STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on October 5-6, 2023.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION 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: Review of Resident #3's current FL-2 dated 08/02/23 revealed: -Diagnoses included diabetes, asthma, and schizoaffective disorder bipolar type. -There was a physician's order for Abilify Maintera injection (used to treat schizophrenia) intramuscularly (IM) every three weeks - home health administer. Review of Resident #3's previous FL-2 dated 05/31/23 revealed: -There was a physician's order for Abilify Maintera IM every three weeks. -The Abilify Maintera IM was last administered on 06/01/23. -Resident #3 was admitted to the facility on	D 273		

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D 273	Continued From page 1 06/01/23. 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 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 "highly agitated." -Resident #3 refused to answer questions. -Resident #3 would not let the nurse practitioner 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 injections 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. Review of a Mental Health Provider's (MHP) visit note for Resident #3 dated 08/15/23 revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 2	D 273		

-Facility staff reported Resident #3 was stealing from other residents, not sleeping, and wandering into other residents' rooms at night.
-Resident #3 had not received her Abilify injection yet.
-Facility staff requested the MHP to administer the Abilify injection on 08/15/23.
-The facility needed to refill the injection.
-Home health was to be called.
-Resident #3 was "minimally cooperative".
-The resident had "delusional thoughts of being pregnant in her arm".
-The resident "endorses visual hallucinations".

Review of the MHP's amended note for Resident #3 dated 08/17/23 revealed:
-Resident #3 was administered the Abilify injection by the provider on 08/17/23.
-Home health was to give the next injection in September (three weeks from 08/17/23).

Review of a fax cover sheet dated 08/17/23 revealed:
-The Administrator sent a fax to a local home health agency on 08/17/23 for a "new" referral.
-The comments documented were "this person got her shot today".

Review of Resident #3's record revealed there was no documentation regarding a referral for home health to administer the Abilify injection prior to 08/17/23.

Review of a Licensed Health Professional Support evaluation dated 06/13/23 revealed Resident #3 got Abilify IM injections every three weeks by the home health nurse.

Review of Resident #3's record on 10/06/23 revealed there was no documentation of

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

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D 273	Continued From page 3	D 273		

administration of the Abilify injection by a home health agency since Resident #3's admission to the facility on 06/01/23.

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 referral.
-There was no documentation of a referral received prior to 08/11/23.

Telephone interview with Resident #3's guardian on 10/06/23 at 1:11pm revealed:
-Resident #3 was admitted to the facility on 06/01/23 from another facility.
-The resident was supposed to be administered an injection for behaviors every three weeks.
-The resident had not received the injection timely because there was a delay with the facility establishing care with a mental health provider.
-She was aware Resident #3 was administered the Abilify injection on 08/17/23.
-She did not know of any other dates that Resident #3 was administered the Abilify injection.
-Resident #3 needed the Abilify injection because the resident had "severe mental illness".
-Resident #3 was currently hospitalized with a diagnosis of small bowel obstruction.

Interview with the Administrator on 10/06/23 at 1:40pm revealed:
-The primary care provider (PCP) administered the Abilify injection to Resident #3 in July 2023.
-Resident #3 got another injection administered by the MHP.

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	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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D 273	Continued From page 4 -She was not sure of the dates for the administration. Second interview with the Administrator on 10/06/23 at 2:53pm revealed: -She sent a fax referral to a local home health agency on 08/17/23 for Resident #3's injection to be administered. -She did not get a response from the home health agency. -She thought the home health agency did not accept the referral because of an insurance issue. -She did not follow up with the home health agency or another home health agency about services for administration of Resident #3's Abilify injection. -She asked the provider to administer the Abilify injection. Telephone interview with the MHP on 10/06/23 at 2:08pm revealed: -She administered the Abilify injection to Resident #3 once. -She wrote the physician's order for the Abilify injection. -The facility was responsible for making a referral to home health for administering the Abilify injection. -Home health would be responsible for administering the Abilify injections every three weeks. -She would have concerns for Resident #3's psychiatric behaviors escalating if Resident #3 was not administered the Abilify injection. -She had concerns for the resident wandering at night. -The resident could get out of the facility at night and staff would not be aware which could be detrimental.	D 273		

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

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D 273	Continued From page 5 -Resident #3 cognitively should not be on her own without someone looking out for her. -Resident #3 needed the Abilify injection administered every three weeks. -She last saw Resident #3 on 09/20/23. -She was told by facility staff (no name provided) on 09/20/23 that home health would be at the facility to administer the next Abilify injection. Resident #3 was not available in the facility during the survey for interview. _____ The facility failed to ensure health care referral and follow-up for Resident #3 who had a physician's order for a referral to a home health agency for a skilled nurse to administer an intramuscular injectable medication every three weeks used to maintain psychiatric behaviors. This failure resulted in the administration of the resident's injections extended past the three-week timeframe. The resident experienced an increase in psychiatric behaviors including agitation, sleeplessness, and wandering behaviors. The failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 134D-34 on 10/06/23 for his violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 21, 2023.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 282	Continued From page 6 (a) Food Procurement and Safety in Adult Care Homes: (1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, and interviews, the facility failed to ensure food items being stored and served to residents were dated and labeled. The findings are: Observation of the refrigerator on 10/05/23 at 9:30am revealed: -There were five food items in the refrigerator that were not labeled with the dates or what the items were. -There was a plastic storage bag containing sliced ham. -There was a plastic storage bag containing sliced cheese. -There was a plastic storage bag containing nine cooked hotdogs. -There was a plastic storage bag containing a half onion. -There was a half onion wrapped in aluminum foil. Observation of the freezer above the refrigerator on 10/05/23 at 9:30am revealed: -There were 16 food items in plastic freezer bags that were not labeled with the dates or what the items were. -There was a plastic storage bag of chicken.	D 282		

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D 282	Continued From page 7 -There were 8 storage bags of gravy. -There was a plastic storage bag of cabbage. -There was a plastic storage bag of sweet green peas. -There were two plastic storage bags of hash browns. -There were three plastic storage bags of yeast rolls. -There was a plastic storage bag of slaw. -There was a plastic storage bag of 4 waffles. Interview with a personal care aide (PCP) on 10/05/23 at 8:44am revealed: -She prepared and served the meals to the residents. -She stored left over food items in the refrigerator. -Food items were purchased in bulk and delivered to a nearby building where the main dry storage area and kitchen were located on the compound that consisted of three buildings. -Food items were separated and taken out of the original container at the nearby building and brought to the facility. -The staff person separating the food items did not date or label the food items before bringing them to the facility. -She was aware food items that were taken out of their original container were supposed to be dated and labeled. -She could not give a specific reason as to why she had not dated and labeled the food items brought to the facility and placed in the freezer. Interview with the Administrator on 10/06/23 at 4:00pm revealed: -She was aware items taken out of their original container and placed in another container should be dated and labeled with what the food item was.	D 282		

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	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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D 282	Continued From page 8 -Food items were purchased in bulk and taken out of their original container at a nearby building. -She did not recall instructing the PCA, who had been employed for about two weeks, to label food items with the date and what the item was. -The staff person separating the bulk items and taking them out of their original containers should have dated and labeled the food items before bringing them to the facility.	D 282		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure there was a corresponding therapeutic or modified menu available for guidance for 2 of 3 sampled residents (#1, #2) who were on a no concentrated sweet diet. The findings are: 1. Review of Resident #1's current FL-2 dated 03/07/23 revealed diagnoses included asthma, depression, and hypertension.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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D 296	Continued From page 9 Review of Resident #1's diet order dated 02/10/23 revealed a no concentrated sweet (NCS) diet. Observation of the lunch meal on 10/05/23 at 12:00pm revealed: -Resident #1 was served chicken rice soup, a bowl of mandarin orange slices, green beans, crackers, and apple juice that contained 28grams of sugar. -She ate 100% of the lunch meal. -She was served the regular diet menu. Observation of the kitchen on 10/06/23 at 12:30pm revealed: -There was a menu for regular diet for the week of 10/02/23. -There was no corresponding menu posted for residents on a NCS diet. Observation of the regular diet menu for the lunch meal on 10/06/23 at 12:00pm revealed: -There was an entry for Chicken Rice Soup. -There was an entry for mixed melons (the facility substituted mandarin orange slices). -There was an entry for green beans. -There was an entry for crackers. Interview with the personal care aide (PCA) on 10/06/23 at 12:40pm revealed: -She prepared and served the meals to the residents. -She did not know Resident #1 was on a no NCS until now. -She knew Resident #1 was a diabetic and she had to watch her sugar intake. -She was not aware that a corresponding menu should be posted in the kitchen for residents on modified diets to provide guidance.	D 296		

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

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D 296	Continued From page 10 Refer to 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 osteoporosis, diabetes, anxiety, depression DVT bilateral lower extremity cellulitis and lower back and hip pain. Review of Resident #1's diet order dated 03/06/23 revealed a no concentrated sweet (NCS) diet. Observation of the lunch meal on 10/05/23 at 12:00pm revealed: -Resident #2 was served chicken rice soup, a bowl of mandarin orange slices, green beans, crackers, and apple juice that contained 28 grams of sugar. -She ate 50% of the lunch meal. -She was served the regular diet menu. Observation of the kitchen on 10/06/23 revealed: -There was a menu for a regular diet for the week of 10/02/23. -There was no corresponding menu posted for residents on NCS diet. Observation of the regular diet menu for the lunch meal on 10/06/23 revealed at 12:00pm: -There was an entry for Chicken Rice Soup. -There was an entry for mixed melons (the facility substituted mandarin orange slices). -There was an entry for green beans. -There was an entry for crackers. Interview with the personal care aide (PCA) on 10/06/23 at 12:40pm -She prepared and served the meals to the residents.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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D 296	Continued From page 11 -She did not know Resident #2 was on a no concentrated sweet diet (NCS) until now -She knew Resident #1 was a diabetic and she had to watch her sugar intake. -She was not aware that a corresponding menu should be posted in the kitchen for residents on modified diets to provide guidance. Refer to interview with the Administrator on 10/06/23 at 4:00pm. _____ Interview with the Administrator on 10/06/23 at 4:00pm -She was aware there was supposed to be a corresponding menu for residents on therapeutic or modified diets posted in the kitchen for guidance. -She had a modified corresponding menu posted in the kitchen, but someone must have moved it. -The company the facility used to provide menus had a consistent carbohydrate control diet (CCHO) and not a no concentrated sweet (NCS). -The facility had recently contracted with another food distribution company that had a no concentrated sweet menu to be consistent with the diet order.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.	D 309		

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

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D 309	Continued From page 12	D 309		

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to maintain a current list with physician ordered therapeutic or modified diets for guidance of food service for 2 of 3 sampled residents (#1, #2).

The findings are:

1. Review of Resident #1's current FL-2 dated 03/07/23 revealed diagnoses included asthma, depression, and hypertension.

Review of Resident #1's diet order dated 02/10/23 revealed a no concentrated sweet (NCS) diet.

Observation of the lunch meal on 10/05/23 at 12:00pm revealed:
-Resident #1 was served chicken rice soup, a bowl of mandarin orange slices, green beans, crackers, and apple juice that contained 28gm of sugar.
-She ate 100% of the lunch meal.
-She was served a regular diet menu.

Observation of the regular diet menu for the lunch meal on 10/06/23 at 12:00pm revealed:
-There was an entry for Chicken Rice Soup.
-There was an entry for mixed melons (the facility substituted mandarin orange slices).
-There was an entry for green beans.
-There was an entry for crackers.

Observation of the kitchen on 10/06/23 revealed:
-There was no list of residents on therapeutic or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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D 309	Continued From page 13	D 309		

modified diets available.
-There was a list of residents posted in the kitchen who were diabetics, including Resident #1.

Interview with the personal care aide (PCA) on 10/06/23 at 12:40pm.
-She prepared and served the meals to the residents.
-She did not know Resident #1 was on a no concentrated sweet diet (NCS) until now.
-She knew Resident #1 was a diabetic because her name was posted on a list in the kitchen.

Interview with the medication aide (MA) on 10/06/23 at 11:10pm revealed:
-She was not aware Resident #1 was on a NCS diet until now.
-She did not know a resident's diet order should be posted in the kitchen.

Interview with the Administrator on 10/06/23 at 4:00pm.
-She was not aware there needed to be a list of residents posted in the kitchen who were on therapeutic or modified diets and what the diet was.
-She posted a list of residents in the kitchen that were diabetics.

2. Review of Resident #2's current FL-2 dated 03/06/23 revealed diagnoses included osteoporosis, diabetes, anxiety, depression, lower back and hip pain.

Review of Resident #2's diet order dated 03/06/23 revealed a no concentrated sweet (NCS) diet.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 309	Continued From page 14 12:00pm revealed: -Resident #2 was served chicken rice soup, a bowl of mandarin orange slices, green beans, crackers, and apple juice that contained 28gm of sugar -She ate 50% of the lunch meal. -She was served a regular diet menu. Observation of the regular diet menu for the lunch meal on 10/06/23 at 12:00pm revealed: -There was an entry for Chicken Rice Soup. -There was an entry for mixed melons (the facility substituted mandarin orange slices). -There was an entry for green beans. -There was an entry for crackers. Observation of the kitchen on 10/06/23 revealed: -There was no list of residents on therapeutic or modified diet available. -There was a list of residents posted in the kitchen who were diabetics, including Resident #2. Interview with the personal care aide (PCA) on 10/06/23 at 12:40pm. -She prepared and served the meals to the residents. -She did not know Resident #2 was on a no concentrated sweet diet (NCS). -She knew Resident #2 was a diabetic because her name was posted on a list in the kitchen. Interview with the Administrator on 10/06/23 at 4:00pm. -She was not aware there needed to be a list of residents posted in the kitchen who were on therapeutic or modified diets and what the diet was. -She posted a list of residents in the kitchen who were diabetics.	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2, #3) including a medication used to treat depression, obsessive-compulsive disorder, and anxiety disorder, and a supplement (#1); medications used to treat heart disease and dietary supplements (#2) and medications used to treat mood disorders and side effects of mood altering medications (#3). The findings are: Review of the facility's Medication Administration Policies and Procedures (undated) revealed: -The facility's contracted pharmacy's standard hours of operation are 9:00am to 5:00pm, Monday through Friday. -In the case of an emergency, the contracted pharmacy may be contacted to fill and deliver medications at any time.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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D 358	Continued From page 16	D 358		

-Normal delivery would be between 6:00pm and 7:00pm, Monday through Friday.
-Medications shall be administered per physician orders and shall be documented on the MAR immediately after administration.
-Medications shall be ordered when the medication card showed there was only an 8-day supply on hand.
-The MA was responsible for filling out the refill/reorder request form.
-The request form should be given to the RCC or Administrator before noon so it could be faxed to the pharmacy.
-The medication would be delivered to the facility within __ business days (the number of days was left blank).
-When a new medication was ordered, most physician's offices would electronically prescribe (e-scribe) the prescription.
-If not escribed, the Administrator or RCC should fax the prescription to the pharmacy.

1. Review Resident #1's current FL-2 dated 03/07/23 revealed diagnoses included asthma, depression, and hypertension.

a. Review of Resident #1's signed physician order update report dated 05/25/23 revealed Zoloft HCL 100mg, 1 tablet daily in the morning. (Zoloft is a medication used for depression, obsessive-compulsive disorder, and anxiety disorder).

Review of Resident #1's signed Mental Health (MH) provider visit report dated 08/09/21 and faxed to the pharmacy on 08/11/23 (2 years later) revealed:
-There was an order to discontinue Zoloft HCL 50mg, 1 tablet daily for depression on 08/09/21
-There was an order to start Zoloft HCL 50mg,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 17 1.5 tablets (75mg) daily for depression on 08/09/21. -There was a handwritten note on the bottom right of the order documenting the order was faxed to the pharmacy by the facility on 08/11/23. (Two years later). Review of Resident #1's August 2023 medication administration record (MAR) revealed: -There was an entry for Zoloft HCL 100mg, 1 tablet daily. -There was an entry for Zoloft HCL 50mg, 1 and ½ tablets (75mg) daily. -There was documentation the Zoloft HCL 100mg, 1 tablet daily was administered at 8:00am from 08/01/23 through 08/11/23. -There was documentation the Zoloft HCL 50mg, 1 and ½ (75mg) tablets daily was administered at 8:00am on 08/12/23 through 08/31/23. Review of Resident #1's September 2023 MAR revealed: -There was an entry for Zoloft HCL 100mg, 1 tablet daily. -There was an entry for Zoloft HCL 50mg, 1 and ½ (75mg) tablets daily. -There was documentation Zoloft HCL 100mg, 1 tablet daily was administered at 8:00am from 09/01/23 through 09/15/23. -There was documentation Zoloft HCL 50mg, 1 and ½ tablets (75mg) was administered at 8:00am from 09/01/23 through 09/31/23. -Resident #1 Zoloft HCL was documented as administered 175mg from 09/01/23 through 09/15/23. Review of Resident #1's October 2023 MAR revealed: -There was an entry for Zoloft HCL 50mg, 1 and ½ (75mg) tablets daily.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 18	D 358		

-There was documentation Zoloft HCL 50mg, 1 and ½ tablets (75mg) daily was administered at 8:00am on 10/01/23 through 10/05/23.

Telephone interview with the facility's contracted pharmacist on 10/06/23 at 9:45am revealed:
-The current order in the pharmacy system was observed to be Zoloft HCL 50mg 1 and ½ tablets (75mg) daily dispensed on 08/11/23.
-The pharmacist immediately stated the Zoloft HCL order that was faxed to them on 08/11/23 for 50mg 1 and ½ tablets (75mg) by the facility was dated 08/09/21.
-The pharmacist could not understand why the facility faxed them an old medication order.
-The pharmacist did not notice the medication order was dated 08/09/21 and the medication was dispensed on 08/11/23 and placed on the MAR, which was an error.
-The original order was Zoloft HCL 100mg, 1 tablet daily, which was the current order.
-The resident would not notice a change in the medication dose of 25mg in terms of how she felt because it was a small amount.

Review of Resident #1's pharmacy review dated 09/15/23 revealed
-Need discontinue order for Zoloft HCL 100mg daily ordered on 03/23/22.
-Patient appeared to be receiving Zoloft HCL 100mg, 1 tablet and Zoloft HCL 50mg, 1 and ½ tablets (75mg) daily ordered on 08/11/23 concurrently.
-Zoloft HCL 100mg had been removed from cart.
-There was a handwritten note on the bottom right of the review that the review was faxed to the primary provider (PCP) on 10/05/23 by the facility.

Review of Resident #1's pharmacy report faxed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 19	D 358		

to the facility on 10/06/23 revealed:
-Zoloft HCL 100mg, 1 tablet was dispensed on 03/21/23 for a quantity of 90 tablets
-Zoloft HCL 50mg, 1 and ½ tablets was dispensed on 08/11/23 for a quantity of 45 doses.
-Zoloft HCL 50mg, 1 and ½ tablets was dispensed on 09/06/23 for a quantity of 45 doses.
-Zoloft HCL 50mg, 1 and ½ tablets was dispensed on 10/02/23 for a quantity of 45 doses.

Observation of medications on hand on 10/06/23 at 11:00am revealed there were 33 doses (1 and 1/2 tablets in each bubble=75mg) of Zoloft HCL in the bubble cards with a dispense date of 10/02/23.

Interview with Resident #1 on 10/06/23 at 2:15pm revealed:
-She did not feel sad.
-She liked doing word find puzzles.

Observation of Resident #1 intermittently on 10/05/23 and 10/06/23 from at 9:00am to 5:00pm revealed:
-She sat on the front porch of the facility with other residents working on a word find puzzle.
-She ate breakfast, lunch, and dinner on 10/05/23 and 10/06/23 in the dining room with three other residents at the table.
-She ate 100% of her lunch meal on 10/05/23 during the meal observation.
-She pushed her oxygen concentrator in the dining room for the lunch meal on 10/06/23.

Interview with the medication aide (MA) on 10/06/23 at 3:15pm revealed
-There were no behavior issues with Resident #1.
-She loved watching Christmas movies and doing word find puzzles.
-She liked to push the oxygen concentrator to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 20	D 358		

dining room sometimes because she says doing so was her "work out."

Telephone interview with the MH provider on 10/06/23 at 2:00pm revealed:
-She managed Resident #1's mental health medications, including Zoloft HCL.
-Resident #1's medication order for Zoloft 50mg, 1 and ½ tablets (75mg) was written on 08/09/21 and a subsequent order was written on 02/28/22 for Zoloft HCL 100mg, 1 tablet daily.
-The current medication order for Resident #1's Zoloft was 100mg, 1 tablet daily.
-The change in Resident #1's Zoloft HCL dose on 08/11/23 was concerning because she did not write the order.
-An assessment was not done prior to the Zoloft HCL 100mg being incorrectly changed to Zoloft HCL 75mg that could cause an increase in depression and anxiety.
-She last visited Resident #1 on 09/20/23 and the resident was assessed to be stable.

Interview with the Administrator on 10/06/23 at 4:00pm revealed:
-The medication order for Zoloft HCL 50mg, 1 and ½ tablets (75mg) daily dated 08/09/21 was incorrectly faxed to the pharmacy by the previous Resident Care Coordinator (RCC) on 08/11/23.
-She was not aware that the medication order dated 08/09/21 was faxed to pharmacy on 08/11/23 until now, and this was a major error that was "unacceptable."
-She did not know or understand how an old medication order dated 08/09/21 was faxed to pharmacy on 08/11/23.
-The process was to fax the medication order when received from the prescriber to the pharmacy, check the medication when received from the pharmacy with the MAR for accuracy,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 21	D 358		

and file the medication order in the resident's record.
-A review of Resident #1's August 2023 MAR showed documentation Zoloft HCL 175mg was administered from 09/01/23 through 09/15/23.
-She could not explain why Zoloft HCL 175mg was administered to Resident #1 from 09/01/23 through 09/15/23.
-She expected medication orders to be checked by the RCC for accuracy before sending the order to the pharmacy, and for medications to be administered as ordered.

b. Review of Resident #1's physician order dated 05/24/23 revealed an order for Vitamin C 1000mg every other morning. (Vitamin C is a supplement)
.
Review of Resident #1's August 2023 medication administration record (MAR) revealed:
-There was an entry for Vitamin C 1000mg, 1 tablet every other morning.
-There was documentation Vitamin C 1000mg, 1 tablet was administered on 08/17/23 and 08/19/23, but should not have been.
-There was no documentation Vitamin C 1000mg, 1 tablet was administered on 08/22/23 and 08/24/23, but should have been, no reason was given as to why it was not administered.

Review of Resident #1's September 2023 MAR revealed:
-There was an entry for Vitamin C 1000mg, 1 tablet every other morning.
-There was documentation Vitamin C 1000mg, 1 tablet was administered every day from 09/01/23 through 09/30/23 (30 days), instead of every other day.

Review of Resident #1's October 2023 MAR revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 22 -There was an entry for Vitamin C 1000mg, 1 tablet every other morning. -Vitamin C 1000mg should have been administered on 10/02/23, 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 facility. -She did not notice the Vitamin C supplement was ordered every other day for Resident #1. -She administered Resident #1's Vitamin C supplement everyday. -Every 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 day. -It should have been highlighted on the MAR that Vitamin C was to be administered every other day. 2. Review of Resident #2's current FL-2 dated 03/06/23 revealed diagnoses included	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 23	D 358		

paroxysmal supraventricular tachycardia, osteoporosis, lower back pain, anxiety, and depression.

a. Review of physician's orders for Resident #2 dated 03/06/23, 05/25/23, 06/10/23, and 08/01/23 revealed there was a physician's order for Atorvastatin (used in treatment of heart disease) 10mg tablet daily with the evening meal.

Review of Resident #2's September 2023 medication administration records (MARs) revealed:
-There was a printed entry for Atorvastatin 10mg table take one tablet once daily in the evening with a meal scheduled for administration at 5:00pm.
-There were circled initials on the MAR for 09/17/23 through 09/20/23.

Review of medication notes on the back of resident 32's September MARs revealed:
-On 09/17/23 and 09/18/23, the medication aide (MA) documented the Atorvastatin was "out of house" [not in the facility].
-There was no staff signature or initials for the 09/18/23 note entry.

Observation of medication on hand with the medication aide (MA) on 10/05/23 at 12:30pm revealed there was a blister pack for Atorvastatin Calcium 10mg tablets daily in the evening with a meal dispensed on 09/19/23, quantity 30. There were 16 tablets remaining.

Interview with the MA on 10/05/23 at 2:03pm revealed when a resident was out of medication, she circled her initials and documented on the back of the resident's MARs that the medication was out of the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 24 Telephone interview with the contracted pharmacy provider on 10/06/23 between 10:10am and 10:25am revealed: -A 90-day supply for Atorvastatin 10mg tablet was filled on 06/20/23 which should have lasted until 09/20/23. -A 30-day supply for Atorvastatin 10mg tablet was filled on 09/15/23. -The pharmacy began sending 30-day medication supply in September 2023 because the facility was requesting refills in less than 90 days due to no medication on hand. Interview with the Administrator on 10/06/23 at 10:55am revealed: -The resident could have been out of the medication if the MAs initials were circled on the MARs. -When a resident's medications needed reordering, the MAs were supposed to give her a completed medication reorder sheet. -Medications were supposed to be reordered at least seven days in advance of the supply on hand being gone. -She or the MAs were responsible for faxing the medication reorder sheets to the contracted provider pharmacy. -The facility had a backup pharmacy but could not get medications from the backup pharmacy without a prescription. -Receipt of resident medications from the contracted pharmacy provider was an "ongoing" issue. -She expected the medications to be received at the facility on the same day as medication reorder sheet was faxed to the pharmacy. b. Review of a physician's order for Resident #2 dated 08/01/23 revealed there was a physician's	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 25	D 358		

order for Vitamin B-12 (dietary supplement) take one tablet daily in the morning.

Review of Resident #2's September 2023 medication administration records (MARs) revealed:
-There was a printed entry for Vitamin B-12 2500mcg tablet take one tablet once daily in the morning scheduled for administration at 8:00am.
-There were circled initials on the MAR for 09/11/23 through 09/15/23.

Review of medication notes on the back of Resident #2's September MARs revealed:
-There were handwritten entries for 09/11/23 through 09/15/23 that the Vitamin B-12 was not given with a reason of "OFH".
-There was no staff signature or initials for the 09/11/23 through 09/15/23 entry notes.

Observation of medication on hand with the medication aide (MA) on 10/05/23 at 12:30pm revealed there was a blister pack for Vitamin B-12 tablets daily dispensed on 09/15/23, quantity 30. There were 10 tablets remaining.

Interview with the MA on 10/05/23 at 2:03pm revealed when a resident was out of medication, she circled her initials and documented on the back of the resident's MARs that the medication was out of the facility.

Telephone interview with the contracted pharmacy provider on 10/06/23 between 10:10am and 10:25am revealed:
-A 90-day supply for Vitamin B-12 2500mcg was filled on 06/20/23 which should have lasted until 09/20/23.
-A 30-day supply for Vitamin B-12 2500mcg was filled on 09/15/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 26 -The pharmacy began sending 30-day medication supply in September 2023 because the facility was requesting refills in less than 90 days due to no medication on hand. Interview with the Administrator on 10/06/23 at 10:55am revealed: -The staff who circled their initials for 09/11/23 through 09/15/23 for Resident #2's Vitamin B-12 was no longer employed at the facility. -She had instructed that staff not to circle their initials if the resident was administered the medication. -The resident could have been out of the medication if the MAs initials were circled on the MARs. -When a resident's medications needed reordering, the MAs were supposed to give her a completed medication reorder sheet. -Medications were supposed to be reordered at least seven days in advance of the supply on hand being out. -She or the MAs were responsible for faxing the medication reorder sheets to the contracted provider pharmacy. -The facility had a backup pharmacy but could not get medications from the backup pharmacy without a prescription. -Receipt of resident medications from the contracted pharmacy provider was an "ongoing" issue. -She expected the medications to be received at the facility on the same day as medication reorder sheet was faxed to the pharmacy. c. Review of a physician's orders for Resident #2 dated 08/01/23 revealed there was a physician's order for Calcium 600 - Vitamin D (dietary supplement) take one tablet twice daily.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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

Review of Resident #2's September 2023 medication administration records (MARs) revealed:
-There was a printed entry for Calcium 600-Vitamin D3 400 tablet take one tablet two times a day scheduled for administration at 2:00pm and 8:00pm.
-There were circled initials on the MAR for 09/08/23 at 8:00pm, 09/09/23 at 2:00pm, 09/12/23 at 2:00pm and 8:00pm, 09/13/23 at 2:00pm, 09/17/23 at 8:00pm through 09/21/23 at 8:00pm.

Review of medication notes on the back of resident #2's September MARs revealed:
-There was a handwritten entry for 09/17/23 at 8:00pm "no more Calcium 600".
-The staff initialed the 09/17/23 entry note.

Observation of medication on hand with the medication aide (MA) on 10/05/23 at 12:30pm revealed there was a blister pack for Calcium 600-Vitamin D tablets two times a day dispensed on 09/20/23, quantity 60. There were 4 tablets remaining.

Interview with the MA on 10/05/23 at 2:03pm revealed when a resident was out of medication, she circled her initials and documented on the back of the resident's MARs that the medication was out of the facility.

Telephone interview with the contracted pharmacy provider on 10/06/23 between 10:10am and 10:25am revealed:
-A 90-day supply for Calcium 600-Vitamin D was filled on 06/20/23 which should have lasted until 09/20/23.
-A 30-day supply for Calcium 600-Vitamin D was filled on 09/15/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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D 358	Continued From page 28 -The pharmacy began sending 30-day medication supply in September 2023 because the facility was requesting refills in less than 90 days due to no medication on hand. Interview with the Administrator on 10/06/23 at 10:55am revealed: -The staff who circled their initials for 09/08/23, 09/09/23, 09/12/23, and 09/13/23 for Resident #2's Calcium was no longer employed at the facility. -She had instructed that staff not to circle their initials if the resident was administered the medication. -The resident could have been out of the medication if the MAs initials were circled on the MARs. -When a resident's medications needed reordering, the MAs were supposed to give her a completed medication reorder sheet. -Medications were supposed t be reordered at least seven days in advance of the supply on hand being gone. -She or the MAs were responsible for faxing the medication reorder sheets to the contracted provider pharmacy. -The facility had a backup pharmacy but could not get medications from the backup pharmacy without a prescription. -Receipt of resident medications from the contracted pharmacy provider was an "ongoing" issue. -She expected the medications to be received at the facility on the same day as medication reorder sheet was faxed to the pharmacy. Interview with Resident #2 on 10/05/23 at 8:40am revealed: -She was administered medications by the MA at 8:00am, 2:00pm, 4:00pm, and 8:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 29 -She had missed medications when medications had been ordered and not received at the facility from the pharmacy. -She had missed medications "a day or two, once in a while". -She had to wait for the pharmacy to deliver the medications to the facility. -She had not missed any medications that were life threatening. -She did not know the names of all her medications. -She was supposed to take two pills for her heart. 3. Review of Resident #3's current FL-2 dated 08/02/23 revealed diagnoses included diabetes, asthma, and schizoaffective disorder bipolar type. a. Review of physician's orders for Resident #3 dated 08/02/23 revealed there was a physician's order for Wellbutrin XL (used to treat mood disorder) 300mg tablet daily. Review of Resident #3's September 2023 medication administration records (MARs) revealed: -There was a printed entry for Wellbutrin XL 300mg take one tablet once daily in the morning for mood, scheduled for administration at 8:00am. -There were circled initials on the MAR for 09/05/23 through 09/13/23. Review of medication notes on the back of Resident #3's September MARs revealed: -There were handwritten entries for 09/06/23 through 09/10/23 documenting "OFH" and "didn't take." -There were no medication names listed. -There was no staff signature or initials for the 09/06/23 through 09/10/23 entry notes.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 30	D 358		

Observation of medication on hand with the medication aide (MA) on 10/05/23 at 4:15pm revealed there was a blister pack for Wellbutrin XL 300mg tablets daily in the morning dispensed on 09/12/23, quantity 30. There were 10 tablets remaining. There was a second blister pack dispensed on 10/02/23, quantity of 30, and 30 tablets on hand.

Interview with the MA on 10/05/23 at 2:03pm revealed when a resident was out of medication, she circled her initials and documented on the back of the resident's MARs that the medication was out of the facility.

Telephone interview with the contracted pharmacy provider on 10/06/23 between 9:54am and 10:04am revealed:
-A 30-day supply for Wellbutrin XL was filled on 07/07/23, 08/07/23, and 09/12/23.
-The only way the resident's medication would not have been available for administration would have been if the medications were removed from the medication cart.

b. Review of physician's orders for Resident #3 dated 08/02/23 revealed there was a physician's order for Vraylar (used to treat bipolar depressive disorder) 4.5mg capsule once daily at noon.

Review of Resident #3's September 2023 MARs revealed:
-There was a printed entry for Vraylar 4.5mg capsule once daily at noon scheduled for administration at 12:00pm.
-There were circled initials on the MAR for 09/06/23 through 09/10/23.

Review of medication notes on the back of Resident #3's September MARs revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 31 -There were handwritten entries for 09/06/23 through 09/10/23 documenting "OFH" and "didn't take." -There were no medication names listed. -There was no staff signature or initials for the 09/06/23 through 09/10/23 entry notes. Observation of medication on hand with the medication aide (MA) on 10/05/23 at 4:15pm revealed there was a blister pack for Vraylar 4.5mg tablets daily at noon dispensed on 08/28/23, quantity 30. There were 4 tablets remaining. There was a second blister pack dispensed on 09/26/23, quantity of 30, and 30 tablets on hand. Interview with the MA on 10/05/23 at 2:03pm revealed when a resident was out of medication, she circled her initials and documented on the back of the resident's MARs that the medication was out of the facility. Telephone interview with the contracted pharmacy provider on 10/06/23 between 9:54am and 10:04am revealed: -A 30-day supply for Vraylar was filled on 07/07/23, 08/01/23, 08/28/23 and 09/26/23. -The only way the resident's medication would not have been available for administration would have been if the medications were removed from the medication cart. c. Review of physician's orders for Resident #3 dated 08/02/23 revealed there was a physician's order for Cogentin (used to treat tremors associated with psychotropic medications) 2mg tablet once daily at noon. Review of Resident #3's September 2023 MARs revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 32	D 358		

-There was a printed entry for Benztropine Mesylate (generic for Cogentin) 2mg tablet once daily at noon scheduled for administration at 12:00pm.
-There were circled initials on the MAR for 09/06/23 through 09/13/23.

Review of medication notes on the back of Resident #3's September MARs revealed:
-There were handwritten entries for 09/06/23 through 09/10/23 documenting "OFH" and "didn't take."
-There were no medication names listed.
-There was no staff signature or initials for the 09/06/23 through 09/10/23 entry notes.

Observation of medication on hand with the medication aide (MA) on 10/05/23 at 4:15pm revealed there was a blister pack for Cogentin 2mg tablets daily at noon dispensed on 09/12/23, quantity 30. There were 11 tablets remaining. There was a second blister pack dispensed on 10/02/23, quantity of 30, and 30 tablets on hand.

Interview with the MA on 10/05/23 at 2:03pm revealed when a resident was out of medication, she circled her initials and documented on the back of the resident's MARs that the medication was out of the facility.

Telephone interview with the contracted pharmacy provider on 10/06/23 between 9:54am and 10:04am revealed:
-A 30-day supply for Cogentin was filled on 07/07/23, 08/07/23, 09/12/23 and 10/02/23.
-There should be no reason the Cogentin was not available for administration at the facility.
-The medications are delivered the same day or next day when the facility requested a reorder.
-The only time a medication was not delivered

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	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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D 358	Continued From page 33 was if there were no refills on the prescription and a new prescription was needed, or if the medication was on back order. Interview with the Administrator on 10/06/23 at 10:55am revealed: -The resident could have been out of the medication if the MAs initials were circled on the MARs. -When a resident's medications needed reordering, the MAs were supposed to give her a completed medication reorder sheet. -Medications were supposed to be reordered at least seven days in advance of the supply on hand being gone. -She or the MAs were responsible for faxing the medication reorder sheets to the contracted provider pharmacy. -The facility had a backup pharmacy but could not get medications from the backup pharmacy without a prescription. -Receipt of resident medications from the contracted pharmacy provider was an "ongoing" issue. -She expected the medications to be received at the facility on the same day as medication reorder sheet was faxed to the pharmacy. Resident #3 was not available in the facility during the survey for interview.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	D 367		

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	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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D 367	Continued From page 34 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the medication administration records for 3 of 3 sampled residents (#1, #2, #3) as evidenced by the medication aide who administered the medications recording the initials of another staff person. The findings are: Review of the facility's undated Instructions for Medication Aides (MAs) form maintained in the medication administration record (MAR) notebook revealed: -Check your holes (omissions) daily. -Make sure all documentation was done daily. 1. Review Resident #1's current FL-2 dated 03/07/23 revealed diagnoses included asthma, depression, and hypertension.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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D 367	Continued From page 35 Review of Resident #1's September 2023 medication administration record (MAR) revealed: -There was an entry for Zoloft HCL 50mg for depression, 1 and 1/2 tablets (75mg) to be administered at 8:00am. There was documentation Zoloft HCL 50mg, 1 and 1/2 tablets (75mg) was administered at from 09/16/23 through 09/30/23 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 09/16/23 through 09/30/23 at 8:00am. -There was an entry for Vitamin C 1000mg for a supplement, 1 tablet daily in the morning every other day at 8:00am. There was documentation Vitamin C 1000mg, 1 tablet was administered from 09/16/23 through 09/30/23 at 8:00am. -There was an entry for Hydrochlorothiazide 25mg for high blood pressure and fluid retention, 1 tablet daily in the morning at 8:00am. There was documentation Hydrochlorothiazide was administered from 09/16/23 through 09/30/23 at 8:00am. -There 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 Potassium Chloride CRYS ER was administered from 09/16/23 through 09/30/23 at 8:00am. -There was an entry for Vitamin D3 2000units for Vitamin D deficiency, 1 tablet daily in the morning at 8:00am. There was documentation Vitamin D3, 2000 unit was administered from 09/01/23 through 09/30/23 at 8:00am. -There was an entry for B-Complex Plus Vitamin C CP for a vitamin supplement,1 tablet daily in the morning a 8:00am. There was documentation B-Complex Plus Vitamin C CP was administered from 09/16/23 through 09/30/23 at 8:00am.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 36 -There was an entry for Stiolto Respimate 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 Stiolto Respimate 2.5-2.5 MC was administered from 09/16/23 through 09/30/23 at 8:00am. -There was an entry for Amlodipine 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 8:00am. -There 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 5:00pm. -There 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 5:00pm. -There was an entry for Melatonin 5mg for a sleep aide, 1 tablet daily at bedtime at 8:00pm. There was documentation Melatonin 5mg, 1 tablet was administered from 09/16/23 through 09/30/23 at 8:00pm. -There was an entry for Olmesartan Medoxomil 40mg for high blood pressure, 1 tablet daily at bedtime at 8:00pm. There was documentation Olmesartan Medoxomil 40mg, 1 tablet was administered from 09/16/23 through 09/30/23 at 8:00pm. -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 09/16/23 through 09/30/23 at	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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D 367	Continued From page 37 8:00pm. -The initials of the Administrator was recorded on the MAR from 09/16/23 through 09/30/23 for the administration of Resident #1's medications. Review of Resident #1's October 2023 MAR revealed: There was an entry for Zoloft HCL 50mg for depression, 1 and 1/2 tablets (75mg) to be administered at 8:00am. There was 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 10/05/23 at 8:00am. -There was an entry for Vitamin C 1000mg for a supplement, 1 tablet daily in the morning every other day at 8:00am. There was documentation Vitamin C 1000mg, 1 tablet was administered from 10/01/23 through 10/05/23 at 8:00am. -There was an entry for Hydrochlorothiazide 25mg for high blood pressure and fluid retention, 1 tablet daily in the morning at 8:00am. There was documentation Hydrochlorothiazide was administered from 10/01/23 through 10/05/23 at 8:00am. -There 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 Potassium Chloride CRYS ER was administered from 10/01/23 through 10/05/23 at 8:00am. -There was an entry for Vitamin D3 2000units for Vitamin D deficiency, 1 tablet daily in the morning at 8:00am. There was documentation Vitamin D3, 2000 unit was administered from 10/01/23 through 10/05/23 at 8:00am.	D 367		

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

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D 367	Continued From page 38 -There was an entry for B-Complex Plus Vitamin C CP for a vitamin supplement,1 tablet daily in the morning a 8:00am. There was documentation B-Complex Plus Vitamin C CP was administered from 10/01/23 through 10/05/23 at 8:00am. -There was an entry for Stiolto Respimate 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 Stiolto Respimate 2.5-2.5 MC was administered from 10/01/23 through 10/05/23 at 8:00am. -There was an entry for Amlodipine 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 10/01/23 through 10/05/23 at 8:00am. -There 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 10/01/23 through 10/05/23 at 8:00am and 5:00pm. -There 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 10/01/23 through 10/05/23 at 8:00am and 5:00pm. -There was an entry for Melatonin 5mg for a sleep aide, 1 tablet daily at bedtime at 8:00pm. There was documentation Melatonin 5mg, 1 tablet was administered from 10/01/23 through 10/05/23 at 8:00pm. -There was an entry for Olmesartan Medoxomil 40mg for high blood pressure, 1 tablet daily at bedtime at 8:00pm. There was documentation Olmesartan Medoxomil 40mg, 1 tablet was administered from 10/01/23 through 10/05/23 at 8:00pm.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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D 367	Continued From page 39	D 367		

-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 8:00pm.
-The initials of the Administrator was recorded on the MAR from 10/01/23 through 10/05/23 for the administration of Resident #1's medications.

-Interview with the MA on 10/06/23 at 3:15pm revealed:
-She was hired at the facility as a MA on 09/15/23.
-She administered the medications to Resident #1 from 09/16/23 through 10/05/23.
-She completed the competency validation training and the 15 hours medication training and was scheduled to take the medication aide test in December 2023.
-She 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 medication aide on 10/05/23 at 2:03pm.

Refer to the interview with the Administrator on 10/05/23 at 2:20pm.

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 osteoporosis, gastric esophageal reflux disease,

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	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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D 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 day. -There was a physician's order for Alprazolam 0.5mg (generic for Xanax and used to treat anxiety) one tablet three times a day. -There was a physician's order for Fenofibrate 160mg (generic for Tricor and used to treat high cholesterol) one tablet three times a day. -There was a physician's order for Mirtazapine 45mg (generic for Remeron and used to treat depression) one tablet once a day at bedtime. -There was a physician's order for Quetiapine Fumarate 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 8:00pm. -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. -There was no documentation for administration of the Alprazolam 0.5mg tablet at 8:00pm on 07/31/23.	D 367		

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

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D 367	Continued From page 41 -There was no documentation to explain the omission of documentation for the scheduled dose of Alprazolam 0.5mg tablet. c. There was a printed entry for Fenofibrate 160mg one tablet once daily scheduled at 8:00pm. -There was no documentation for administration of the Fenofibrate 160mg tablet at 8:00pm on 07/31/23. -There was no documentation to explain the omission of documentation for the scheduled dose of Fenofibrate 160mg tablet. d. There was a printed entry for Mirtazapine 45mg one tablet once a day at bedtime scheduled at 8:00pm. -There was no documentation for administration of the Mirtazapine 45mg tablet at 8:00pm on 07/31/23. -There was no documentation to explain the omission of documentation for the scheduled dose of Mirtazapine 45mg tablet. e. There was a printed entry for Quetiapine Fumarate 400mg one tablet once a day at bedtime scheduled at 8:00pm. -There was no documentation for administration of the Quetiapine Fumarate 400mg tablet at 8:00pm on 07/31/23. -There was no documentation to explain the omission of documentation for the scheduled dose of Quetiapine Fumarate 400mg tablet. Review of August 2023 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 Calcium 600-Vitamin D3 tablet at 8:00pm on 08/02/23 and 08/31/23. -There was no documentation to explain the	D 367		

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D 367	Continued From page 42	D 367		

omission of documentation for the scheduled doses of Calcium 600-Vitamin D3 tablets.
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 Alprazolam 0.5mg tablet at 8:00pm on 08/10/23 and 08/31/23.
-There was no documentation to explain the omission of documentation for the scheduled doses of Alprazolam 0.5mg tablets.
c. There was a printed entry for Fenofibrate 160mg one tablet once daily scheduled at 8:00pm.
-There was no documentation for administration of the Fenofibrate 160mg tablet at 8:00pm on 08/30/23 and 08/31/23. T
-here was no documentation to explain the omission of documentation for the scheduled doses of Fenofibrate 160mg tablets.
d. There was a printed entry for Mirtazapine 45mg one tablet once a day at bedtime scheduled at 8:00pm.
-There was no documentation for administration of the Mirtazapine 45mg tablet at 8:00pm on 08/30/23 and 08/31/23.
-There was no documentation to explain the omission of documentation for the scheduled doses of Mirtazapine 45mg tablets.
e. There was a physician's order for Quetiapine Fumarate 400mg one tablet once a day at bedtime scheduled at 8:00pm.
-There was no documentation for administration of the Quetiapine Fumarate 400mg tablet at 8:00pm on 08/30/23 and 08/31/23.
-There was no documentation to explain the omission of documentation for the scheduled doses of Quetiapine Fumarate 400mg tablets.

Review of the September 2023 MARs for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 43 Resident #2 revealed: -There were printed entries for Vitamin B-12 (dietary supplement)2500mcg once daily, Atorvastatin (used to treat high cholesterol and heart disease) 10mg tablet once daily, Levothyroxine Sodium (a hormone replacement used to treat thyroid disease) 25mcg tablet once daily in the morning on an empty stomach, Calcium 600-Vitamin D3 400mg tablet two times a day, Trijardy XR (used to treat diabetes) 12.5-2.5-1000mg tablet once daily, Alprazolam 0.5mg tablet three times a day, Fenofibrate 160mg tablet once daily at bedtime, Mirtazapine 45mg tablet once daily at bedtime, and Quetiapine Fumarate 400mg tablet once daily at bedtime. -From 09/16/23 at 8:00am through 09/25/23 at 8:00am the staff initials for documentation of administration of for the medications printed on the MARs was written over with different initials. -There was documentation for administration of the medications printed on the MARs by the same staff from 09/15/23 through 09/30/23. Refer to interview with the medication aide on 10/05/23 at 2:03pm. Refer to the interview with the Administrator on 10/05/23 at 2:20pm. 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. 3. Review of Resident #3's current FL-2 dated 08/02/23 revealed diagnoses included diabetes, asthma, and schizoaffective disorder bipolar type.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 10/06/2023

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

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D 367	Continued From page 44 Review of physician's orders for Resident #3 dated 08/02/2023 revealed: -There was a physician's order for Cogentin 2mg (used to treat side effects of psychotropic medications such as involuntary movement) daily at noon. -There was a physician's order for Wellbutrin XL 300mg (used to treat depression) one tablet daily. -There was a physician's order for Vraylar 4.5mg (used to treat mood disorders) once daily. -There was a physician's order for ProAir HFA 90mcg Inhaler (used to treat breathing disorders) two puffs every six hours as needed. Review of subsequent physician's order for Resident #3 dated 07/19/23 revealed: -There was a physician's order for Trazadone 50mg (used to treat insomnia and depression) one tablet at bedtime. -There was a physician's order for Quetiapine Fumarate 50mg (generic for Seroquel and used to treat depression and schizophrenia) one tablet once a day. Review of the September 2023 MARs for Resident #2 revealed: -There were printed entries for Cogentin 2mg daily at noon and scheduled for administration at 12:00pm, Wellbutrin XL 300mg one tablet daily scheduled at 8:00am, Vraylar 4.5mg once daily at noon and scheduled at 12:00pm, Trazadone 50mg one tablet at bedtime scheduled at 8:00pm, and Quetiapine Fumarate 50mg one tablet once a day scheduled at 8:00am. -There was a printed entry for ProAir HFA 90mcg Inhaler two puffs every six hours as needed with documentation of administration on 09/15/23, 09/17/23, 09/18/23, 09/23/23, and 09/27/23 with no documentation for the reason administered or the effectiveness of the medication administered.	D 367		

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

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D 367	Continued From page 45 -From 09/15/23 at 12:00pm through 09/25/23 at 12:00pm the staff initials for documentation of administration of the medications printed on the MARs was written over with different initials. -There was documentation for administration of the medications printed on the MARs by the same staff from 09/15/23 through 09/30/23. Refer to the interview with the medication aide on 10/05/23 at 2:03pm. Refer to the interview with the Administrator on 10/05/23 at 2:20pm. 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. _____ Interview with the MA on 10/05/23 at 2:03pm revealed: -The Administrator wrote her initials over the MAs initials. -She administered medications at 8:00am, 12:00pm, 2:00pm, 5:00pm, and 8:00pm when she worked at the facility. -When the scheduled medication administration times were on the residents' MARs, she had administered the residents' medications starting two weeks ago. -She was documenting her initials when administering medications until "maybe last week" when she was instructed by the Administrator to document the Administrator's initials. -She documented the initials for the Administrator on the MARs when she administered medications. -The Administrator told her to document the	D 367		

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

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D 367	Continued From page 46	D 367		

Administrator's initials on the MARs when documenting administration of medications because she (MA) had not taken the medication aide test.
-She was scheduled to take the medication aide test in December 2023.
-She had received training with the facility nurse including proper documentation of medication administration.
-She was supposed to document her initials on the MARs when she administered medications.
-She was currently documenting the Administrator's initials on the MARs when she (MA) administered medications at the facility.

Interview with the Administrator on 10/05/23 at 2:20pm revealed:
-She was in the facility when the MA administered medications.
-She prepared the medications and the MA gave the medications to the residents as she watched the MA.
-She instructed the MA to document her (Administrator) initials on the MARs because she (Administrator) was "right there".
-She thought the MA could not document administration of medications if the MA had not taken and passed the state approved MA test.

Telephone interview with the facility nurse on 10/05/23 at 3:21pm revealed:
-She had completed the medication clinical skills evaluation for the MA on 09/12/23.
-She was not aware the MA was signing someone else's initials on the MARs when documenting administration of medications.

Interview with the Administrator on 10/06/23 at 4:00pm revealed:
-The MA was hired on 09/15/23 as a medication

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D 367	Continued From page 47 aide. -She MA administered medications under her supervision because the MA had not taken the medication aide test yet, which was scheduled for December 2023. -She instructed the MA to put her initials on the MAR when she administered medications. -She thought because the MA had not taken the medication aide test yet, she could not place her initials on the MAR.	D 367		