

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL051064	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/26/2021
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CLASSIC CARE HOMES # 2

103 ANNIE PARKER CIRCLE
SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow survey and annual survey on May 25-26, 2021.	D 000	Education of Medication Technician (MT) staff will be completed by 6/21/21 and no MT will work until education completed. Education will be done by the resident care coordinator (RCC) and will cover documentation of as needed medications (PRN), why they are used and were they effective.	6/21/21
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records were accurate and complete for 2 of 3 residents sampled (#1, #2) with documentation for effectiveness of as needed medications including oxycodone used to treat pain and lorazepam used to treat agitation	D 367	Resident chart audit completed by RCC by 6/21/21 to ensure no other resident had missed documentation for PRN medications. 1:1 education provided where needed. The RCC or Executive Director will be responsible for monitoring the documentation of PRN medications. 1:1 education will be provided if needed.	

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

6099

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If continuation sheet 1 of 9

received via email on 06/22/21.

reviewed and accepted 06/22/21. - M. Lark, R. Licensure Consultant

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D 367	Continued From page 1 and anxiety (Resident #1); and Tylenol used to treat pain (#2). The findings are: 1. Review of Resident #1's current FL-2 dated 04/20/21 and a previous FL-2 dated 12/15/2020 revealed diagnoses included chronic back pain, chronic kidney disease, coronary artery disease, chronic obstructive pulmonary disease, and depression. a. Review of physician orders for Resident #1 dated 04/20/21 and 12/15/20 revealed there was a physician's order for Oxycodone HCL (a controlled drug used to treat pain) 10 milligrams (mg) one tablet every four hours as needed for pain. Review of Resident #1's March 2021 medication administration records (MARs) revealed: -There was a printed computer-generated entry for oxycodone HCL 10mg one tablet every four hours as needed (prn) for pain "hold for sedation or respiratory rate less than 12 per minute". -There was documentation for administration of 60 doses of the oxycodone 10mg tablet from 03/01/21 through 03/31/21. -There was no documentation for the reason or the effectiveness of the as needed oxycodone 10mg tablet. Review of Resident #1's April 2021 medication administration records (MARs) revealed: -There was a printed computer-generated entry for oxycodone HCL 10mg one tablet every four hours as needed (prn) for pain "hold for sedation or respiratory rate less than 12 per minute". -There was documentation for administration of 61 doses of the oxycodone 10mg tablet from 04/01/21 through 04/30/21.	D 367	Monitoring will be as follows: 1 resident per day for 9 days, 3 residents per week for 3 weeks, 1 resident per month until substantial compliance has been accomplished. RCC will report findings to quarterly QA meeting for 3 months.	

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PRINTED: 06/07/2021
FORM APPROVED

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CLASSIC CARE HOMES # 2**103 ANNIE PARKER CIRCLE
SMITHFIELD, NC 27577**

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D 367	Continued From page 2 -There was no documentation for the reason or the effectiveness of the as needed oxycodone 10 mg tablet. Review of Resident #1's May 2021 medication administration records (MARs) revealed: -There was a printed computer-generated entry for oxycodone HCL 10mg one tablet every four hours as needed (prn) for pain "hold for sedation or respiratory rate less than 12 per minute". -There was documentation for administration of 29 doses of the oxycodone 10mg tablet from 05/01/21 through 05/26/21. -There was no documentation for 20 of the 29 opportunities of administration for the reason or the effectiveness of the as needed oxycodone 10mg tablet. Refer to the interview with the Administrator on 05/26/21 at 11:10am. Refer to the interview with the Resident Care Coordinator on 05/26/21 at 12:41pm. Refer to the interview with the Administrator on 05/26/21 at 12:56pm. Refer to the interview with a Medication Aide (MA) on 05/26/21 at 2:16pm. b. Review of physician orders for Resident #1's current FL-2 dated 04/20/21 and 12/15/2020 revealed there was a physician's order for Lorazepam (a controlled drug used to treat anxiety and agitation) 1mg tablet every six hours as needed for anxiety/agitation. Review of Resident #1's March 2021 medication administration records (MARs) revealed: -There was a printed computer-generated entry	D 367		

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STATE FORM

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NAME OF PROVIDER OR SUPPLIER CLASSIC CARE HOMES # 2			STREET ADDRESS, CITY, STATE, ZIP CODE 103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27677		
(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 3 for lorazepam 1mg one tablet every six hours as needed (prn) for agitation and anxiety. -There was documentation for administration of 81 doses of the lorazepam 1mg tablet from 03/01/21 through 03/31/21. -There was no documentation for the reason or the effectiveness of the as needed lorazepam 1mg tablet. Review of Resident #1's April 2021 medication administration records (MARs) revealed: -There was a printed computer-generated entry for lorazepam 1mg one tablet every six hours as needed (prn) for agitation and anxiety. -There was documentation for administration of 36 doses of the lorazepam 1mg tablet from 04/01/21 through 04/30/21. -There was no documentation for the reason or the effectiveness of the as needed lorazepam 1mg tablet. Review of Resident #1's May 2021 medication administration records (MARs) revealed: -There was a printed computer-generated entry for lorazepam 1mg one tablet every six hours as needed (prn) for agitation and anxiety. -There was documentation for administration of 36 doses of the lorazepam 1mg tablet from 05/01/21 through 05/26/21. -There was no documentation for 35 of the 36 opportunities of administration for the reason or the effectiveness of the as needed oxycodone 10mg tablet. Interview with Resident #1 on 05/26/21 at 2:40pm revealed: -He was prescribed pain pills. -He asked for his pain medications when he could get it. -Sometimes the MAs came back and asked him if	D 367			

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D 367	Continued From page 4 the pain was "regulated". Refer to the interview with the Administrator on 05/26/21 at 11:10am. Refer to the interview with the Resident Care Coordinator on 05/26/21 at 12:41pm. Refer to the interview with the Administrator on 05/26/21 at 12:58pm. Refer to the interview with a Medication Aide (MA) on 05/26/21 at 2:16pm. c. Review of physician orders for Resident #1 dated 01/26/21 revealed there was a physician's order for Senna-Plus (used to treat constipation) 18.6-50mg tablet may take one additional tablet as needed. Review of Resident #1's March 2021 MARs revealed: -There was a printed computer-generated entry for Senna-Plus 8.6-50mg one tablet once daily as needed for constipation. -There was documentation for administration of 6 doses of the Senna-Plus 8.6-50mg tablet from 03/01/21 through 03/31/21. -There was no documentation for the reason or the effectiveness of the as needed Senna-Plus 8.6-50mg tablet. Review of Resident #1's April 2021 MARs revealed: -There was a printed computer-generated entry for Senna-Plus 8.6-50mg one tablet once daily as needed for constipation. -There was documentation for administration of 14 doses of the Senna-Plus 8.6-50mg tablet from 04/01/21 through 04/30/21.	D 367			

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D 367	Continued From page 5 -There was no documentation for the reason or the effectiveness of the as needed Senna-Plus 8.6-50mg tablet. Refer to the interview with the Administrator on 05/26/21 at 11:10am. Refer to the interview with the Resident Care Coordinator on 05/26/21 at 12:41pm. Refer to the interview with the Administrator on 05/26/21 at 12:56pm. Refer to the interview with a Medication Aide (MA) on 05/26/21 at 2:16pm. 2. Review of Resident #2's current FL-2 dated 12/15/2020 revealed diagnoses included acute respiratory failure, SIRS [systemic inflammatory response syndrome], and HFREF [heart failure with reduced ejection fraction]. Review of physician orders for Resident #2 dated 12/30/20 revealed there was a physician's order for Tylenol (used to treat pain) 325 milligrams (mg) two tablets every six hours as needed for pain. Review of Resident #2's March 2021 medication administration records (MARs) revealed: -There was a printed computer-generated entry for Tylenol 325mg two tablets every six hours as needed (prn) for pain. -There was documentation for administration of 31 doses of the Tylenol 325mg two tablets from 03/01/21 through 03/31/21. -There was no documentation for the reason or the effectiveness of the as needed Tylenol 325mg two tablets. Review of Resident #2's April 2021 MARs	D 367			

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D 367	Continued From page 6 revealed: -There was a printed computer-generated entry for Tylenol 325mg two tablets every six hours as needed (prn) for pain. -There was documentation for administration of 18 doses of the Tylenol 325mg two tablets from 03/01/21 through 03/31/21. -There was no documentation for the reason or the effectiveness of the as needed Tylenol 325mg two tablets for 4 of the 18 doses documented as administered. Interview with Resident #2 on 05/26/21 at 2:45pm revealed: -He was administered Tylenol for pain. -The "medicine not very good". -Staff did not check to see if the Tylenol pain medication had been effective. Refer to the interview with the Administrator on 05/26/21 at 11:10am. Refer to the interview with the Resident Care Coordinator on 05/26/21 at 12:41pm. Refer to the interview with the Administrator on 05/26/21 at 12:56pm. Refer to the interview with a Medication Aide (MA) on 05/26/21 at 2:16pm. Interview with the Administrator on 05/26/21 at 11:10am revealed documentation of as medication usage should be on the back of the residents MARs. Interview with the Resident Care Coordinator (RCC) on 05/26/21 at 12:41pm revealed: -She reviewed resident MARs once a month when the upcoming months MARs were received	D 367		

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D 367	Continued From page 7 from the pharmacy. -The effectiveness of as needed medication administered to a resident should be documented on the back of the MARs. -When a Medication Aide (MA) administered an as needed medication to a resident, the MA was supposed to sign their initials on the front of the MAR documenting the administration for the medication, and document on the back of the residents MAR the date, time, resident complaint, medication name, and medication dosage. The MA was supposed to follow up "later" with documenting the effectiveness of the as needed medication administered. -She did not know why the MAs were not documenting the effectiveness of as needed medication administered to the residents. -She tried to remind the MAs to document the effectiveness of as needed medications. -She "sometimes" paid attention to the MAs not completing the documentation on the MARs for as needed medications administered to residents and was too busy a lot of the time. -She had not reported to management that the MAs were not documenting the effectiveness of as needed medications on the MARs because she thought the MAs would "get in the habit of doing it" once she told them about it. -She could not remember the last time she checked the MARs to determine if the MAs were documenting the effectiveness of as needed medications administered to the residents. Interview with the Administrator on 05/26/21 at 12:56pm revealed: -She expected the MAs to document the effectiveness of as needed medication administered to residents. -She needed the MAs to document the effectiveness of as needed medications	D 367		

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D 367	Continued From page 8 administered "in a couple hours after giving it". -She was aware the RCC had told the MAs to document the effectiveness of as needed medications administered to the residents. Interview with a Medication Aide (MA) on 05/26/21 at 2:16pm revealed: -Residents were administered an as needed (PRN) medication when the residents asked for the medication. -She would document on the back of the medication administration records (MARs) the residents name and time the PRN medication was administered and would "go back in a few hours to check to see if it helped". -She thought she had documented the PRN medications and effectiveness on the MARs but had not documented any PRN medications on the back of the MARs for this month yet -She did not know why she had not documented the PRN medications she had administered to the residents. -She usually documented the effectiveness of PRN medications administered on the residents MARs. -She knew she was supposed to sign and document the PRN medications and effectiveness on the back of the residents MARs.	D 367			