux disease, Parkinson's disease, seborrheic dermatitis, and carcinoma of the neck/skin.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 03/27/23.

Review of Resident #3's list of medications received upon admission on 03/27/23 revealed there were 30 Mirtazapine 30mg tablets brought with the resident upon admission to the facility. (Mirtazapine is an antidepressant.)

Review of Resident #3's current FL-2 dated 04/12/23 revealed there was no order for Mirtazapine.

Review of Resident #3's physician's order sheet dated 05/24/23 revealed there was no order for Mirtazapine.

Review of Resident #3's April 2023 medication administration record (MAR) revealed there was no entry for Mirtazapine, and none was documented as administered.

Review of Resident #3's May 2023 MAR revealed:
-There was a handwritten entry for Mirtazapine 30mg take 1 and ½ tablets at bedtime scheduled for 9:00pm.
-Mirtazapine was documented as administered from 05/01/23 - 05/31/23.

Review of Resident #3's June 2023 MAR revealed there was no entry for Mirtazapine, and none was documented as administered.

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D 344	Continued From page 13 Review of Resident #3's medications on hand on 06/22/23 at 6:36pm revealed there was no Mirtazapine available for administration. Review of Resident #3's physician's orders revealed no documentation to indicate the administration of Mirtazapine was verified or clarified with the resident's provider. Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/22/23 at 3:29pm revealed they never received an order for Mirtazapine and never dispensed any for Resident #3. Interview with a medication aide (MA) on 06/22/23 at 5:15pm revealed: -There was currently no Mirtazapine on hand for Resident #3. -She was unsure why Resident #3 received Mirtazapine in May 2023 or if the resident had an order to receive it. -She thought the Resident Care Coordinator (RCC) or the Administrator usually clarified medication orders. Interview with the Administrator on 06/22/23 at 2:30pm revealed: -Resident #3 brought some medications to the facility when he was admitted. -She was unsure why Resident #3 received Mirtazapine in May 2023 if there was no order for it. -She was unsure who transcribed the entry for Mirtazapine on the May 2023 MAR. -If there was no order for a medication that was brought in with the resident upon admission, the resident's provider should have been contacted for clarification.	D 344		

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D 344	Continued From page 14 Telephone interview with Resident #3's mental health provider (MHP) on 06/23/23 at 3:08pm revealed: -Resident #3 was taking Mirtazapine at one point in the past (could not recall specific dates). -There was no order in May 2023 for the resident to receive Mirtazapine. -There was no current order for the resident to receive Mirtazapine. -Receiving Mirtazapine could have caused the resident to have increased sedation. -No one from the facility contacted her to clarify or verify if Resident #3 should have received Mirtazapine.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#1, #3) sampled including errors with medications used to treat mood disorders and an antibiotic for infection (#3) and a controlled substance used to treat anxiety and agitation	D 358		

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(#1).

The findings are:

Review of the facility's Medication Administration Policies and Procedures (undated) revealed:
-The facility's contracted pharmacy's standard hours of operation are 9:00am to 5:00pm, Monday through Friday.
-In the case of an emergency, the contracted pharmacy may be contacted to fill and deliver medications at any time.
-Normal delivery would be between 6:00pm and 7:00pm, Monday through Friday.
-Medications shall be administered per physician orders and shall be documented on the medication administration record (MAR) immediately after administration.
-Medications shall be ordered when the medication card showed there was only an 8-day supply on hand.
-The medication aide (MA) was responsible for filling out the refill/reorder request form.
-The request form should be given to the Resident Care Coordinator (RCC) or Administrator before noon so it could be faxed to the pharmacy.
-The medication would be delivered to the facility within __ business days (the number of days was left blank).
-When a new medication was ordered, most physician's offices would electronically prescribe (e-scribe) the prescription.
-If not escribed, the Administrator or RCC should fax the prescription to the pharmacy.

1. Review of Resident #3's current FL-2 dated 04/12/23 revealed diagnoses included schizophrenia, major depressive disorder, hypothyroidism, gastroesophageal reflux disease,

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Parkinson's disease, seborrheic dermatitis, and carcinoma of the neck/skin.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 03/27/23.

a. Review of Resident #3's facility progress note dated 05/29/23 revealed:
-The resident was sent out to the hospital emergency department (ED).
-The resident stated that he could not urinate.
-The resident returned from the hospital ED with a urinary tract infection (UTI).
-Keflex was prescribed. (Keflex is an antibiotic used to treat infections.)

Review of Resident #3's telephone order dated 05/29/23 received by the facility's contracted pharmacy revealed:
-There was an order for Keflex 500mg 1 capsule 4 times day for 7 days.
-There was a handwritten note by facility staff below the telephone order that the medication started on 05/30/23.
-There was a handwritten note by facility staff indicating the facility received a paper copy of the telephone order on 06/01/23.

Review of Resident #3's hospital ED after visit summary dated 05/29/23 revealed:
-The resident was seen and diagnosed with inflammation of the bladder and a UTI.
-The resident was to start Keflex 500mg 1 capsule 4 times a day for 7 days for treatment of the UTI.
-The resident was administered one Keflex at the hospital on 05/29/23 at 11:43pm.
-There were instructions to pick up Keflex from any pharmacy with the printed prescription.

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Review of Resident #3's primary care provider (PCP) visit note dated 05/31/23 revealed:
-The reason for this visit was for a urinary tract infection.
-The PCP was seeing the resident for a follow-up after the resident went to the hospital ED for urinary retention.
-The resident was diagnosed with a UTI and treated with an antibiotic.
-The resident stated he was feeling much better and he complained of no symptoms today.
-The PCP discussed with the resident to notify staff of any urinary symptoms so they could contact her.

Review of Resident #3's May 2023 medication administration record (MAR) revealed:
-There was a handwritten entry for Keflex 500mg take 1 capsule 4 times a day for 7 days scheduled for 9:00am, 3:00pm, 9:00pm, and 3:00am.
-There was an arrow drawn to the block for 05/30/23.
-Keflex was documented as administered once on 05/29/23 at 3:00pm.
-Documentation for 05/30/23 at 9:00am, 9:00pm, and 3:00am were blank with no reason for the omissions.
-Documentation for 05/31/23 at 9:00am, 9:00pm, and 3:00am were blank with no reason for the omissions.
-Initials were circled for 3:00pm on 05/31/23 and Keflex was documented as not administered due to the medication being on order.

Review of Resident #3's June 2023 MAR revealed:
-There was a handwritten entry for Keflex 500mg take 1 capsule 4 times a day for 7 days (28

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doses) scheduled for 9:00am, 3:00pm, 9:00pm, and 3:00am.
-There were 13 doses of Keflex documented as administered including 9:00am, 3:00pm, and 9:00pm from 06/01/23 - 06/04/23 and 9;00pm on 06/05/23.
-The 3:00am doses from 06/01/23 - 06/05/23 were blank with no reason for the omissions.
-Documentation for 9:00am and 3:00pm on 06/05/23 were blank with no reason for the omissions.
-There was a handwritten note to please take vital signs and record on antibiotic sheet.

Review of the facility's pharmacy delivery log revealed 28 Keflex 500mg capsules were delivered to the facility for Resident #3 on 05/31/23.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/22/23 at 3:29pm revealed:
-They never received an order dated 05/29/23 for Resident #3's Keflex.
-The facility contacted them on 05/31/23 asking about the Keflex.
-The prescription for Keflex was sent to the hospital pharmacy originally so the facility's contracted pharmacy got a new prescription called in on 05/31/23 after it was brought to their attention by the facility.
-The facility did not contact them regarding Keflex prior to 05/31/23.
-The facility's contracted pharmacy dispensed 28 Keflex 500mg capsules for Resident #3 on 05/31/23 and it was delivered to the facility between 10:00pm - 11:00pm on 05/31/23.

Interview with the MA on 06/22/23 at 5:15pm revealed:

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D 358	Continued From page 19 -She was unsure why Resident #3's Keflex was not documented as administered 4 times a day as ordered. -She administered the first dose of Keflex to the resident on 06/01/23. -She did not know why there was a delay in getting Keflex for the resident. Interview with Resident #3 on 06/22/23 at 5:00pm revealed: -He just returned to the facility today (06/22/23) from the hospital. -He went to the hospital for his mood and having suicidal thoughts. -He also had another UTI when he was admitted to the hospital about a week ago. -He had a UTI a few weeks prior to that UTI and went to the hospital ED for it. -He did not know if he received an antibiotic for the UTI when he went to the hospital ED a few weeks ago. Interview with the Administrator on 06/22/23 at 6:30pm revealed: -She just found the supply of Resident #3's Keflex 500mg capsules dispensed on 05/31/23 in the overstock medication supply closet. -There were some Keflex 500mg capsule in the card that had not been administered. -All the Keflex should have been administered to Resident #3. -She did not know why all the Keflex was not administered to Resident #3 as ordered. Observation of Resident #3's medications on hand on 06/22/23 at 6:36pm revealed: -There was a supply of Keflex 500mg capsules dispensed on 05/31/23. -Staff initialed and dated on the card that the first dose was administered on 06/01/23 at 9:00am.	D 358		

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-There were 11 of 28 capsules of Keflex 500mg capsules remaining in the card.
-Only 17 of 28 doses had been used from the supply dispensed on 05/31/23.

Review of Resident #3's hospital after visit summary and hospital discharge summary dated 06/22/23 revealed:
-The resident was admitted to the hospital on 06/14/23 and discharged on 06/22/23.
-The resident was admitted to the behavioral health unit.
-The resident had complaints of increased urinary frequency and burning upon urination for one week.
-The resident's urine culture had bacteria indicating the resident had a UTI and he was started on an antibiotic.
-The resident's discharge diagnoses included acute cystitis (inflammation of the bladder) without hematuria (blood in the urine).
-The resident was discharged with an order for an antibiotic for the UTI.

Telephone interview with Resident #3's PCP on 06/22/23 at 4:36pm revealed:
-There should not have been a delay in the resident receiving Keflex for the UTI diagnosed at the hospital ED on 05/29/23.
-Resident #3 should have received the full 28 doses of the Keflex as ordered.
-The delay in receiving the antibiotic could have caused the resident's UTI symptoms to get worse.
-Not receiving the full course of antibiotics for the UTI diagnosed at the ED visit in May 2023 could have caused the UTI not to clear up completely, resulting in the resident having a recurrent UTI diagnosed at the hospital visit in June 2023.

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b. Review of Resident #3's current FL-2 dated 04/12/23 revealed an order for Fluvoxamine 150mg at bedtime. (Fluvoxamine is an antidepressant.)

Review of Resident #3's primary care provider (PCP) visit notes dated 05/10/23 revealed:
-The facility staff had behavioral concerns about the resident.
-Last week, the resident stated he got "dizzy" and fell onto his right side.
-Per witnesses, the resident laid himself down on the floor and then began to have complaints.
-The resident stated he had bruising on his right shoulder but none was noted and there was no decreased range of motion either.
-The PCP discussed with the resident that his actions were inappropriate.
-The resident got upset and was adamant that he "fell".
-The resident's speech was fast paced and he kept jumping from subject to subject.
-The resident's diastolic blood pressure was elevated most likely due to his manic state.
-Staff stated they would discuss this with the resident's mental health provider (MHP).

Review of Resident #3's MHP prescription dated 05/12/23 revealed:
-There was an electronic prescription (e-script) for Fluvoxamine 100mg take 1.5 tablets at bedtime.
-There was a handwritten note below the prescription indicating the pharmacy did not have anyone else taking this medication and they had ordered it and it would be delivered on Monday, 05/15/23.

Review of Resident #3's MHP visit note dated 05/17/23 revealed an order to discontinue the

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D 358	Continued From page 22 current Fluvoxamine order and start Fluvoxamine 100mg take 2 tablets at bedtime for mood. Review of Resident #3's May 2023 medication administration record (MAR) revealed: -There was a handwritten entry for Fluvoxamine (no strength) take 1 and ½ tablets (150mg) at bedtime scheduled for 9:00pm. -Initials were circled for Fluvoxamine from 05/01/23 - 05/11/23 and 05/16/23 due to the medication being on order. -There was a handwritten note the order was changed on 05/17/23. -There was a second handwritten entry for Fluvoxamine 100mg take 2 tablets once daily at bedtime for mood scheduled for 9:00pm with an arrow pointing to the block for 05/18/23. -Documentation for Fluvoxamine 100mg was blank on 05/18/23, 05/19/23, 05/24/23, and 05/30/23 with no reason for the omissions. -Fluvoxamine 100mg (2 tablets) was documented as administered from 05/20/23 - 05/23/23, 05/25/23 - 05/29/23, and 05/31/23. Review of Resident #3's June 2023 MAR revealed: -There was an entry for Fluvoxamine 100mg take 2 tablets (200mg) once daily at bedtime for mood scheduled for 9:00pm. -Fluvoxamine was documented as administered daily at 9:00pm from 06/01/23 - 06/12/23. -Fluvoxamine was documented as not administered from 06/13/23 - 06/20/23 due to the resident being out of the facility. Review of Resident #3's list of medications received upon the resident's admission on 03/27/23 revealed there was a total of 30 Fluvoxamine 100mg tablets brought with the resident upon admission to the facility.	D 358		

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Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/22/23 at 3:29pm revealed:
-The pharmacy dispensed and delivered 135 Fluvoxamine 100mg tablets for Resident #3 on 05/12/23.
-The pharmacy relabeled the Fluvoxamine on 05/18/23 for the order change on 05/17/23.

Observation of Resident #3's medications on hand on 06/22/23 at 2:01pm revealed there was a card of Fluvoxamine 100mg tablets dispensed on 05/18/23 with 60 of 60 tablets remaining.

Interview with a medication aide (MA) on 06/22/23 at 5:15pm revealed:
-The MAs or the Resident Care Coordinator (RCC) could order medications.
-She usually ordered medications when it got down to the blue strip on the card if there was none in the back-up medication closet.
-She did not know why Resident #3 did not receive the Fluvoxamine as ordered in May 2023.

Interview with the Administrator on 06/21/23 at 12:32pm revealed:
-On 06/12/23, Resident #3 was "acting out", cursing at the MA and getting in the MA's face.
-The next morning, the resident continued to act out so she contacted the resident's MHP and the resident was taken to the hospital.
-Later that day on 06/13/23, a nurse from the hospital called and said the resident had been acting out at the hospital and he was being treated by the hospital's MHPs.
-The resident was supposed to return from the hospital to the facility tomorrow on 06/22/23.

A second interview with the Administrator on

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D 358	Continued From page 24 06/22/23 at 2:30pm revealed: -Resident #3 ran out of some of his mental health medications because they were having a hard time getting refills because the PCP would not refill the mental health medications. -She was finally able to get refills through the resident's MHP (could not recall dates). -The resident was "fine" when he missed doses of his mental health medications. Interview with the RCC on 06/22/23 at 5:20pm revealed: -She was uncertain why Resident #3's Fluvoxamine was documented as unavailable in May 2023. -The Administrator had been ordering all of the medications at one time but the medications were not coming in from the pharmacy. -She had been ordering medications lately when the medication got down to the blue strip on the card and the medications had been coming in "pretty good". Review of Resident #3's hospital after visit summary dated 06/22/23 revealed: -The resident was admitted to the hospital on 06/14/23 and discharged on 06/22/23. -The resident was admitted to the behavioral health unit. Review of Resident #3's hospital FL-2 dated 06/22/23 revealed: -The resident was admitted to the hospital on 06/14/23 and discharged on 06/22/23. -Diagnoses included severe episode of recurrent major depressive disorder, without psychotic features, benign essential hypertension, Parkinson's disease, and schizophrenia. Interview with Resident #3 on 06/22/23 at 5:00pm	D 358		

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revealed:
-He just returned to the facility today (06/22/23) from the hospital.
-He went to the hospital for his mood and having suicidal thoughts.
-He did not know if he had missed any doses of medications.

Telephone interview with Resident #3's MHP on 06/23/23 at 3:08pm revealed:
-She started providing services for Resident #3 in April 2023.
-She was not aware Resident #3 had missed doses of Fluvoxamine.
-It was not good for the resident to miss doses of his medications because he had outbursts and was very unstable.
-Missing doses of his mental health medications could definitely affect his mood and behaviors.
-It could increase his outbursts or make them more severe.
-It could also increase his depression because the level of the medication in his system could drop when he missed doses.

c. Review of Resident #3's current FL-2 dated 04/12/23 revealed an order for Topiramate 100mg take 1 tablet twice a day. (Topiramate may be used to treat mood disorders.)

Review of Resident #3's physician's order sheet dated 05/24/23 revealed an order for Topiramate 100mg take 1 tablet twice a day, morning and bedtime.

Review of Resident #3's May 2023 medication administration record (MAR) revealed:
-There was a handwritten entry for Topiramate 100mg take 2 tablets twice a day scheduled for 9:00am and 9:00pm.

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-Topiramate was documented as not administered from 05/04/23 - 05/10/23 due to the medication being on order.
-Documentation for Topiramate was blank at 9:00pm on 05/19/23 - 05/21/236, 05/24/23, 05/26/23, and 05/29/23 with no reason for the omissions.

Review of Resident #3's list of medications received upon the resident's admission on 03/27/23 revealed there was a total of 59 Topiramate 100mg tablets brought with the resident upon admission to the facility.

Observation of Resident #3's medications on hand on 06/22/23 at 1:51pm revealed there was a card of Topiramate 100mg tablets dispensed on 05/10/23 with 20 tablets remaining.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/22/23 at 3:29pm revealed the pharmacy dispensed and delivered 180 Topiramate 100mg tablets for Resident #3 on 05/10/23.

Interview with a medication aide (MA) on 06/22/23 at 5:15pm revealed:
-The MAs or the Resident Care Coordinator (RCC) could order medications.
-She usually ordered medications when it got down to the blue strip on the card if there was none in the back-up medication closet.
-She did not know why Resident #3 ran out of Topiramate in May 2023.

Interview with the Administrator on 06/21/23 at 12:32pm revealed:
-On 06/12/23, Resident #3 was "acting out", cursing at the MA and getting in the MA's face.
-The next morning, the resident continued to act

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D 358	Continued From page 27 out so she contacted the resident's mental health provider (MHP) and the resident was taken to the hospital. -Later that day on 06/13/23, a nurse from the hospital called and said the resident had been acting out at the hospital and he was being treated by the hospital's MHPs. -The resident was supposed to return from the hospital to the facility tomorrow on 06/22/23. A second interview with the Administrator on 06/22/23 at 2:30pm revealed: -Resident #3 ran out of some of his mental health medications because they were having a hard time getting refills because the primary care provider (PCP) would not refill the mental health medications. -She was finally able to get refills through the resident's MHP (could not recall dates). -The resident was "fine" when he missed doses of his mental health medications. Interview with the RCC on 06/22/23 at 5:20pm revealed: -She was uncertain why Resident #3's Topiramate had ran out. -The Administrator had been ordering all of the medications at one time but the medications were not coming in from the pharmacy. -She had been ordering medications lately when the medication got down to the blue strip on the card and the medications had been coming in "pretty good". Review of Resident #3's hospital after visit summary dated 06/22/23 revealed: -The resident was admitted to the hospital on 06/14/23 and discharged on 06/22/23. -The resident was admitted to the behavioral health unit.	D 358		

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Review of Resident #3's hospital FL-2 dated 06/22/23 revealed:
-The resident was admitted to the hospital on 06/14/23 and discharged on 06/22/23.
-Diagnoses included severe episode of recurrent major depressive disorder, without psychotic features, benign essential hypertension, Parkinson's disease, and schizophrenia.

Interview with Resident #3 on 06/22/23 at 5:00pm revealed:
-He just returned to the facility today (06/22/23) from the hospital.
-He went to the hospital for his mood and having suicidal thoughts.
-He did know if he had missed any doses of medications.

Telephone interview with Resident #3's MHP on 06/23/23 at 3:08pm revealed:
-She started providing services for Resident #3 in April 2023.
-She was not aware Resident #3 had missed doses of Topiramate.
-It was not good for the resident to miss doses of his medications because he had outbursts and was very unstable.
-Missing doses of his mental health medications could definitely affect his mood and behaviors.
-It could increase his outbursts or make them more severe.
-It could also increase his depression because the level of the medication in his system could drop when he missed doses.

d. Review of Resident #3's current FL-2 dated 04/12/23 revealed an order for Seroquel XR 300mg take 1 tablet once daily in the evening. (Seroquel ER is an antipsychotic medication used

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to treat schizophrenia.)

Review of Resident #3's April 2023 medication administration record (MAR) revealed:
-There was a handwritten entry for Seroquel ER 300mg take 1 tablet once daily in the evening scheduled for 6:00pm.
-Seroquel ER 300mg was documented as administered from 04/01/23 - 04/27/23 and 04/29/23.
-Documentation for Seroquel ER on 04/28/23 was blank with no reason noted.
-Seroquel ER was documented with circled initials and not administered on 04/30/23 due to the medication being on order.

Review of Resident #3's May 2023 MAR revealed:
-There was a handwritten entry for Seroquel ER 300mg take 1 tablet once daily in the evening scheduled for 6:00pm.
-Seroquel ER was documented as not administered on 05/01/23 due to being on order.
-Seroquel ER 300mg was documented as administered from 05/02/23 - 05/30/23.

Review of Resident #3's list of medications received upon the resident's admission on 03/27/23 revealed there was a total of 30 Seroquel XR 300mg tablets brought with the resident upon admission to the facility.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/22/23 at 3:29pm revealed the pharmacy dispensed and delivered 90 Seroquel ER 300mg tablets for Resident #3 on 04/27/23.

Observation of Resident #3's medications on hand on 06/22/23 at 2:01pm revealed there was a

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card of Seroquel ER 300mg tablets dispensed on 04/27/23 with 11 tablets remaining.

Interview with a medication aide (MA) on 06/22/23 at 5:15pm revealed:
-The MAs or the Resident Care Coordinator (RCC) could order medications.
-She usually ordered medications when it got down to the blue strip on the card if there was none in the back-up medication closet.
-She did not know why Resident #3's Seroquel ER was documented as unavailable and not administered in May 2023.

Interview with the Administrator on 06/21/23 at 12:32pm revealed:
-On 06/12/23, Resident #3 was "acting out", cursing at the MA and getting in the MA's face.
-The next morning, the resident continued to act out so she contacted the resident's mental health provider (MHP) and the resident was taken to the hospital.
-Later that day on 06/13/23, a nurse from the hospital called and said the resident had been acting out at the hospital and he was being treated by the hospital's MHPs.
-The resident was supposed to return from the hospital to the facility tomorrow on 06/22/23.

A second interview with the Administrator on 06/22/23 at 2:30pm revealed:
-Resident #3 ran out of some of his mental health medications because they were having a hard time getting refills because the primary care provider (PCP) would not refill the mental health medications.
-She was finally able to get refills through the resident's MHP (could not recall dates).
-The resident was "fine" when he missed doses of his mental health medications.

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Interview with the RCC on 06/22/23 at 5:20pm revealed:
-She was uncertain why Resident #3's Seroquel ER was documented as unavailable and not administered.
-The Administrator had been ordering all of the medications at one time but the medications were not coming in from the pharmacy.
-She had been ordering medications lately when the medication got down to the blue strip on the card and the medications had been coming in "pretty good".

Review of Resident #3's hospital after visit summary dated 06/22/23 revealed:
-The resident was admitted to the hospital on 06/14/23 and discharged on 06/22/23.
-The resident was admitted to the behavioral health unit.

Review of Resident #3's hospital FL-2 dated 06/22/23 revealed:
-The resident was admitted to the hospital on 06/14/23 and discharged on 06/22/23.
-Diagnoses included severe episode of recurrent major depressive disorder, without psychotic features, benign essential hypertension, Parkinson's disease, and schizophrenia.

Interview with Resident #3 on 06/22/23 at 5:00pm revealed:
-He just returned to the facility today (06/22/23) from the hospital.
-He went to the hospital for his mood and having suicidal thoughts.
-He did know if he had missed any doses of medications.

Telephone interview with Resident #3's MHP on

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D 358	Continued From page 32 06/23/23 at 3:08pm revealed: -She started providing services for Resident #3 in April 2023. -She was not aware Resident #3 had missed doses of Seroquel ER. -It was not good for the resident to miss doses of his medications because he had outbursts and was very unstable. -Missing doses of his mental health medications could definitely affect his mood and behaviors. -It could increase his outbursts or make them more severe. -It could also increase his depression because the level of the medication in his system could drop when he missed doses. 2. Review of Resident #1's current FL-2 dated 01/12/23 revealed diagnoses included hypertension, type 2 diabetes, hyperlipidemia, chronic obstructive pulmonary disease, coronary artery disease, debility, chronic kidney disease, depression, and chronic back pain. Review of a physician's order for Resident #1 dated 01/12/23 revealed a physician's order for Lorazepam 1mg tablet (a schedule IV-controlled substance used to treat anxiety) three times a day. Interview with Resident #1 on 06/21/23 at 9:05am revealed: -It was difficult for him to stand for long periods of time. -Staff administered the resident medications. -He was administered about 15 medications. -He had missed medications as recent as "this past week". -The prescribed Lorazepam was not available for administration on 06/19/23. -The resident did not know why the Lorazepam	D 358		

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was not delivered from the pharmacy.
-When he was out of the Lorazepam, he was "ill, anxious".

Review of Resident #1's June 2023 medication administration records (MARs) revealed:
-There was a printed entry for Lorazepam 1mg tablet three times a day scheduled at 9:00am, 2:00pm, and 9:00pm.
-Staff initialed 06/01/23 through 06/17/23 at 9:00am, 2:00pm, and 9:00pm as administered.
-Staff initials were circled on 06/18/23 at 9:00am, 2:00pm, and 9:00pm, and 06/19/23 at 9:00pm.
-Staff initials documented on the MAR for the Lorazepam 1mg tablet on 06/19/23 at 9:00am and 2:00pm were not circled.

Review of the medication notes on the June MARs for Resident #1 revealed:
-On 06/18/23, the staff with circled initials on the MAR for 06/18/23 at 8:00am documented the Lorazepam was on order.
-On 06/19/23, a second staff with initials on the MAR for 06/19/23 at 8:00am, and 2:00pm, and 06/20/23 at 8:00am documented the Lorazepam was on order and not administered.
-There was no documentation for administration of the 06/20/23 scheduled 2:00pm dose of Lorazepam.

Observation of Resident #1's medications on hand on 06/21/23 revealed:
-There were 90 tablets of Lorazepam 1mg tablets dispensed on 06/19/23.
-There were 27 tablets remaining in a bubble card locked in the medication cart and labeled with a pharmacy generated prescription labeled for 1 of 3.

Review of the controlled substance count sheet

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(CSCS) on 06/21/23 for Resident #1's Lorazepam 1mg tablets revealed:
-There was a pharmacy printed label on the 1 of 3 CSCS dated 06/19/23.
-The CSCS documentation of 27 tablets on hand on 06/21/23 after the 8:00am dose was administered matched the medication on hand kept in the medication cart.
-There were no documented entries on the CSCS for 06/18/23 for 8:00am, 2:00pm, or 8:00pm.
-There were no documented entries on the CSCS for 06/19/23 for 8:00am, 2:00pm, or 8:00pm.
-There was no documented entry on the CSCS for 06/20/23 for 8:00am.

Interview with a medication aide (MA) on 06/22/23 at 6:08pm revealed:
-The MA recalled Resident #1's medication not being available for administration.
-The Resident Care Coordinator (RCC) and Administrator reordered medications from the pharmacy.
-She notified the RCC or Administrator when medication was not available for administering to the resident.

Interview with the RCC on 06/22/23 at 6:25pm revealed:
-She was responsible for ensuring resident medications were available in the facility.
-She asked the MAs everyday if medications needed to be ordered for residents.
-Medications were ordered when the resident was down to a 7-day supply.
-It had been difficult getting medications in the facility.
-The facility was on a 90-day cycle refill from the contracted provider pharmacy.

Interview with the Administrator on 06/22/23 at

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6:18pm revealed:
-She expected medications to be administered as ordered.
-There had been times when it was hard to get residents medications delivered to the facility from the contracted provider pharmacy.
-The physician's usually e-scripted prescriptions to the contracted provider pharmacy.
-The facility could not use their backup pharmacy to order medications without a prescription.

Telephone with the contracted provider pharmacy on 06/22/23 at 4:00pm revealed:
-The facility was supposed to request a refill for Resident #1's Lorazepam when there was a 7-day supply remaining.
-The facility faxed the reorder request for Resident #1's Lorazepam 1mg tablet on 06/19/23.
-The refill request was filled on 06/19/23 and delivered to the facility.
-Resident #1 ran out of the Lorazepam 1mg tablet because a 7-day advance refill request from the facility did not occur.

____

The facility failed to administer medications as ordered to 2 of 3 residents sampled. Resident #3 did not receive his first dose of an antibiotic at the facility for a urinary tract infection (UTI) until 06/01/23, three days after it was ordered and only 17 of 28 doses were administered putting the resident at risk of worsening symptoms and recurrent UTIs, including the UTI the resident was diagnosed with at a subsequent hospitalization in June 2023. The failure of the facility to administer medications as ordered placed the residents at substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation.

____

The facility provided a plan of protection in

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D 358	Continued From page 36 accordance with G.S. 131D-34 on 06/22/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 22, 2023.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#3) including inaccurate documentation for a controlled	D 367		

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substance used to treat anxiety, a medication for mood disorders, and an antihistamine for seasonal allergies.

The findings are:

Review of the facility's undated Instructions for Medication Aides (MAs) form maintained in the medication administration record (MAR) notebook revealed:
-Check your holes (omissions) daily.
-Make sure all documentation was done daily.

Review of Resident #3's current FL-2 dated 04/12/23 revealed diagnoses included schizophrenia, major depressive disorder, hypothyroidism, gastroesophageal reflux disease, Parkinson's disease, seborrheic dermatitis, and carcinoma of the neck/skin.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 03/27/23.

a. Review of Resident #3's current FL-2 dated 04/12/23 revealed an order for Lorazepam 0.5mg 1 tablet twice a day prn (as needed) for anxiety. (Lorazepam is a controlled substance used to treat anxiety.)

Review of Resident #3's controlled substance (CS) count sheet for April 2023 for the prn Lorazepam revealed it was documented as administered on 04/09/23 at 9:38pm.

Review of Resident #3's April 2023 medication administration record (MAR) revealed:
-There was a handwritten entry for Lorazepam 0.5mg take 1 tablet twice prn for anxiety.
-There was no prn Lorazepam documented as

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administered on any day, including 04/09/23.
-The documentation on the MAR did not match the CS count sheet for April 2023.

Review of Resident #3's CS count sheet for May 2023 for the prn Lorazepam revealed the prn Lorazepam was documented as administered on 05/10/23 at 9:00pm and 05/14/23 at 4:00pm.

Review of Resident #3's May 2023 MAR revealed:
-There was a handwritten entry for Lorazepam 0.5mg take 1 tablet twice prn for anxiety.
-There was no documentation of prn Lorazepam being administered on 05/10/23 or 05/14/23.
-The prn Lorazepam was documented as administered on one occasion on 05/25/23.
-There was no time, reason, or effectiveness of administration documented for the prn Lorazepam.
-The documentation on the MAR did not match the CS count sheet for May 2023.

Review of Resident #3's CS count sheet for June 2023 for the prn Lorazepam revealed the prn Lorazepam was documented as administered on 06/12/23 at 8:00pm.

Review of Resident #3's June 2023 MAR revealed:
-There was a handwritten entry for Lorazepam 0.5mg take 1 tablet twice prn for anxiety.
-The prn Lorazepam was documented as administered on one occasion on 06/12/23 at 8:00pm for anxiety.
-There was no result or effectiveness of the administration documented for the prn Lorazepam.

Interview with the medication aide (MA) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051064	A. BUILDING: ______ B. WING ______	R 06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 2	103 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 367	Continued From page 39	D 367		

06/22/23 at 5:15pm revealed:
-The MAs were supposed to document on the MAR and the CS count sheet when a controlled substance was administered.
-The MAs were supposed to document the time, reason, and effect of a prn medication.
-She did know why Resident #3's prn Lorazepam documentation was not accurate on the MAR.

Interview with the Administrator on 06/22/23 at 2:30pm revealed:
-The MAs were supposed to document on the MARs and the CS count sheets each time a controlled substance was administered.
-The documentation for Resident #3's prn Lorazepam should be accurate on the MAR and include the time, reason, and effectiveness of the prn medication.

Refer to interview with the Administrator on 06/22/23 at 2:30pm.

b. Review of Resident #3's current FL-2 dated 04/12/23 revealed an order for Depakote 125mg take 5 tablets twice daily. (Depakote is used to treat mood disorders.)

Review of Resident #3's April 2023 medication administration record (MAR) revealed:
-There was a handwritten entry for Depakote 125mg take 5 tablets twice daily scheduled for 8:00am and 8:00pm.
-Staff initials were circled at 8:00am on 04/30/23 and at 8:00pm on 04/29/23 and 8:00am and 8:00pm.
-There was no reason documented on those 3 occasions to indicate why Depakote was not administered.
-Documentation for Depakote was blank at 8:00pm on 04/28/23 with no reason for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051064	A. BUILDING: ____ B. WING ____	R 06/22/2023

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CLASSIC CARE HOMES # 2	103 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 367	Continued From page 40 omission documented. Review of Resident #3's May 2023 MAR revealed: -There was a handwritten entry for Depakote 125mg take 5 tablets twice daily scheduled for 9:00am and 9:00pm. -Staff initials were circled on 05/01/23 at 9:00am and 9:00pm. -There was no reason documented on those 2 occasions to indicate why Depakote was not administered. -Documentation for Depakote was blank at 8:00pm on 05/29/23 with no reason for the omission documented. Interview with the MA on 06/22/23 at 5:15pm revealed: -The MAs were supposed to document on the MAR when medications were administered. -She did not know why initials were circled or blanks for the documentation of Resident #3's Depakote. Refer to interview with the Administrator on 06/22/23 at 2:30pm. c. Review of Resident #3's current FL-2 dated 04/12/23 revealed an order for Loratadine 10mg take 1 tablet once a day. (Loratadine is an antihistamine used to treat seasonal allergies.) Review of Resident #3's May 2023 medication administration record (MAR) revealed: -There was a handwritten entry for Allergy Relief (Loratadine) 10mg take 1 tablet once daily at bedtime scheduled at 9:00pm. -Documentation for Loratadine was blank from 05/01/23 - 05/15/23, 05/19/23, and 05/29/23 with no reason for the omissions.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051064	A. BUILDING: ______ B. WING ______	R 06/22/2023

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D 367	Continued From page 41 Interview with the MA on 06/22/23 at 5:15pm revealed: -The MAs were supposed to document on the MAR when medications were administered. -She did not know why there were blanks for the documentation of Resident #3's Loratadine. Refer to interview with the Administrator on 06/22/23 at 2:30pm. ___________________________ Interview with the Administrator on 06/22/23 at 2:30pm revealed: -She or the Resident Care Coordinator (RCC) usually did daily checks of the MARs for accuracy. -They usually checked for holes (omissions) and prn documentation. -She did not always get to check every day because of her other job duties.	D 367		