Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLI	בובט
		HAL051062	HAL051062 B. WING		10/0	R 6/ <b>2023</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		PARKER CIRC	CLE		
		SMITHFIEL	.D, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	_	sure Section conducted an survey on October 5-6,				
D 273	10A NCAC 13F .0902	2(b) Health Care	D 273			
	•	2 Health Care assure referral and follow-up nd acute health care needs				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	Based on record reviews and interviews, the facility failed to ensure health care referral and follow up for 1 of 3 sampled residents (#3) related to physician orders for administration of an intramuscular injectable psychotropic medication every three weeks by a home health skilled nuse.					
	The findings are:					
	08/02/23 revealed: -Diagnoses included schizoaffective disord -There was a physicia injection (used to treat	an's order for Abilify Maintera				
	05/31/23 revealed: -There was a physicia IM every three weeks -The Abilify Maintera 06/01/23.	IM was last administered on				
	-Resident #3 was adr	mitted to the facility on				

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

TITLE (X6) DATE

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  101 ANNIE PARKER CIRCLE  SMITHFIELD, NC 27577  TAG  SUMMARY STATEMENT OF DEFICIENCES BY THAT THE DEFICIENCY NUMBER OF RECEDED BY THAT THAT THAT THE DEFICIENCY NUMBER OF RECEDED BY THAT THAT THAT THAT THE DEFICIENCY NUMBER OF RECEDED BY THAT THAT THAT THAT THAT THAT THAT THA	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		, , ,	E SURVEY IPLETED	
CLASSIC CARE HOMES # 1   SUMMARY STATEMENT OF DEFICIENCIES   SMITHFIELD, NO. 27577			HAL051062	B. WING		1	
PREFIX TAG  REGULATORY OR ISC IDENTIFYING INFORMATION)  D 273  Continued From page 1  06/01/23.  Based on the documented date of 06/01/23 for the administration of the Ability Maintera IM injections would have been due on 06/22/23.  There was no documentation of administration of the next Ability Maintera IM injection to Resident #3; the bility Injection of the Interest			101 AN	NIE PARKER CIRCL			
Based on the documented date of 06/01/23 for the administration of the Abilify Maintera IM injection to Resident #3, the Abilify Maintera IM injection to Resident #3, the Abilify Maintera IM injections would have been due on 06/22/23. There was no documentation of administration of the next Abilify Maintera IM injection until 07/05/23.  Review of Resident #3's history and physical report completed by the Nurse Practitioner dated 07/05/23 revealed:  -Resident #3 was seen to establish care and review her chronic health conditions.  -The resident was followed by a mental health practice for management of her schizophrenia and bipolar disorder.  -Resident #3 was due for her Abilify injection.  -The home health skilled nurse had not come to the facility to administer the Abilify injection.  -Per staff, Resident #3 was due to have the Abilify injection three weeks ago.  -Resident #3 was to to have the Abilify injection.  -Resident #3 was use to have the Abilify injection do a full assessment.  -The Abilify injection was given per the mental health provider's orders.  Based on the documented date of 07/05/23 for the administration of the Abilify Maintera IM injection to Resident #3, the Abilify Maintera IM injection would have been due on 07/26/23.  There was no documentation of administration of the next Abilify Maintera IM injection would have been due on 07/26/23.  There was no documentation of administration of the next Abilify Maintera IM injection until 08/17/23.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
Review of a Mental Health Provider's (MHP) visit	D 273	Based on the docume the administration of injections would have There was no docum the next Abilify Mainto 07/05/23.  Review of Resident # report completed by to 07/05/23 revealed: -Resident #3 was see review her chronic here in the resident was followed practice for managen and bipolar disorderResident #3 was due. The home health skifthe facility to administe injection three weeks in the facility to administe injection three weeks in the facility injection would not a full assessmentThe Abilify injection whealth provider's order the administration of injection to Resident injections would have the mext Abilify Mainto 08/17/23.	ented date of 06/01/23 for the Abilify Maintera IM #3, the Abilify Maintera IM been due on 06/22/23. entation of administration of era IM injection until #3's history and physical the Nurse Practitioner dated ento establish care and ealth conditions. lowed by a mental health ment of her schizophrenia er for her Abilify injection. Hed nurse had not come to ter the Abilify injection. Was due to have the Abilify ago. In ghly agitated."  To answer questions. In the nurse practitioner was given per the mental ers.  The Abilify Maintera IM #3, the Abilify Maintera IM was entation of administration of era IM injection until	D 273			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		HAL051062	B. WING		10	R 0/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		IE PARKER CIRC ELD, NC 27577	CLE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	from other residents, into other residents, into other residents' regression of the Abilify injection of the Abilify needed to the Abilify needed to the Abilify injection of the Abilify injection that the ability injection the Abilify and injection by the proving the Abilify injection by the proving the Abilify injection by the proving the Abilify injection of the Abil	d Resident #3 was stealing not sleeping, and wandering rooms at night. It received her Abilify injection ed the MHP to administer in 08/15/23. It refill the injection. It be called. Inimally cooperative. It is elusional thoughts of being it is ess visual hallucinations. It is amended note for Resident vealed: Inimistered the Abilify der on 08/17/23. It is give the next injection in the seks from 08/17/23. It is a fax to a local home in the second revealed there is a fax to a local home in the second revealed there is a fax to a local home in the second revealed there in regarding a referral for inster the Abilify injection in the second revealed there is a fax to a local home in the second revealed the	D 273			
	Review of Resident #	t3's record on 10/06/23				

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revealed there was no documentation of

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. BOILBING			
		HAL051062	B. WING		R 10/06/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
01.40010	CARE HOMES #4	101 ANN	IE PARKER CIRC	CLE		
CLASSIC	CARE HOMES # 1	SMITHFII	ELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	3	D 273			
	administration of the	Abilify injection by a home Resident #3's admission to				
	Telephone interview with the Regional Sales Manager for the local home health agency on 10/06/23 at 3:35pm revealed: -The agency received faxed referrals from the					
facility on 08/11/23 and on 08/17/23.  -The referral was declined due to payor source.  -She contacted a facility staff about declining the						
	referralThere was no docum received prior to 08/1	nentation of a referral				
	Telephone interview on 10/06/23 at 1:11pr -Resident #3 was adr 06/01/23 from anothe -The resident was sulan injection for behave -The resident had not because there was a establishing care with -She was aware Resident Abilify injection or -She did not know of Resident #3 was adm injectionResident #3 needed the resident #3 was cur diagnosis of small book	with Resident #3's guardian in revealed: mitted to the facility on a facility. poposed to be administered iors every three weeks. I received the injection timely delay with the facility a mental health provider. I dent #3 was administered in 08/17/23. I any other dates that inistered the Abilify  the Abilify injection because ere mental illness". I rently hospitalized with a wel obstruction.				
	1:40pm revealed: -The primary care protection to	ninistrator on 10/06/23 at ovider (PCP) administered Resident #3 in July 2023. ther injection administered				

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by the MHP.

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DIVISION C	of Health Service Regu	lation			
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			_		
			B. WING		R
		HAL051062			10/06/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STAT	TE. ZIP CODE	
			E PARKER CIRC	•	
CLASSIC	CARE HOMES # 1		ELD, NC 27577	,,,,	
	Г		LD, NC ZISII		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	\ -/
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
17.0		,	,,,,	DEFICIENCY)	
			+		
D 273	Continued From page	e 4	D 273		
	-She was not sure of	the dates for the			
	administration.	the dates for the			
	duliiiiisti duoii.				
	Second interview with	h the Administrator on			
	10/06/23 at 2:53pm re				
		ral to a local home health			
		for Resident #3's injection to			
	be administered.	of Nesident #03 injection to			
		sponse from the home health			
	agency.	sponse nom me nome neam			
	, ,	ne health agency did not			
		ecause of an insurance			
	issue.	cause of all insurance			
		o with the home health			
		ome health agency about			
ļ					
		ration of Resident #3's Abilify			
	injection.	dente administer the Abilify			
		der to administer the Abilify			
	injection.				
	T-lambama internious	10/06/22 of			
	2:08pm revealed:	with the MHP on 10/06/23 at			
		- At-106, interstante Decident			
		e Abilify injection to Resident			
	#3 once.	sian's order for the Abilify			
		cian's order for the Abilify			
	injection.	anaible for making a referral			
	_	onsible for making a referral			
	injection.	Iministering the Abilify			
	Injection. -Home health would b	tiblo for			
		•			
	weeks.	ilify injections every three			
		cerns for Resident #3's			
		s escalating if Resident #3			
	was not administered				
		or the resident wandering at			
	night.				
	_	get out of the facility at night			
ļ	, and staff would not be	e aware which could be			

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detrimental.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R	
		HAL051062	B. WING		10/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CLASSIC	CARE HOMES # 1		E PARKER CIR( ELD, NC 27577	CLE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 273	without someone look-Resident #3 needed administered every the She last saw Resider She was told by facility on 09/20/23 that home facility to administer the Resident #3 was not at the survey for intervied.  The facility failed to end follow-up for Resident's order for a agency for a skilled not intramuscular injectable weeks used to maintate This failure resulted in resident's injections entiree-week timeframe an increase in psychical agitation, sleeplessness behaviors. The failure health, safety, and we constitutes a Type B Note The facility provided a accordance with G.S. his violation.	ely should not be on her own king out for her. the Abilify injection ree weeks. Int #3 on 09/20/23. ity staff (no name provided) he health would be at the he next Abilify injection.  available in the facility during liv.  Insure health care referral ident #3 who had a referral to a home health curse to administer an ole medication every three hin psychiatric behaviors. In the administration of the extended past the live. The resident experienced latric behaviors including lives, and wandering live was detrimental to the leftare of the resident and violation.	D 273		
D 282	Service	e(a)(1) Nutrition and Food	D 282		
	10A NCAC 13F .0904	Nutrition and Food Service			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETE	
		HAL051062	B. WING		R 10/06/2	023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CI VSSIC	CARE HOMES # 1	101 ANNIE	PARKER CIRC	CLE		
CLASSIC	CARE HOWES # 1	SMITHFIEL	D, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 282	Continued From page	e 6	D 282			
5 202	(a) Food Procurement Homes: (1) Facilities with a ligner residents shall ensure Rules Governing the Care Facilities set for which are hereby incoincluding subsequent storage, preparation, beverage under sanit	censed capacity of 7 to 12 e food services comply with Sanitation of Residential th in 15A NCAC 18A .1600 orporated by reference, amendments, assuring and serving food and ary conditions.	5 202			
	failed to ensure food	ns, and interviews, the facility items being stored and ere dated and labeled.				
	9:30am revealed: -There were five food were not labeled with wereThere was a plastic s sliced hamThere was a plastic s sliced cheeseThere was a plastic s cooked hotdogsThere was a plastic s onionThere was a half onion Observation of the fre on 10/05/23 at 9:30ar					
	that were not labeled items were.	items in plastic freezer bags with the dates or what the storage bag of chicken.				

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DIVISION	n nealth Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					_
			D 14//10		R
		HAL051062	B. WING		10/06/2023
NAME OF D	DOVIDED OD CUDDUED	CTDEET AD	DECC CITY CTA	TE 710 CODE	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
CL ASSIC	CARE HOMES # 1	101 ANNIE	PARKER CIRC	CLE	
OLAGGIO	OAKE HOMEO# 1	SMITHFIE	LD, NC 27577		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 282	Continued From page	. 7	D 282		
D 202	Continued From page	<del>5</del> 1	5 202		
	-There were 8 storage	e bags of gravy.			
	-There was a plastic s	storage bag of cabbage.			
	-There was a plastic s	storage bag of sweet green			
	peas.	gg g			
	•	tic storage bags of hash			
	browns.	no storago bago or nasm			
		stic storage bags of yeast			
		istic storage bags or yeast			
	rolls.	-t b			
	-There was a plastic s	3 3			
	- I nere was a plastic s	storage bag of 4 waffles.			
	1 1 2 20	(DOD)			
	•	onal care aide (PCP) on			
	10/05/23 at 8:44am re				
	T T	erved the meals to the			
	residents.				
	-She stored left over	food items in the			
	refrigerator.				
	-Food items were pur				
	delivered to a nearby	building where the main dry			
	storage area and kitcl	hen were located on the			
	compound that consis	sted of three buildings.			
	-Food items were sep	parated and taken out of the			
		he nearby building and			
	brought to the facility.				
	•	arating the food items did			
	·	ood items before bringing			
	them to the facility.	TTT HOME SOLOTO SITTING			
		items that were taken out of			
	dated and labeled.	r were supposed to be			
		·e.			
		specific reason as to why			
		d labeled the food items			
	brought to the facility	and placed in the freezer.			
		10/00/00			
		ministrator on 10/06/23 at			
	4:00pm revealed:				
		s taken out of their original			
	container and placed	in another container should			
	be dated and labeled	with what the food item			

was.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL051062	B. WING		R <b>10/06/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CI ASSIC	CARE HOMES # 1	101 ANNIE	PARKER CIRC	CLE	
CLASSIC	CARE HOMES # 1	SMITHFIEL	D, NC 27577		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 282	Continued From page	e 8	D 282		
	out of their original co -She did not recall ins been employed for all food items with the da -The staff person sep taking them out of the	chased in bulk and taken bottainer at a nearby building. Structing the PCA, who had bout two weeks, to label ate and what the item was. arating the bulk items and beir original containers should ed the food items before accility.			
D 296	10A NCAC 13F .0904 Service	(c)(7) Nutrition And Food	D 296		
	10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.				
	interviews, the facility corresponding therap available for guidance	ns, record reviews, and failed to ensure there was a eutic or modified menu			
	The findings are:				
		t #1's current FL-2 dated agnoses included asthma, ertension.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
					R
		HAL051062	B. WING		10/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
01.40010	0.155 H01450 # 4	101 ANNIE	PARKER CIRC	CLE	
CLASSIC	CARE HOMES # 1	SMITHFIEL	D, NC 27577		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	, ID	PROVIDER'S PLAN OF CORRECTION	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 296	Continued From page	9	D 296		
	Review of Resident #1's diet order dated 02/10/23 revealed a no concentrated sweet (NCS) diet.				
	12:00pm revealed:	nch meal on 10/05/23 at			
	-Resident #1 was ser	ved chicken rice soup, a			
		nge slices, green beans,			
		uice that contained 28grams			
	of sugar.				
	-She ate 100% of the				
	-She was served the	regular diet menu.			
	Observation of the kit 12:30pm revealed:	chen on 10/06/23 at			
	•	or regular diet for the week			
	-There was no corres residents on a NCS d	ponding menu posted for iet.			
	Observation of the remeal on 10/06/23 at 1	gular diet menu for the lunch I2:00pm revealed:			
	-There was an entry f	or Chicken Rice Soup.			
	_	or mixed melons (the facility			
	substituted mandarin	orange slices).			
	-There was an entry f	•			
	-There was an entry f	or crackers.			
	10/06/23 at 12:40pm				
	-She prepared and se residents.	erved the meals to the			
	-She did not know Re until now.	esident #1 was on a no NCS			
		#1 was a diabetic and she			
	had to watch her suga				
	_	hat a corresponding menu			
		ne kitchen for residents on			
	modified diets to prov				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BUILDING:			Б
		HAL051062	B. WING		10	R / <b>06/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		IE PARKER CIRC	CLE		
	I	SMITHFI	ELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 296	Continued From page	e 10	D 296			
	Refer to interview wit 10/06/23 at 4:00pm.	h the Administrator on				
	03/06/23 revealed dia osteoporosis, diabete	t #2's current FL-2 dated agnoses included as, anxiety, depression DVT ity cellulitis and lower back				
	Review of Resident # 03/06/23 revealed a r (NCS) diet.	1's diet order dated no concentrated sweet				
	12:00pm revealed: -Resident #2 was ser bowl of mandarin ora					
	-There was a menu for of 10/02/23.	chen on 10/06/23 revealed: or a regular diet for the week ponding menu posted for t.				
	meal on 10/06/23 rev -There was an entry f -There was an entry f substituted mandarin -There was an entry f -There was an entry f	or Chicken Rice Soup. for mixed melons (the facility orange slices). for green beans.				
	10/06/23 at 12:40pm -She prepared and se	erved the meals to the				

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residents.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	A. BOILDING.			R	
		HAL051062	B. WING		10/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
CI ASSIC	CARE HOMES # 1	101 ANN	IE PARKER CIRC	CLE	
OLAGGIO	TARE HOMEO # 1	SMITHFI	ELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 296	Continued From page	e 11	D 296		
	concentrated sweet de-She knew Resident and to watch her sugar-She was not aware to should be posted in the modified diets to prove Refer to interview with 10/06/23 at 4:00pm.  Interview with the Adra 4:00pm.  Interview with the Adra 4:00pm.  She was aware there corresponding menulor modified diets post guidance.  She had a modified on the kitchen, but sor and a consistent carb (CCHO) and not a no	#1 was a diabetic and she ar intake. hat a corresponding menume kitchen for residents on ride guidance. h the Administrator on ministrator on 10/06/23 at e was supposed to be a for residents on therapeutic and in the kitchen for corresponding menu posted meone must have moved it. cility used to provide menus			
	food distribution comp	pany that had a no			
	the diet order.	nenu to be consistent with			
D 309	10A NCAC 13F .0904 Service	(e)(3) Nutrition and Food	D 309		
	(e) Therapeutic Diets (3) The facility shall r	Nutrition and Food Service in Adult Care Homes: maintain a current listing of an-ordered therapeutic diets service staff.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL051062	B. WING		R 10/06/2023
					10/06/2023
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT		
CLASSIC	CARE HOMES # 1		IIE PARKER CIRC ELD, NC 27577	CLE	
()(1) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORREC	TION
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 309	Continued From page	e 12	D 309		
	This Rule is not met	as evidenced hv			
		ns, record reviews, and			
		failed to maintain a current			
		ered therapeutic or modified			
	diets for guidance of f				
	sampled residents (#	1, #2).			
	The findings are:				
	1. Review of Residen	t #1's current FL-2 dated			
		agnoses included asthma,			
	depression, and hype	ertension.			
	Review of Resident #	1's diet order dated			
		no concentrated sweet			
	(NCS) diet.				
	Observation of the lur	nch meal on 10/05/23 at			
	12:00pm revealed:				
		ved chicken rice soup, a			
		nge slices, green beans, uice that contained 28gm of			
	sugar.	dice that contained 20gm of			
	-She ate 100% of the	lunch meal.			
	-She was served a re	gular diet menu.			
	Observation of the red	gular diet menu for the lunch			
	meal on 10/06/23 at 1				
	-	or Chicken Rice Soup.			
		or mixed melons (the facility			
	substituted mandarin	,			
	-There was an entry f -There was an entry f				
	- THOIC WAS ALL CHUY I	or ordered.			
		chen on 10/06/23 revealed:			
	-There was no list of r	residents on therapeutic or			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SU	
			A. BUILDING		R	
		HAL051062	B. WING			6/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		PARKER CIRC	CLE		
			_D, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 309	Continued From page	: 13	D 309			
	modified diets availab -There was a list of re kitchen who were dial #1.					
	10/06/23 at 12:40pmShe prepared and se	rsonal care aide (PCA) on erved the meals to the				
	concentrated sweet d	sident #1 was on a no iet (NCS) until now. #1 was a diabetic because				
		on a list in the kitchen.				
	diet until now.	revealed: Resident #1 was on a NCS esident's diet order should				
	4:00pmShe was not aware the residents posted in the therapeutic or modified was.	ninistrator on 10/06/23 at here needed to be a list of e kitchen who were on d diets and what the diet esidents in the kitchen that				
	03/06/23 revealed dia osteoporosis, diabete back and hip pain. Review of Resident #	s, anxiety, depression, lower				

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Observation of the lunch meal on 10/05/23 at

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DIVISION	n nealth Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			1			
					R	2
		HAL051062	B. WING	<del></del>	10/0	6/2023
NAME OF D	DOVIDED OD CUDDUED	CTDEET ADI	DECC CITY CTA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA			
CL ASSIC	CARE HOMES # 1	101 ANNIE	PARKER CIR	CLE		
02/100/0	o,	SMITHFIE	LD, NC 27577			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE	DATE
				DEFICIENCY)		
D 309	Continued From page	- 1/	D 309			
D 000	Continued i form page	5 1 <del>4</del>	5 000			
	12:00pm revealed:					
	-Resident #2 was ser	ved chicken rice soup, a				
	bowl of mandarin oral	nge slices, green beans,				
		uice that contained 28gm of				
	sugar					
	-She ate 50% of the li	unch meal				
	-She was served a re					
	-One was served a re	gulai diet menu.				
	Observation of the re-	gular diet many for the lunch				
		gular diet menu for the lunch				
	meal on 10/06/23 at 1					
	-	or Chicken Rice Soup.				
	_	or mixed melons (the facility				
	substituted mandarin					
	-There was an entry f	or green beans.				
	-There was an entry f	or crackers.				
	Observation of the kit	chen on 10/06/23 revealed:				
	-There was no list of r	residents on therapeutic or				
	modified diet available	· · · · · · · · · · · · · · · · · · ·				
	-There was a list of re					
		betics, including Resident				
	#2.	bottoo, morading recordence				
	11 <b>L</b> .					
	Interview with the ner	sonal care aide (PCA) on				
	10/06/23 at 12:40pm.	, ,				
	•					
	residents.	erved the meals to the				
		: 1 4 40				
		esident #2 was on a no				
	concentrated sweet d	` ,				
		#2 was a diabetic because				
	her name was posted	I on a list in the kitchen.				
		ministrator on 10/06/23 at				
	4:00pm.					
	-She was not aware t	here needed to be a list of				
	residents posted in th	e kitchen who were on				
		ed diets and what the diet				
	was.					
		esidents in the kitchen who				

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were diabetics.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
						R
		HAL051062	B. WING		10	0/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CLASSIC	CARE HOMES # 1		IIE PARKER CIRCL	E		
	T	SMITHF	IELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	(a) An adult care he preparation and adr prescription and nor by staff are in accor (1) orders by a licel which are maintaine (2) rules in this Sec and procedures.  This Rule is not me FOLLOW-UP TO TY	D4 Medication Administration ome shall assure that the ninistration of medications, n-prescription, and treatments dance with: nsed prescribing practitioner ad in the resident's record; and tion and the facility's policies t as evidenced by:	D 358			
	interviews, the facilimedications as orderesidents (#1, #2, #3 to treat depression, disorder, and anxiet (#1); medications us dietary supplements to treat mood disordaltering medications.  The findings are:  Review of the facility Policies and Procedurations of operation and Monday through Frilling the case of an electric residence.	y's Medication Administration ures (undated) revealed: octed pharmacy's standard are 9:00am to 5:00pm, day. mergency, the contracted ontacted to fill and deliver				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		1141.054000	B. WING		R	
		HAL051062			10/06/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STA	TE, ZIP CODE		
		101 ANNI	IE PARKER CIRC	CLE		
CLASSIC	CARE HOMES # 1		ELD, NC 27577			
	CUMMADV CT			PROVIDEDIO DI ANI OF CODDECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( - /	TE
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		
				DEFICIENCY)		
D 358	Cantinued From page	- 40	D 358			
D 556	Continued From page		D 330			
		lld be between 6:00pm and				
	7:00pm, Monday through Friday.					
		administered per physician				
		ocumented on the MAR				
	immediately after adn					
	-Medications shall be					
		ved there was only an 8-day				
	supply on hand.					
	-The MA was respons	•				
	refill/reorder request f					
	I	ould be given to the RCC or				
		noon so it could be faxed to				
	the pharmacy.	ld be delivered to the facility				
		ays (the number of days was				
	left blank).	lys (the number of days was				
	·	tion was ordered, most				
		ould electronically prescribe				
	(e-scribe) the prescrip					
		administrator or RCC should				
	fax the prescription to					
		#1's current FL-2 dated				
		agnoses included asthma,				
	depression, and hype	rtension.				
	- Daview of Deciden					
		at #1's signed physician order				
		05/25/23 revealed Zoloft HCL in the morning. (Zoloft is a				
	medication used for d					
		e disorder, and anxiety				
	disorder).	s disorder, and anxiety				
	uisoruer <i>j</i> .					
	Review of Resident #	t1's signed Mental Health				
		port dated 08/09/21 and				
	, , , ,	y on 08/11/23 (2 years later)				
	revealed:	,				
	-There was an order	to discontinue Zoloft HCL				
	50mg, 1 tablet daily for	or depression on 08/09/21				
		to start Zoloft HCL 50mg,				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
741012741	or contraction	IDENTIFICATION NO.	A. BUILDING: _		
		HAL051062	B. WING		R 10/06/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
CI VESIC	CARE HOMES # 1	101 ANNI	E PARKER CIRC	CLE	
CLASSIC	CARE HOMES # 1	SMITHFIE	ELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 17	D 358		
	right of the order doct faxed to the pharmac (Two years later).  Review of Resident # administration record -There was an entry f tablet dailyThere was an entry f ½ tablets (75mg) daily -There was documen 100mg, 1 tablet daily from 08/01/23 through -There was documen	itten note on the bottom umenting the order was y by the facility on 08/11/23.  11's August 2023 medication (MAR) revealed: for Zoloft HCL 100mg, 1 for Zoloft HCL 50mg, 1 and y. tation the Zoloft HCL was administered at 8:00am in 08/11/23. tation the Zoloft HCL 50mg, its daily was administered at			
	revealed: -There was an entry f tablet daily.	or Zoloft HCL 100mg, 1 for Zoloft HCL 50mg, 1 and			
	-There was documen tablet daily was admit 09/01/23 through 09/7-There was documen and ½ tablets (75mg) 8:00am from 09/01/23-Resident #1 Zoloft H	tation Zoloft HCL 100mg, 1 nistered at 8:00am from 15/23. tation Zoloft HCL 50mg, 1 was administered at			
	revealed:	1's October 2023 MAR for Zoloft HCL 50mg, 1 and			

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½ (75mg) tablets daily.

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DIVISION	or riealin Service Negu	lation	_			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR\	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			_		_	
			D WING		R	
		HAL051062	B. WING		10/0	6/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TVAIVIL OF T	NOVIDEN ON GOLT EIEN					
CLASSIC	CARE HOMES # 1		E PARKER CIR	CLE		
		SMITHFIE	LD, NC 27577			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	NAIE	DAIL
				,		
D 358	Continued From page	e 18	D 358			
		tation Zoloft HCL 50mg, 1				
	and ½ tablets (75mg) daily was administered at					
	8:00am on 10/01/23 t	hrough 10/05/23.				
		vith the facility's contracted				
	l -	23 at 9:45am revealed:				
		the pharmacy system was				
		HCL 50mg 1 and ½ tablets				
	(75mg) daily dispense					
	-The pharmacist imm	ediately stated the Zoloft				
	HCL order that was fa	exed to them on 08/11/23 for				
	50mg 1 and ½ tablets	(75mg) by the facility was				
	dated 08/09/21.					
	-The pharmacist could	d not understand why the				
	facility faxed them an					
	-	not notice the medication				
		9/21 and the medication				
		/11/23 and placed on the				
	MAR, which was an e					
		as Zoloft HCL 100mg, 1				
	tablet daily, which wa					
		not notice a change in the				
		5mg in terms of how she felt				
	because it was a sma	•				
	because it was a sine	in amount.				
	Review of Resident #	1's pharmacy review dated				
	09/15/23 revealed	13 priarriacy review dated				
		der for Zoloft HCL 100mg				
	daily ordered on 03/2	•				
		be receiving Zoloft HCL				
		Zoloft HCL 50mg, 1 and ½				
	tablets (75mg) daily o				ľ	
	, -, -	ildered on 00/11/23				
	concurrently.	ad boon romayad from sout			ľ	
	_	ad been removed from cart.				
		itten note on the bottom			ľ	
	_	t the review was faxed to				
		PCP) on 10/05/23 by the				
	facility.					

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Review of Resident #1's pharmacy report faxed

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BOILDING.			R
		HAL051062	B. WING		10	)/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
01.40010	0.155 H01150 # 4	101 ANN	NIE PARKER CIRCL	E		
CLASSIC	CARE HOMES # 1	SMITHF	IELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	to the facility on 10/0-Zoloft HCL 100mg, 703/21/23 for a quanti-Zoloft HCL 50mg, 1 dispensed on 08/11/2-Zoloft HCL 50mg, 1 dispensed on 09/06/2-Zoloft HCL 50mg, 1 dispensed on 10/02/2 Observation of medicat 11:00am revealed 1/2 tablets in each buin the bubble cards w 10/02/23.  Interview with Residerevealed: -She did not feel sad-She liked doing word.	6/23 revealed: 1 tablet was dispensed on ty of 90 tablets and ½ tablets was 23 for a quantity of 45 doses. and ½ tablets was 23 for a quantity of 45 doses. and ½ tablets was 23 for a quantity of 45 doses. and ½ tablets was 23 for a quantity of 45 doses. cations on hand on 10/06/23 there were 33 doses (1 and abble=75mg) of Zoloft HCL with a dispense date of	D 358			
	other residents worki -She ate breakfast, lu and 10/06/23 in the considents at the table -She ate 100% of her during the meal obset- -She pushed her oxy dining room for the lu	r lunch meal on 10/05/23				
	10/06/23 at 3:15pm r -There were no beha -She loved watching word find puzzles.	, ,				

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Division of	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					-	,
		1141.054000	B. WING		F	
		HAL051062			10/0	06/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		101 ANNI	E PARKER CIR	CLE		
CLASSIC	CARE HOMES # 1		LD, NC 27577			
	CUMMA DV CT		<u> </u>	DROVIDEDIC DI ANI CE CODDECTIO		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	20	D 358			
D 000	Continued From page	5 20	5 556			
	dining room sometime	es because she says doing				
	so was her "work out.	·• ·				
	•	with the MH provider on				
	10/06/23 at 2:00pm re					
	<u> </u>	ent #1's mental health				
	medications, including	<del>-</del>				
		ation order for Zoloft 50mg,				
		g) was written on 08/09/21				
	-	der was written on 02/28/22				
	for Zoloft HCL 100mg	•				
		ion order for Resident #1's				
	Zoloft was 100mg, 1					
		lent #1's Zoloft HCL dose on				
	08/11/23 was concern	ning because she did not				
	write the order.					
		not done prior to the Zoloft				
		correctly changed to Zoloft				
	HCL 75mg that could					
	depression and anxie					
		dent #1 on 09/20/23 and the				
	resident was assesse	ed to be stable.				
		ministrator on 10/06/23 at				
	4:00pm revealed:					
		er for Zoloft HCL 50mg, 1				
	, -	) daily dated 08/09/21 was				
		ne pharmacy by the previous				
		inator (RCC) on 08/11/23.				
		hat the medication order				
	dated 08/09/21 was fa	,				
		nd this was a major error				
	that was "unacceptab					
		understand how an old				
		ed 08/09/21 was faxed to				
	pharmacy on 08/11/2					
		fax the medication order				
	when received from t					
		medication when received				
	from the pharmacy w	ith the MAR for accuracy,				

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DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
					-	<u> </u>
			B. WING		F	
		HAL051062	B. Wto		1 10/0	06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
		101 ANNIE	PARKER CIRC	CLE		
CLASSIC	CARE HOMES # 1	SMITHFIEL	D, NC 27577			
0(0)15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTI		0(5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	21	D 358			
	. •					
		n order in the resident's				
	record.	#41 A 1 0000 MAR				
		: #1's August 2023 MAR				
		on Zoloft HCL 175mg was				
		/01/23 through 09/15/23.				
	•	n why Zoloft HCL 175mg				
		Resident #1 from 09/01/23				
	through 09/15/23.					
	-	ation orders to be checked				
	by the RCC for accuracy before sending the order to the pharmacy, and for medications to be					
	administered as order	rea.				
	h Review of Residen	t #1's physician order dated				
		order for Vitamin C 1000mg				
		(Vitamin C is a supplement)				
		(viaiiiii)				
	Review of Resident #	1's August 2023 medication				
	administration record					
	-There was an entry f	or Vitamin C 1000mg, 1				
	tablet every other mo	rning.				
	-There was documen	tation Vitamin C 1000mg, 1				
	tablet was administer	ed on 08/17/23 and				
	08/19/23, but should i	not have been.				
	-There was no docum	nentation Vitamin C 1000mg,				
	1 tablet was administed	ered on 08/22/23 and				
	08/24/23, but should I	have been, no reason was				
	given as to why it was	s not administered.				
During A David Lift Co. 1 1 2000 1105						
		1's September 2023 MAR				
	revealed:	for Vitamin C 1000mg 1				
	tablet every other mo	for Vitamin C 1000mg, 1				
		rning. tation Vitamin C 1000mg, 1				
		ed every day from 09/01/23				
		days), instead of every				
	other day.	uaya, ilialeau oi every				
	onioi day.					
	Review of Resident #	1's October 2023 MAR				

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revealed:

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY. STATE. 2IP CODE 101 ANNIE PARKER CIRCLE SMITHFIELD, NC. 27877  D SUMMARY STATEMENT OF DEFICIENCES MITHFIELD, NC. 27877  TAG  SUMMARY STATEMENT OF DEFICIENCES MITHFIELD, NC. 27877  D SUMMARY STATEMENT OF DEFICIENCES (EACH CORRECTIVE ACTION SHOULD BE CACH DEFICIENCY MAYS BE PRECEDED BY PULL PREPRY TAG  TAG  TO STATE AND A SUMMARY STATEMENT OF DEFICIENCES  EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCES TO THE APPROPRIATE DEFICIENCY TAG  TO STATE  THERE WAS AN END AND A SUMMARY STATEMENT OF DEFICIENCES  OVER THE WAS AND A SUMMARY STATEMENT OF DEFICIENCES  TAG  TO STATE  THERE WAS A SOCIETY OF THE WAS MOREMATION  OVER THE WAS AND A SUMMARY STATEMENT OF DEFICIENCY TAG  TO STATE  THERE WAS A SOCIETY OF THE		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		' '	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  CLASSIC CARE HOMES # 1  101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577  PROVIDERS ALMOT CORRECTION PRICTOR TAG  CANDIDATE CONTROLL OF PROVIDERS ALMOT CORRECTION PRICTOR TAG  CONTINUED TO SUPPLIES AND CORRECTION PROVIDERS ALMOT CORRECTION PRICTOR TAG  CONTINUED TO SUPPLIES AND CORRECTION PRICTOR TAG  CONTINUED TO SUPPLIES AND CORRECTION PRICTOR TAG  CONTINUED TO SUPPLIES AND CORRECTION PROVIDERS ALMOT CORRECTION PROVIDERS			HAI 051062			10	
CLASSIC CARE HOMES # 1   SUMMARY STATEMENT OF DEFICIENCES   SMITHFIELD, NC. 27577   TOTAL PRIVATE   TAG	NAME OF B	DOVIDED OD SLIDDI IED		DDBESS CITY STATE	7ID CODE		70072023
CLASSIC CARE HOMES #1   SMITHFIELD, NC 27577   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION OF CRACH CORRECTIVE ACTION SHOULD BE CROSS-AEFRENCED TO THE APPROPRIATE   DATE	NAME OF F	NOVIDER ON SUFFLIER					
D 358 Continued From page 22 -There was an entry for Vitamin C 1000mg, 1 tablet very other morningVitamin C 1000mg should have been administered on 10/02/23, 10/04/23 and 10/06/23There was documentation Vitamin C 1000mg, 1 tablet was not administered on 10/02/23, 10/04/23 and 10/06/23 at 11:30am revealed there was a full bottle of over-the counter Vitamin C 1000mg that was purchased on 10/06/23 at 11:30am revealed there was a full bottle of over-the counter Vitamin C 1000mg that was purchased on 10/06/23 on 10/06/23 at 11:30am revealed there was a full bottle of over-the counter Vitamin C 1000mg that was purchased on 10/06/23 roughly on 10/06/23 at 11:30am revealed there was a full bottle of over-the counter Vitamin C 1000mg that was purchased on 10/06/23 on	CLASSIC	CARE HOMES # 1			_		
- There was an entry for Vitamin C 1000mg, 1 tablet every other morning Vitamin C 1000mg should have been administered on 1002/23, 10/04/23, and 10/06/23 There was documentation Vitamin C 1000mg, 1 tablet was not administered 10/02/23, 10/04/23 and 10/06/23 because it was not available on the medication cart.  Observation of medications on hand on 10/06/23 at 11:30am revealed there was a full bottle of over-the counter Vitamin C 1000mg that was purchased on 10/06/23 containing a quantity of 100 tablets.  Interview with the medication aide (MA) on 10/06/23 at 3:15pm revealed: -She administered medications to residents in the facilityShe did not notice the Vitamin C supplement was ordered every other day for Resident #1She administered Resident #1's Vitamin C supplement everydayEvery other day should have been crossed out or highlighted on the MAR to show the Vitamin C supplement was to be administered every other day.  Interview with the Administrator on 10/06/23 at 4:00pm revealed: -She was not aware the Vitamin C supplement for Resident #1 was supposed to be administered every other dayIt should have been highlighted on the MAR that Vitamin C was to be administered every other	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
Review of Resident #2's current FL-2 dated     03/06/23 revealed diagnoses included	D 358	-There was an entry fitablet every other mo -Vitamin C 1000mg signal administered on 10/0. 10/06/23There was documentablet was not administered on administered was not administered was medication cart.  Observation of medication at 11:30am revealed over-the counter Vital purchased on 10/06/2. 100 tablets.  Interview with the me 10/06/23 at 3:15pm re-She administered medicalityShe did not notice the was ordered every other day shown highlighted on the Masupplement was to be day.  Interview with the Administered was not aware to the was not awar	for Vitamin C 1000mg, 1 rning. hould have been 2/23, 10/04/23, and tation Vitamin C 1000mg, 1 stered 10/02/23, 10/04/23 e it was not available on the ations on hand on 10/06/23 there was a full bottle of min C 1000mg that was 23 containing a quantity of dication aide (MA) on evealed: edications to residents in the ee Vitamin C supplement her day for Resident #1. esident #1's Vitamin C and have been crossed out or and to show the Vitamin C and have been crossed out or and to show the Vitamin C and the vitamin C supplement for posed to be administered thighlighted on the MAR that administered every other and #2's current FL-2 dated	D 358			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMP	SURVEY LETED
		HAL051062	B. WING			R <b>06/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
CLASSIC	CARE HOMES # 1		IE PARKER CIRCI	LE		
		SMITHFI	ELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 358	Continued From page	23	D 358			
	paroxysmal supraven osteoporosis, lower b depression.	tricular tachycardia, ack pain, anxiety, and				
	dated 03/06/23, 05/25 revealed there was a	treatment of heart disease)				
	table take one tablet of with a meal scheduled 5:00pmThere were circled in	entry for Atorvastatin 10mg once daily in the evening d for administration at				
	(MA) documented the house" [not in the faci	notes on the back of ber MARs revealed: 18/23, the medication aide Atorvastatin was "out of				
	medication aide (MA) revealed there was a Calcium 10mg tablets	ation on hand with the on 10/05/23 at 12:30pm blister pack for Atorvastatin daily in the evening with a 0/19/23, quantity 30. There ining.				
	revealed when a residual she circled her initials	on 10/05/23 at 2:03pm dent was out of medication, and documented on the MARs that the medication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:	
		HAL051062	B. WING		R 10/06/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CI ASSIC	CARE HOMES # 1	101 ANNII	PARKER CIRC	CLE	
OLAGGIO		SMITHFIE	LD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 24	D 358		
	and 10:25am reveale  -A 90-day supply for A filled on 06/20/23 whi 09/20/23.  -A 30-day supply for A filled on 09/15/23.  -The pharmacy began supply in September was requesting refills no medication on han Interview with the Adr 10:55am revealed:  -The resident could h medication if the MAs MARs.  -When a resident's m reordering, the MAs w completed medicatior  -Medications were su least seven days in a hand being gone.  -She or the MAs were medication reorder sh provider pharmacy.  -The facility had a bag get medications from without a prescription -Receipt of resident in contracted pharmacy issue.  -She expected the me the facility on the sam sheet was faxed to th	a 10/06/23 between 10:10am d: Atorvastatin 10mg tablet was ch should have lasted until Atorvastatin 10mg tablet was a sending 30-day medication 2023 because the facility in less than 90 days due to id.  ministrator on 10/06/23 at ave been out of the sinitials were circled on the edications needed were supposed to give her an reorder sheet. pposed to be reordered at dvance of the supply on expensible for faxing the neets to the contracted ckup pharmacy but could not the backup pharmacy .  nedications from the provider was an "ongoing" edications to be received at needay as medication reorder.			
		cian's order for Resident #2 led there was a physician's			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PUBLISHING: COMPI		SURVEY PLETED			
			7. BOILBING.	A. BUILDING:		R
		HAL051062	B. WING			/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		PARKER CIR	CLE		
	Т		LD, NC 27577	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 25	D 358			
	order for Vitamin B-12 one tablet daily in the	2 (dietary supplement) take morning.				
	2500mcg tablet take	entry for Vitamin B-12 one tablet once daily in the or administration at 8:00am. nitials on the MAR for				
	Resident #2's Septen -There were handwrit through 09/15/23 that given with a reason o	ten entries for 09/11/23 t the Vitamin B-12 was not f "OFH". ignature or initials for the				
	medication aide (MA) revealed there was a	eation on hand with the on 10/05/23 at 12:30pm blister pack for Vitamin B-12 ed on 09/15/23, quantity 30. s remaining.				
	revealed when a residual she circled her initials	on 10/05/23 at 2:03pm dent was out of medication, and documented on the MARs that the medication				
	and 10:25am reveale -A 90-day supply for villed on 06/20/23 white 09/20/23.	n 10/06/23 between 10:10am				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING	<del></del>	
		HAL051062	B. WING		R <b>10/06/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CI ASSIC	CARE HOMES # 1	101 ANNI	E PARKER CIRC	CLE	
CLASSIC	CARE HOWES # 1	SMITHFIE	LD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 26	D 358		
	supply in September	n sending 30-day medication 2023 because the facility in less than 90 days due to id.			
	10:55am revealed: -The staff who circled through 09/15/23 for I was no longer employShe had instructed the initials if the resident medicationThe resident could had medication if the MAS MARsWhen a resident's materials may be made to make the medication of the MAS was completed medicationMedications were suleast seven days in an and being out.	nat staff not to circle their was administered the ave been out of the sinitials were circled on the edications needed were supposed to give her a			
	medication reorder sh provider pharmacy.  -The facility had a bad get medications from without a prescription -Receipt of resident n contracted pharmacy issue.  -She expected the me the facility on the sam sheet was faxed to th	ckup pharmacy but could not the backup pharmacy . nedications from the provider was an "ongoing" edications to be received at ne day as medication reorder e pharmacy. cian's orders for Resident #2 led there was a physician's 0 - Vitamin D (dietary			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE  A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL051062	B. WING		R 10/06/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	.DDRESS, CITY, STAT	TE, ZIP CODE	-
CI ASSIC	CARE HOMES # 1	101 ANN	IIE PARKER CIRC	CLE	
CLASSIC	CARE HOMES # 1	SMITHF	ELD, NC 27577		<u>,                                      </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	27	D 358		
	times a day scheduled 2:00pm and 8:00pm.  -There were circled in 09/08/23 at 8:00pm, 0 09/12/23 at 2:00pm a 2:00pm, 09/17/23 at 8:00pm.  Review of medication resident #2's Septementary of the staff initialed the comparison of medication aide (MA) revealed there was a 600-Vitamin D tablets on 09/20/23, quantity remaining.  Interview with the MA revealed when a residency of the resident's was out of the facility.  Telephone interview with the facility.  Telephone interview with the mand of the facility.  Telephone interview with the facility.  Telephone interview with the mand 10:25am revealed and 10:25am reveale	entry for Calcium ablet take one tablet two d for administration at hitials on the MAR for 19/09/23 at 2:00pm, and 8:00pm, 09/13/23 at 3:00pm through 09/21/23 at 3:00pm through 09/17/23 at 12:30pm blister pack for Calcium at two times a day dispensed 60. There were 4 tablets  1. on 10/05/23 at 2:03pm then was out of medication, and documented on the MARs that the medication with the contracted at 10/06/23 between 10:10am			

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Division c	it Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					R	<b>,</b>
		HAL051062	B. WING		1	6/2023
		HAL051002			10/0	6/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		101 ANNIE	PARKER CIR	CLE		
CLASSIC	CARE HOMES # 1	SMITHFIE	LD, NC 27577			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
			1	DEFICIENCY)		
D 358	Continued From page	e 28	D 358			
		n sending 30-day medication				
		2023 because the facility				
	was requesting refills	in less than 90 days due to				
	no medication on han	ıd.				
		ministrator on 10/06/23 at				
	10:55am revealed:					
		their initials for 09/08/23,				
	· · · · · · · · · · · · · · · · · · ·	nd 09/13/23 for Resident				
	#2's Calcium was no	longer employed at the				
	facility.					
	-She had instructed the	nat staff not to circle their				
	initials if the resident	was administered the				
	medication.					
	-The resident could h	ave been out of the				
	medication if the MAs	initials were circled on the				
	MARs.					
	-When a resident's m	edications needed				
	reordering, the MAs v	vere supposed to give her a				
	completed medication					
	-Medications were su	pposed t be reordered at				
	least seven days in a	dvance of the supply on				
	hand being gone.					
	-She or the MAs were	e responsible for faxing the				
		neets to the contracted				
	provider pharmacy.					
		ckup pharmacy but could not				
		the backup pharmacy				
	without a prescription					
	-Receipt of resident n					
		provider was an "ongoing"				
	issue.	provider was air engenig				
		edications to be received at				
		ne day as medication reorder				
	sheet was faxed to th	-				
	SHOOL WAS IANGU IU III	o phaimacy.			ĺ	
	Interview with Reside	nt #2 on 10/05/23 at 8:40am			ĺ	
	revealed:	111 #2 011 10/03/23 at 0.40a111				
	revealeu.					i l

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-She was administered medications by the MA at

8:00am, 2:00pm, 4:00pm, and 8:00pm.

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DIVISION	n nealth Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			1		_
			D 14//10		R
		HAL051062	B. WING		10/06/2023
NAME OF D	DOVIDED OD CUDDUED	CTDEET AD	DRESS, CITY, STA	TE 710 CODE	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	JRESS, CITY, STA	TE, ZIP CODE	
CL ASSIC	CARE HOMES # 1	101 ANNIE	PARKER CIRC	CLE	
OLAGGIO	OAKE HOMEO# 1	SMITHFIE	LD, NC 27577		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	( - /
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
			1	DEFICIENCY)	
D 250	0	- 00	D 358		
D 358	Continued From page	29	D 356		
	-She had missed med	dications when medications			
		d not received at the facility			
	from the pharmacy.	a not received at the lacinty			
		dications "a day or two, once			
	in a while".	dications a day of two, office			
		ne pharmacy to deliver the			
	medications to the fac	•			
		any medications that were			
	life threatening.				
	-She did not know the	e names of all her			
	medications.				
	-She was supposed to	o take two pills for her heart.			
	• •	·			
	3. Review of Resider	nt #3's current FL-2 dated			
		agnoses included diabetes,			
		fective disorder bipolar type.			
	astrina, and somzoar	rective disorder bipolar type.			
	a Paviou of physicis	an's orders for Resident #3			
		led there was a physician's			
	order for Wellbutrin X	•			
	disorder) 300mg table	et daily.			
	Review of Resident #	•			
	medication administra	ation records (MARs)			
	revealed:				
	-There was a printed	entry for Wellbutrin XL			
	300mg take one table	et once daily in the morning			
	for mood, scheduled	for administration at 8:00am.			
	-There were circled in				
	09/05/23 through 09/				
	Review of medication	notes on the back of			
	Resident #3's Septem				
	•	ten entries for 09/06/23			
	-	umenting "OFH" and "didn't			
	take."				
	-There were no medic				
	-There was no staff si	ignature or initials for the			
	09/06/23 through 09/2	10/23 entry notes.			

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			71. BOILBING.		
		HAL051062	B. WING		R 10/06/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CLASSIC	CARE HOMES # 1		PARKER CIRC	CLE	
			D, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	<del>2</del> 30	D 358		
	medication aide (MA) revealed there was a XL 300mg tablets dail on 09/12/23, quantity remaining. There wa dispensed on 10/02/2 tablets on hand.  Interview with the MA revealed when a residence was a second control of the control of	ation on hand with the on 10/05/23 at 4:15pm blister pack for Wellbutrin ly in the morning dispensed 30. There were 10 tablets a second blister pack 13, quantity of 30, and 30 on 10/05/23 at 2:03pm dent was out of medication, and documented on the			
		MARs that the medication			
	and 10:04am reveale -A 30-day supply for \ 07/07/23, 08/07/23, a -The only way the res have been available f	n 10/06/23 between 9:54am d: Wellbutrin XL was filled on			
	dated 08/02/23 revea order for Vraylar (use disorder) 4.5mg caps	an's orders for Resident #3 led there was a physician's d to treat bipolar depressive ule once daily at noon. 3's September 2023 MARs			
	revealed:	entry for Vraylar 4.5mg noon scheduled for 0pm. iitials on the MAR for 10/23. notes on the back of			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL051062	B. WING		10	R 0/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
CLASSIC	CARE HOMES # 1		IIE PARKER CIRCL	E		
(VA) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	ELD, NC 27577	PROVIDER'S PLAN OF	COPPECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 31	D 358			
	through 09/10/23 door take."  -There were no medical and a staff of the staff of take."  Observation of medical and and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of take.  Observation of medical and a staff of the staff of take.  Observation of medical and a staff of take.	signature or initials for the 10/23 entry notes.  cation on hand with the on 10/05/23 at 4:15pm of the blister pack for Vraylar at noon dispensed on one of the were 4 tablets as a second blister pack 23, quantity of 30, and 30 on 10/05/23 at 2:03pm dent was out of medication, as and documented on the semantic of the				
	and 10:04am revealed -A 30-day supply for 07/07/23, 08/01/23, 02-The only way the rest have been availabled have been if the medication cart.  c. Review of physicial dated 08/02/23 reveal order for Cogentin (unassociated with psyctablet once daily at not of the control of the	n 10/06/23 between 9:54am ed: Vraylar was filled on 08/28/23 and 09/26/23. sident's medication would not for administration would lications were removed from an's orders for Resident #3 aled there was a physician's sed to treat tremors hotropic medications) 2mg				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
			A. BUILDING:			_
		HAL051062	B. WING	<del> </del>	10	R / <b>06/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	= ZIP CODE	•	
NAME OF T	NOVIDEN ON 3011 EIEN		IIE PARKER CIRCI			
CLASSIC	CARE HOMES # 1		ELD, NC 27577	- <b>-</b>		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	IE APPROPRIATE	COMPLETE DATE
D 358	Continued From page	e 32	D 358			
		Cogentin) 2mg tablet once ed for administration at nitials on the MAR for				
	Resident #3's Septen -There were handwrit through 09/10/23 doc take." -There were no medic	ten entries for 09/06/23 umenting "OFH" and "didn't cation names listed. ignature or initials for the				
	medication aide (MA) revealed there was a 2mg tablets daily at r quantity 30. There w There was a second	ation on hand with the on 10/05/23 at 4:15pm blister pack for Cogentin noon dispensed on 09/12/23, ere 11 tablets remaining. blister pack dispensed on 30, and 30 tablets on hand.				
	revealed when a residuals	on 10/05/23 at 2:03pm dent was out of medication, and documented on the MARs that the medication				
	and 10:04am reveale -A 30-day supply for 0 07/07/23, 08/07/23, 0 -There should be no available for administ -The medications are next day when the fac	n 10/06/23 between 9:54am d: Cogentin was filled on 9/12/23 and 10/02/23. reason the Cogentin was not				

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STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL051062	B. WING		10/06/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE	
CI ASSIC	CARE HOMES # 1	101 ANN	IE PARKER CIRC	LE	
02/100/0		SMITHFI	ELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 33	D 358		
	a new prescription was medication was on base Interview with the Adr 10:55am revealed: -The resident could h	ack order. ministrator on 10/06/23 at ave been out of the			
	MARsWhen a resident's m reordering, the MAs v completed medication	vere supposed to give her a			
	least seven days in a hand being goneShe or the MAs were medication reorder sh	dvance of the supply on e responsible for faxing the neets to the contracted			
	get medications from without a prescription -Receipt of resident n	nedications from the			
	issueShe expected the me	provider was an "ongoing" edications to be received at ne day as medication reorder e pharmacy.			
	Resident #3 was not the survey for interview	available in the facility during ew.			
D 367	10A NCAC 13F .1004 Administration	4(j) Medication	D 367		
	(j) The resident's me	Medication Administration dication administration e accurate and include the			

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following:

(1) resident's name;

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL051062	B. WING		R <b>10/06/2023</b>
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	10/00/2020
			PARKER CIRC		
CLASSIC	CARE HOMES # 1	SMITHFIEL	.D, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 34	D 367		
	(3) strength and dosa administered; (4) instructions for ad or treatment; (5) reason or justificat medications or treatmedocumenting the result (6) date and time of a (7) documentation of medications or treatmomission, including reference (8) name or initials of the medication or treatmedocumented and main administration record	any omission of nents and the reason for the efusals; and, the person administering atment. If initials are used, a to those initials is to be intained with the medication (MAR).			
	interviews, the facility accuracy of the medic for 3 of 3 sampled reservidenced by the medical samples are sampled to the medical samples are samples and the samples are samp	ns, record reviews, and failed to ensure the cation administration records sidents (#1, #2, #3) as dication aide who dications recording the			
	The findings are:				
	Medication Aides (MA medication administrative revealed: -Check your holes (or -Make sure all docum	entation was done daily.			
		:1's current FL-2 dated agnoses included asthma, ertension.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co			SURVEY PLETED
AND I LAN OF CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING:		COM	LLILD
	HAL051062	B. WING		10	R / <b>06/2023</b>
				1 10	100/2023
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CLASSIC CARE HOMES # 1	101 ANN	IIE PARKER CIRCL	E		
	SMITHFI	ELD, NC 27577			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 367 Continued From page	e 35	D 367			
Review of Resident # medication administration - There was an entry of depression, 1 and 1/2 administered at 8:00a documentation Zoloft tablets (75mg) was at through 09/30/23 at 8 - There was an entry of deficiency, 1 capsule 8:00am. There was a discounties of the discounties of	ation record (MAR) revealed: for Zoloft HCL 50mg for 2 tablets (75mg) to be am. There was HCL 50mg, 1 and 1/2 dministered at from 09/16/23 3:00am. for Poly-Iron 150mg for iron daily in the morning at ocumentation Poly-Iron ered from 09/16/23 through for Vitamin C 1000mg for a daily in the morning every There was documentation tablet was administered th 09/30/23 at 8:00am. for Hydrochlorothiazide pressure and fluid retention, orning at 8:00am. There dydrochlorothiazide was /16/23 through 09/30/23 at for Potassium Chloride assium level in the body, 1 ming at 8:00am. There was sium Chloride CRYS ER m 09/16/23 through for Vitamin D3 2000units for 1 tablet daily in the morning as documentation Vitamin D3, stered from 09/01/23				

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NAME OF PROVIDER OR SUPPLIER  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  101 ANNIE PARKER CIRCLE	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  101 ANNIE PARKER CIRCLE	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  101 ANNIE PARKER CIRCLE	2023
101 ANNIE PARKER CIRCLE	
CLASSIC CARE HOMES # 1 SMITHFIELD, NC 27577	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367 Continued From page 36 D 367	
Continued From page 36  -There was an entry for Stiotlo Respirate 2.5-2.5 MC for shortness of breath and wheezing, inhale 2 puffs once daily in the morning at 8:00am. There was documentation Stiotlo Respirate 2.5-2.5 MC was administered from 09/16/23 through 09/30/23 at 8:00amThere was an entry for Amdodipine Besylate 5mg for high blood pressure, 1 tablet daily in the morning at 8:00am. There was documentation Amlodipine Besylate 5mg, 1 tablet was administered from 09/16/23 through 09/30/23 at 8:00amThere was an entry for Metformin HCL 500mg for high blood sugar, two tablets (1000mg) two times a day at 8:00am and 5:00pm. There was documentation Metformin HCL 500mg, two tablets (1000mg) was administered from 09/16/23 through 09/30/23 at 8:00am and 5:00pmThere was an entry for Metoprolol Tartrate 50mg for high blood pressure, chest pain and heart failure, 1 tablet daily with meals at 8:00am and 5:00pm. There was documentation Metoprolol Tartrate 50mg was administered from 09/16/23 through 09/30/23 at 8:00am and 5:00pmThere was an entry for Melatonin 5mg for a sleep aide, 1 tablet daily at bedtime at 8:00pmThere was an entry for Olmesartan Medoxomil 40mg for high blood pressure, 1 tablet was administered from 09/16/23 through 09/30/23 at 8:00pmThere was an entry for Olmesartan Medoxomil 40mg for high blood pressure, 1 tablet was administered from 09/16/23 through 09/30/23 at 8:00pmThere was an entry for Olmesartan Medoxomil 40mg for high blood pressure, 1 tablet was administered from 09/16/23 through 09/30/23 at 8:00pmThere was an entry for Jablet was administered from 09/16/23 through 09/30/23 at 8:00pmThere was an entry for Idesartan Medoxomil 40mg for high blood pressure, 1 tablet daily at bedtime at 8:00pmThere was an entry for Idesartan Medoxomil 20mg for high cholesterol, 1 tablet daily at bedtime at 8:00pmThere was an entry for Mornistan Calcium 20mg for high cholesterol, 1 tablet daily at bedtime at 8:00pm.	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
HAL051062			B. WING		R 10/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E ZIP CODE	
NAME OF T	NOVIDEN ON GOLT EIEN		IE PARKER CIRC		
CLASSIC	CARE HOMES # 1		ELD, NC 27577		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 367	Continued From page	: 37	D 367		
	the MAR from 09/16/2	ministrator was recorded on 23 through 09/30/23 for the ident #1's medications.			
	Review of Resident # revealed:	1's October 2023 MAR			
	There was an entry for depression, 1 and 1/2 administered at 8:00a	( 0,			
	documentation Zoloft HCL 50mg, 1 and 1/2 tablets (75mg) was administered from 10/01/23 through 10/05/23 at 8:00am  -There was an entry for Poly-Iron 150mg for iron deficiency, 1 capsule daily in the morning at 8:00am. There was documentation Poly-Iron 150mg was administered from 10/01/23 through				
	supplement, 1 tablet of other day at 8:00am.	or Vitamin C 1000mg for a daily in the morning every There was documentation			
	from 10/01/23 through -There was an entry f	tablet was administered n 10/05/23 at 8:00am. or Hydrochlorothiazide pressure and fluid retention,			
	1 tablet daily in the m was documentation H administered from 10,	orning at 8:00am. There ydrochlorothiazide was /01/23 through 10/05/23 at			
	8:00amThere was an entry for Potassium Chloride CRYS ER for low potassium level in the body, 1 tablet daily in the morning at 8:00am. There was				
	documentation Potass was administered fror 10/05/23 at 8:00am.	sium Chloride CRYS ER n 10/01/23 through			
	Vitamin D deficiency,				

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DIVISION	n nealth Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
				-	,	
HAL051062		B. WING		R		
		HALU51062			1 10/0	6/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
		101 ANNIE	PARKER CIRC	CLE		
CLASSIC	CARE HOMES # 1	SMITHFIEL	D, NC 27577			
040.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	NI.	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
D 367	Continued From page	÷ 38	D 367			
	. •	or B-Complex Plus Vitamin				
		pplement,1 tablet daily in				
		· ·				
		n. There was documentation				
		min C CP was administered			l	
	_	h 10/05/23 at 8:00am.			l	
		or Stiolto Respimate 2.5-2.5			l	
		reath and wheezing, inhale			l	
		he morning at 8:00am. ation Stiolto Respimate				
		nistered from 10/01/23			l	
	through 10/05/23 at 8					
	•	or Amlodipine Besylate 5mg				
	<del>_</del>	re, 1 tablet daily in the				
		here was documentation				
	Amlodipine Besylate					
		/01/23 through 10/05/23 at				
	8:00am.	-				
	•	or Metformin HCL 500mg			l	
		two tablets (1000mg) two				
		n and 5:00pm. There was				
		rmin HCL 500mg, two				
		administered from 10/01/23				
	through 10/05/23 at 8	•				
	<del>_</del>	or Metoprolol Tartrate 50mg				
	•	re, chest pain and heart				
		with meals at 8:00am and				
		ocumentation Metoprolol				
		Iministered from 10/01/23				
	through 10/05/23 at 8					
		or Melatonin 5mg for a				
	•	aily at bedtime at 8:00pm.			ĺ	
		ation Melatonin 5mg, 1				
		ed from 10/01/23 through			ĺ	
	10/05/23 at 8:00pm.				ĺ	
		or Olmesartan Medoxomil			ľ	
		oressure, 1 tablet daily at			ľ	
		here was documentation			ľ	
		nil 40mg, 1 tablet was				
	administered from 10	/01/23 through 10/05/23 at			ļ	

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8:00pm.

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l R	
HAL051062 B. WING 10/06/20	/2023
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  101 ANNIE PARKER CIRCLE  SMITHFIELD, NC 27577	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
D 367  Continued From page 39  -There was an entry for Atorvastatin Calcium 20mg for high cholesterol, 1 tablet daily at bedtime at 8:00pm. There was documentation Atorvastatin Calcium 20mg, 1 tablet was administered from 10/01/23 through 10/05/23 at 8:00pmThe initials of the Administrator was recorded on the MAR from 10/01/23 through 10/05/23 for the administration of Resident #1's medicationsInterview with the MA on 10/06/23 at 3:15pm revealed: -She was hired at the facility as a MA on 09/15/23She administered the medications to Resident #1 from 09/16/23 through 10/05/23She completed the competency validation training and the 15 hours medication raining and was scheduled to take the medication aide test in December 2023She was instructed by the Administrator to put her initials on the MAR when she administered the medication because she had not taken the medication administration test yet.  Refer to the interview with the Administrator on 10/05/23 at 2:05pm.  Refer to the telephone interview with the facility nurse on 10/05/23 at 3:21pm.  Refer to the interview with the Administrator on 10/06/23 at 4:00pm.  2. Review of Resident #2's current FL-2 dated 03/06/23 revealed diagnoses included	

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osteoporosis, gastric esophageal reflux disease,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    AND PLAN OF CORRECTION	Division of	of Health Service Regu	lation				
MALOS1082    NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE				(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER  CLASSIC CARE HOMES # 1  SIMPLANCE OF PROVIDER OR SUPPLIER  CLASSIC CARE HOMES # 1  SUMMARY STATEMENT OF DEFICIENCIES 101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27877  MAJ ID PRETRY (ACA HOMES # 1)  PRETRY (ACA HOMES # 1)  OPPRITY (ACA HOMES # 1)	AND PLAN C	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMF	PLETED
NAME OF PROVIDER OR SUPPLIER  CLASSIC CARE HOMES # 1  STREET ADDRESS, CITY, STATE, ZIP CODE  101 ANNIE PARKER CIRCLE  SMITHFIELD, NC 27577  PROVIDERG R.NA OF CORRECTION  (PACH DOMES THE PRECEDINGS)  PREFIX (PACH DOMES THE APPROPRIATE OF DESCRIPCIONS)  PROVIDER R.N. OF CORRECTION OF DESCRIPCIONS OF THE APPROPRIATE OF DESCRIPCION OF THE APPROPRIATE OF THE APPROPRI				_			_
NAME OF PROVIDER OR SUPPLIER  CLASSIC CARE HOMES # 1  SUMMARY STATEMENT OF DEFICIENCIES SMITHFIELD, NC 27577  (XM) ID PREFIX TAG  CROUNTER TAG  CROSS-REFERENCES TO THE APPROPRIATE ONTE OF THE CONTROL OF TAG  CROSS-REFERENCES TO THE APPROPRIATE ONTE OF THE CROSS-REFERENCES TO THE APPROPRIATE ONTE ONTE OF TAG  CROSS-REFERENCES TO THE APPROPRIATE ONTE ONTE ONTE ONTE OF TAG  CROSS-REFERENCES TO THE APPROPRIATE ONTE ONTE ONTE ONTE ONTE ONTE ONTE ON		HAI 054062		P WING		I	
CLASSIC CARE HOMES # 1   SUMMARY STATEMENT OF DEFICIENCIES   SMITHFIELD, No. 27577   SUMMARY STATEMENT OF DEFICIENCIES   DEFICIENCY MUST SEE PRECEDED BY FILL   TAG   CROSS-REFERENCE TO THE APPROPRIATE   CANCELLATORY OR LEGICIATIVEY NO. RECOULD DEFICIENCY MUST SEE PRECEDED BY FILL   TAG   CROSS-REFERENCE TO THE APPROPRIATE   CANCELLATORY OR LEGICIATIVEY NO. RECOULD DEFICIENCY MUST SEE PRECEDED BY FILL   TAG   CROSS-REFERENCE TO THE APPROPRIATE   CANCELLATORY OR LEGICIATIVE NO. RECOULD DEFICIENCY   CANCE			HAL051062	D. WING		10	/06/2023
CLASSIC CARE HOMES # 1   SUMMARY STATEMENT OF DEFICIENCIES   SMITHFIELD, No. 27577   SUMMARY STATEMENT OF DEFICIENCIES   DEFICIENCY MUST SEE PRECEDED BY FILL   TAG   CROSS-REFERENCE TO THE APPROPRIATE   CANCELLATORY OR LEGICIATIVEY NO. RECOULD DEFICIENCY MUST SEE PRECEDED BY FILL   TAG   CROSS-REFERENCE TO THE APPROPRIATE   CANCELLATORY OR LEGICIATIVEY NO. RECOULD DEFICIENCY MUST SEE PRECEDED BY FILL   TAG   CROSS-REFERENCE TO THE APPROPRIATE   CANCELLATORY OR LEGICIATIVE NO. RECOULD DEFICIENCY   CANCE	NAME OF PE	ROVIDER OR SUPPLIER	STREET AF	DRESS CITY STA	TE ZIP CODE		
CALSSIG CARE HOMES #1  IXA) ID  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  D 367  Continued From page 40  supraventricular tachycardia, deep vein thromosis bilateral left extremity cellulitis, lower back pain, left hip pain, anxiety, and depression.  Review of physician's order for Calcium 600-Vitamin D3 (a dietary supplement) one tablet two times a day.  -There was a physician's order for Alprazolam 0.5mg (generic for Ticor and used to treat anxiety) one tablet three times a day.  -There was a physician's order for Mitazapine 45mg (generic for Ticor and used to treat depression) one tablet three times a day.  -There was a physician's order for Mitazapine 45mg (generic for Remorn and used to treat depression) and schizophrenia) one tablet once a day at bedtime.  -There was a physician's order for Quetiapine Furnartate 400mg (generic for Mitazapine) A5mg (generic for Remorn and used to treat depression) one tablet once a day at bedtime.  -There was a physician's order for Quetiapine Furnartate 400mg (generic for Seroquel and used to treat depression and schizophrenia) one tablet once a day at bedtime.  Review of July 2023 medication administration records (MARs) for Resident #2 revealed:  a. There was a physican's order for Quetiapine Furnartate 400mg (generic for Seroquel and used to treat depression and schizophrenia) one tablet once a day scheduled at 2:00pm and 8:00pm.  -There was a printed entry for Calcium 600-Vitamin D3 tablet two times a day.  -There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled dose of Calcium 600-Vitamin D3 tablet.  b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.							
DATE   PROVIDERS PLANGE CORRECTION	CLASSIC	CARE HOMES # 1			CLE		
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 40  supraventricular tachycardia, deep vein thrombosis bilateral left extremity cellulitis, lower back pain, left hip pain, anxiety, and depression.  Review of physician's orders for Resident #2 dated 06/10/2023 revealed:  -There was a physician's order for Alprazolam 0.5mg (generic for Xanax and used to treat anxiety) one tablet three times a dayThere was a physician's order for Mintazapine 45mg (generic for Mintazapine 45mg (generic for Mintazapine 45mg (generic for Mintazapine 45mg (generic for Resident #2 revealed: -There was a physician's order for Mintazapine 45mg (generic for Resident adayThere was a physician's order for Mintazapine 45mg (generic for Remeron and used to treat depression) one tablet three times a dayThere was a physician's order for Mintazapine 45mg (generic for Remeron and used to treat depression) one tablet once a day at bedtimeThere was a physician's order for Quetiapine Fumarate 40mg (generic for Seroquel and used to treat depression and schizophrenia) one tablet once a day at bedtime.  Review of July 2023 medication administration records (MARs) for Resident #2 revealed: a. There was a printed entry for Calcium 600-Vitamin D3 tool times a day scheduled at 2:00pm and 8:00pmThere was no documentation for administration of the Calcium600-Vitamin D3 table at 8:00pm on 07/31/23There was a printed entry for Alprazolam 0.5mg one tablet the times a day scheduled dose of Calcium 600-Vitamin D3 tablet. b. There was a printed entry for Alprazolam 0.5mg one table the times a day scheduled at 8:00mm, 2:00pm, and 8:00pm.			SMITHFIE	ELD, NC 2/5//			
D 367 Continued From page 40 supraventricular tachycardia, deep vein thrombosis bilateral left extremity cellulitis, lower back pain, left hip pain, anxiety, and depression.  Review of physician's orders for Resident #2 dated 06/10/2023 revealed: -There was a physician's order for Calcium 600-Vitamin D3 (a dietary supplement) one tablet two times a dayThere was a physician's order for Fonofibrate 160mg (generic for Tricor and used to treat anxiety) one tablet three times a dayThere was a physician's order for Mirtazapine 45mg (generic for Remeron and used to treat ligh cholesterol) one tablet three times a dayThere was a physician's order for Mirtazapine 45mg (generic for Remeron and used to treat depression) one tablet once a day at bedtimeThere was a physician's order for Quetlapine Fumarate 40mg (generic for Seroquel and used to treat depression and schizophrenia) one tablet once a day at bedtime. Review of July 2023 medication administration records (MARs) for Resident #2 revealed: a. There was a printed entry for Calcium 600-Vitamin D3 one tablet two times a day scheduled at 2:00pm and 8:00pmThere was no documentation for administration of the Calcium600-VitaminD3 tablet at 8:00pm on 07/31/23There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00mm, and 8:00pm.							
D 367 Continued From page 40 supraventricular tachycardia, deep vein thrombosis bilateral teft extremity cellulitis, lower back pain, left hip pain, anxiety, and depression.  Review of physician's orders for Resident #2 dated 06/10/2023 revealed: -There was a physician's order for Calcium 600-Vitamin D3 (a dietary supplement) one tablet two times a dayThere was a physician's order for Alprazolam 0.5mg (generic for Xanax and used to treat anxiety) one tablet three times a dayThere was a physician's order for Fenofibrate 160mg (generic for Tricor and used to treat high cholesterol) one tablet three times a dayThere was a physician's order for Mirtazapine 45mg (generic for Remeron and used to treat depression) one tablet once a day at bedtimeThere was a physician's order for Quetiapine Furmarate 400mg (generic for Seroquel and used to treat depression) one tablet once a day at bedtimeThere was a physician's order for Guetiapine Furmarate 400mg (generic for Seroquel and used to treat depression and schizophrenia) one tablet once a day at bedtime.  Review of July 2023 medication administration records (MARs) for Resident #2 revealed: a. There was a printed entry for Calcium 600-Vitamin D3 one tablet two times a day scheduled at 2:00pm and 8:00pmThere was no documentation for administration of the Calcium600-VitaminD3 tablet at 8:00pm on 07/31/23There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled dose of Calcium 600-Vitamin D3 tablet. b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00mm.		•					
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Review of July 2023 medication administration records (MARs) for Resident #2 revealed:  a. There was a printed entry for Calcium 600-Vitamin D3 one tablet two times a day scheduled at 2:00pm and 8:00pm.  -There was no documentation for administration of the Calcium600-VitaminD3 tablet at 8:00pm on 07/31/23.  -There was no documentation to explain the omission of documentation for the scheduled dose of Calcium 600-Vitamin D3 tablet.  b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.		to treat depression ar	nd schizophrenia) one tablet				
records (MARs) for Resident #2 revealed: a. There was a printed entry for Calcium 600-Vitamin D3 one tablet two times a day scheduled at 2:00pm and 8:00pm.  -There was no documentation for administration of the Calcium600-VitaminD3 tablet at 8:00pm on 07/31/23.  -There was no documentation to explain the omission of documentation for the scheduled dose of Calcium 600-Vitamin D3 tablet. b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.		once a day at bedtime	e.				
records (MARs) for Resident #2 revealed: a. There was a printed entry for Calcium 600-Vitamin D3 one tablet two times a day scheduled at 2:00pm and 8:00pm.  -There was no documentation for administration of the Calcium600-VitaminD3 tablet at 8:00pm on 07/31/23.  -There was no documentation to explain the omission of documentation for the scheduled dose of Calcium 600-Vitamin D3 tablet. b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.							
a. There was a printed entry for Calcium 600-Vitamin D3 one tablet two times a day scheduled at 2:00pm and 8:00pm.  -There was no documentation for administration of the Calcium600-VitaminD3 tablet at 8:00pm on 07/31/23.  -There was no documentation to explain the omission of documentation for the scheduled dose of Calcium 600-Vitamin D3 tablet. b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.		Review of July 2023 i	medication administration				
600-Vitamin D3 one tablet two times a day scheduled at 2:00pm and 8:00pm.  -There was no documentation for administration of the Calcium600-VitaminD3 tablet at 8:00pm on 07/31/23.  -There was no documentation to explain the omission of documentation for the scheduled dose of Calcium 600-Vitamin D3 tablet.  b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.		records (MARs) for R	esident #2 revealed:				
600-Vitamin D3 one tablet two times a day scheduled at 2:00pm and 8:00pm.  -There was no documentation for administration of the Calcium600-VitaminD3 tablet at 8:00pm on 07/31/23.  -There was no documentation to explain the omission of documentation for the scheduled dose of Calcium 600-Vitamin D3 tablet.  b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.		a. There was a printe	ed entry for Calcium				
-There was no documentation for administration of the Calcium600-VitaminD3 tablet at 8:00pm on 07/31/23There was no documentation to explain the omission of documentation for the scheduled dose of Calcium 600-Vitamin D3 tablet. b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.		•	-				
-There was no documentation for administration of the Calcium600-VitaminD3 tablet at 8:00pm on 07/31/23There was no documentation to explain the omission of documentation for the scheduled dose of Calcium 600-Vitamin D3 tablet. b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.		scheduled at 2:00pm	and 8:00pm.				
of the Calcium600-VitaminD3 tablet at 8:00pm on 07/31/23There was no documentation to explain the omission of documentation for the scheduled dose of Calcium 600-Vitamin D3 tablet. b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.		•	•				
-There was no documentation to explain the omission of documentation for the scheduled dose of Calcium 600-Vitamin D3 tablet. b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.							
-There was no documentation to explain the omission of documentation for the scheduled dose of Calcium 600-Vitamin D3 tablet. b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.		07/31/23.	•				
omission of documentation for the scheduled dose of Calcium 600-Vitamin D3 tablet. b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.			nentation to explain the				
dose of Calcium 600-Vitamin D3 tablet.  b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.							
b. There was a printed entry for Alprazolam 0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.							
0.5mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.							
8:00am, 2:00pm, and 8:00pm.		•					
of the Alprazolam 0.5mg tablet at 8:00pm on							

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07/31/23.

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPL	EIED	
HAI 051062		D WINC		F		
		HAL051062	B. WING		10/0	6/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1	101 ANNII	E PARKER CIR	CLE		
SMITHFIEL			LD, NC 27577	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 41	D 367			
D 307	-There was no document on the Fenofibrate 160 of Fe	nentation to explain the tation for the scheduled .5mg tablet. ed entry for Fenofibrate be daily scheduled at the nentation for administration .5mg tablet at 8:00pm on the nentation to explain the tation for the scheduled .5mg tablet. ed entry for Mirtazapine et a day at bedtime .5mentation for administration .5mg tablet at 8:00pm on the nentation to explain the tation for the scheduled .5mg tablet .5mg tablet. ed entry for Quetiapine et ablet once a day at the tablet once a day at the tablet once a day at the scheduled .5mg tablet at 8:00pmThere was no ministration of the .400mg tablet at 8:00pm on the son documentation to .5mg tablet at 8:00pm on the son documentation for the suetiapine Fumarate 400mg .23 MARs for Resident #2.2mg MARs for Resident #2.2mg MARs for Resident #2.2mg MARs for Calcium ablet two times a day				
	a. There was a printe 600-Vitamin D3 one t scheduled at 2:00pm -There was no docum of the Calcium 600-V on 08/02/23 and 08/3	ablet two times a day and 8:00pm. nentation for administration itamin D3 tablet at 8:00pm				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE S COMPLI	
HAL051062		B. WING		10/0	e 6/2023	
NAME OF D			ODEOO OITY OTA	TF 7/D 00DF	1 10/0	0/2023
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CLASSIC	CARE HOMES # 1		E PARKER CIRO LD, NC 27577	,LE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	÷ 42	D 367			
	omission of documen doses of Calcium 600 b. There was a printe 0.5mg one tablet thre 8:00am, 2:00pm, and -There was no docum of the Alprazolam 0.5 08/10/23 and 08/31/2 -There was no documen doses of Alprazolam 0 c. There was a printe 160mg one tablet onc 8:00pmThere was no documen of the Fenofibrate 160 08/30/23 and 08/31/2 -here was no documen doses of Fenofibrate d. There was a printe 45mg one tablet once scheduled at 8:00pmThere was no documen doses of Fenofibrate d. There was no documen doses of Mirtazapine 450 08/30/23 and 08/31/2 -There was no documen of the Mirtazapine 450 08/30/23 and 08/31/2 -There was no documen doses of Mirtazapine e. There was a physical Fumarate 400mg one bedtime scheduled at -There was no documen of the Quetiapine Fun 8:00pm on 08/30/23 ar -There was no documen omission of documen omission of documen	tation for the scheduled ab-Vitamin D3 tablets. Ed entry for Alprazolam te times a day scheduled at 8:00pm. The tation for administration and tablet at 8:00pm on 3. The tation for the scheduled at 8:00pm on 3. The tation for the scheduled at 8:00pm on 3. The tation for the scheduled at 8:00pm on 3. The tation for the scheduled 160mg tablet at 8:00pm on 3. The tation for the scheduled 160mg tablets. The tation for the scheduled 160mg tablets. The tation for administration and tablet at 8:00pm on 3. The tation for administration and tablet at 8:00pm on 3. The tation for administration and tablet at 8:00pm on 3. The tation for administration and tablet at 8:00pm on 3. The tation for the scheduled 45mg tablets. The tation for the scheduled 45mg tablets. The tablet once a day at 8:00pm. The tation for administration and tablet at 8:00pm the tation for administration and tablet at 8:00pm the tablet at 8:0				

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Review of the September 2023 MARs for

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DIVISION	of Health Service Regu	liation			
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED
					R
	HAL051062				
		HAL051062	B. WING		10/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		101 ANN	IE PARKER CIRC	CLF.	
CLASSIC	CARE HOMES # 1		ELD, NC 27577		
			LLD, NC 27377		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD	()
TREE IN		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
			D 007		
D 367	Continued From page	e 43	D 367		
	Resident #2 revealed	•			
		entries for Vitamin B-12			
	(dietary supplement)2				
	· • • • • • • • • • • • • • • • • • • •	treat high cholesterol and			
	heart disease) 10mg				
		n (a hormone replacement			
		disease) 25mcg tablet once			
		on an empty stomach,			
		D3 400mg tablet two times			
	a day, Trijardy XR (us				
		let once daily, Alprazolam			
	•	nes a day, Fenofibrate			
	•	aily at bedtime, Mirtazapine			
	•	•			
	45mg tablet once dail				
		400mg tablet once daily at			
	bedtime.	20 through 00/25/22 -t			
		00am through 09/25/23 at			
		als for documentation of			
		he medications printed on			
		n over with different initials.			
		tation for administration of			
	·	ed on the MARs by the			
	same staff from 09/15	5/23 through 09/30/23.			
	D ( ) ; ( ) ; ( )				
		h the medication aide on			
	10/05/23 at 2:03pm.				
	564444				
		with the Administrator on			
	10/05/23 at 2:20pm.				
	D ( ) () ()				
		e interview with the facility			
	nurse on 10/05/23 at	3:21pm.			
	<b>5</b> ( ) () ()				
		with the Administrator on			
	10/06/23 at 4:00pm.				
	-	nt #3's current FL-2 dated			
		agnoses included diabetes,			
	asthma, and schizoaf	ffective disorder bipolar type.			

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL051062	B. WING			R 0/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	-	
01.40010	CARE HOMES #4	101 ANN	IIE PARKER CIRCL	E		
CLASSIC	CARE HOMES # 1	SMITHFI	ELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 44	D 367			
	dated 08/02/2023 rev -There was a physicia (used to treat side eff medications such as at noonThere was a physicia 300mg (used to treat -There was a physicia (used to treat mood d -There was a physicia 90mcg Inhaler (used two puffs every six ho Review of subsequen Resident #3 dated 07 -There was a physicia 50mg (used to treat ir one tablet at bedtime -There was a physicia Fumarate 50mg (general	an's order for Cogentin 2mg ects of psychotropic involuntary movement) daily an's order for Wellbutrin XL depression) one tablet daily. an's order for Vraylar 4.5mg isorders) once daily. an's order for ProAir HFA to treat breathing disorders) burs as needed. at physician's order for i/19/23 revealed: an's order for Trazadone asomnia and depression)				
	daily at noon and sch 12:00pm, Wellbutrin X scheduled at 8:00am,					
	50mg one tablet at be and Quetiapine Fuma day scheduled at 8:00 -There was a printed Inhaler two puffs ever documentation of adn 09/17/23, 09/18/23, 0 no documentation for	edtime scheduled at 8:00pm, arate 50mg one tablet once a				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION		E SURVEY PLETED
		74. BOILBING			R	
HAL051062			B. WING		10	0/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E. ZIP CODE		
			IIE PARKER CIRCI			
CLASSIC	CARE HOMES # 1		ELD, NC 27577			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETE DATE
D 367	Continued From page	<del>:</del> 45	D 367			
	12:00pm the staff initi administration of the r MARs was written over There was document the medications printe same staff from 09/15.  Refer to the interview 10/05/23 at 2:03pm.  Refer to the interview 10/05/23 at 2:20pm.  Refer to the telephone nurse on 10/05/23 at 2:23 at 2:20pm.	als for documentation of medications printed on the er with different initials. tation for administration of ed on the MARs by the 5/23 through 09/30/23.  with the medication aide on with the Administrator on e interview with the facility 3:21pm.				
	revealed: -The Administrator wrinitialsShe administered medicationsShe worked at the factory when the scheduled times were on the residual times were on the residual times were administered the residual times were weeks agoShe was documenting administering medicationsShe documented the on the MARs when shimedications.	olopm, and 8:00pm when ility.  medication administration idents' MARs, she had dents' medications starting ag her initials when tions until "maybe last instructed by the ment the Administrator's				

Division of Health Service Regulation

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IDEATH IO THOU NOTICE IN		A. BUILDING: _		
		HAL051062	B. WING		R 10/06/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE	
		101 ANN	IE PARKER CIRC	CLE	
CLASSIC	CARE HOMES # 1	SMITHFII	ELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
D 367	Continued From page	e 46	D 367		
	Administrator's initials documenting adminis because she (MA) ha aide test.  -She was scheduled test in December 202 -She had received traincluding proper docuadministration.  -She was supposed to the MARs when she assumed to the MARs when she assumed to the MARs with the Administrator's initials (MA) administered modulated to the MARs with the Administrator's initials (MA) administered modulated to the MARs with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with the MARS with the Administrator's initials (MA) administered modulated to the MARS with the Administrator's initials (MA) administered modulated to the MARS with t	s on the MARs when tration of medications d not taken the medication aide 3.  ining with the facility nurse mentation of medication of document her initials on administered medications. In our the MARs when she edications at the facility.  In ministrator on 10/05/23 at the medications and the MA gave are residents as she watched			
	(Administrator) was "r -She thought the MA	could not document			
		lications if the MA had not estate approved MA test.			
	10/05/23 at 3:21pm re -She had completed t evaluation for the MA -She was not aware t someone else's initial	he medication clinical skills on 09/12/23. he MA was signing			
	4:00pm revealed:	ministrator on 10/06/23 at			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R	
		HAL051062	B. WING		10/06/2023	_
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
CLASSIC	CARE HOMES # 1		E PARKER CIRC ELD, NC 27577	CLE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETE	<u> </u>
D 367	aideShe MA administered supervision because medication aide test y December 2023She instructed the M MAR when she admir -She thought because	d medications under her the MA had not taken the vet, which was scheduled for A to put her initials on the	D 367			

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