STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL074041	A. BUILDING: ______ B. WING ______	R 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMIE'S FAMILY CARE HOME II	**110 PEARL DR** **GREENVILLE, NC 27834**

(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
{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from October 5, 2023 through October 6, 2023.	{C 000}		
C 100	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that fire evacuation plans (fire drills) were rehearsed at least four times yearly, failed to maintain records that included a description of the fire drill's details resulting in 3 of 3 residents being unable to evacuate the facility without instruction during a fire drill on 10/05/23. The findings are: Review of the facility's State of North Carolina Department of Health and Human Services, Division of Health Service Regulation license	C 100		

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C 100	Continued From page 1	C 100		

certificate revealed:
-The facility's license was issued on 01/01/23.
-The facility's licensed capacity was 4 residents and that were all ambulatory.

Review of the policies provided by the Administrator of the facility revealed there was not a policy of fire drill rehearsals for the facility.

Review of the facility fire evacuation policy with no date revealed:
-In the event of a fire, staff should notify the fire department immediately and evacuate the building.
-If residents are in danger, evacuate the residents first and then call the fire department.
-If there is more than one employee, the supervisor in charge (SIC) will assign one person to call the fire department and the remainder of personnel will evacuate residents.
-Keep residents calm during an evacuation, check all rooms, including bathrooms, closets, and utility rooms to make sure all residents are out of the building.
-Close all doors.
-Have all residents meet in one place a safe distance from the home, have someone stay with the residents.
-If the fire is small or you think you can put it out, try to do so with a fire extinguisher.
-Use the front door for the fire exit, if there is a fire in the front rooms, use the rear exit.
-Call 911 for fire or rescue service.

Interview with a medication aide (MA) on 10/05/23 at 9:15am revealed the facility census was three and all residents were ambulatory.

Review of an Evacuation Plan and Fire Drill Report document framed and on the wall in the

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C 100	Continued From page 2	C 100		

kitchen revealed:
-There was a column on the Evacuation Plan and Fire Drill Report to place a number from 1 to 9 for the description column.
-The report had options listed at the bottom of what the fire drill rehearsal included.
-Staff would choose from options 1 to 9 to list as the description of the fire drill rehearsal which included 1. Complete evacuation of the building, 2. Rehearsal of evacuation without leaving the building, 3. Local fire department present, 4. Operation of fire extinguishers reviewed, 5. Evacuation of semi/non-ambulatory residents rehearsed, 6. Orientation of new staff, 7. Orientation of new residents, 8. Check for fire hazards listed on annual inspection form, and 9. Check fire detectors.

Review of the facility's fire drill rehearsal records revealed:
-There was documentation of a fire drill conducted on 09/22/23 at 8:00pm with a description code of 2, rehearsal of evacuation without leaving the building, with an evacuation time of three minutes.
-There was documentation of a fire drill conducted on 06/19/23 at 4:00pm with a description code of 2, rehearsal of evacuation without leaving the building, with an evacuation time of three minutes.
-There was documentation of a fire drill conducted on 03/21/23 at 10:00am with a description code of 2, rehearsal of evacuation without leaving the building, with an evacuation time of three minutes.

Observation of a fire drill conducted on 10/05/23 between 6:25pm and 6:33pm revealed:
-There were 3 residents sitting in the front living room.

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C 100	Continued From page 3 -The Administrator sounded the alarm in a back bedroom at 6:25pm creating a loud beeping sound. -The fire alarm was audible throughout the entire facility. -Upon hearing the fire alarm, the three residents remained seated in the living room and did not get up to evacuate the facility. -The Administrator sounded the alarm in a back bedroom at 6:28pm for a second time, creating a loud beeping sound. -The 3 residents remained seated in the front living room and did not get up to evacuate the facility. -The Administrator sounded the alarm in a back bedroom at 6:29pm for a third time, creating a loud beeping sound. -The 3 residents remained seated in the front living room and did not get up to evacuate the facility. -At 6:31pm with the fire alarm sounding, the state surveyor asked the 3 residents in the front living room what were they supposed to do when they heard the fire alarm sound. -The Administrator entered the living room and provided verbal instructions to the 3 residents to exit the building because she was conducting a fire drill; she reminded the residents of the importance of exiting the facility when they heard the fire alarm. -After the Administrator provided verbal instructions to the residents to exit the facility, one male resident exited the home and continued to walk to the end of the driveway, a second resident exited the front door of the facility and stood at the left corner of the porch, and a third resident exited the front door and remained on the porch in front of the front door. -None of the 3 residents evacuated until the Administrator provided verbal instructions to exit	C 100		

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C 100	Continued From page 4	C 100		

the building, after the fire alarm sounded for 8 minutes.

Interview with a resident on 10/05/23 at 6:52pm revealed:
-She lived at the facility since May 2023 and had never had a fire drill.
-Staff at the facility had not provided her with education on what to do during a fire drill.
-When she heard the fire alarm earlier, she started to go wave a piece of paper at the fire alarm because she had to do that before with the smoke detector in her bedroom when the battery was low; the smoke detector in her bedroom used to go off frequently but the battery was replaced.
-She had a fire drill at her day program yesterday and knew how to evacuate and where to go when they had a fire drill, but she had never practiced a fire drill at the facility.

Interview with a second resident on 10/05/23 at 6:58pm revealed:
-She was watching television in the living room when she heard the fire drill alarm.
-She was not paying attention to the fire alarm sound and kept focusing on the people talking on the television.
-She did not leave the left side of the porch because she was tired and did not want to walk to the end of the driveway.
-She would have gotten burned if it was a real fire.

Interview with a third resident on 10/05/23 at 7:16pm revealed:
-He had been at the facility since the end of September 2023.
-He did not get up from the couch in the living room when he heard the fire drill alarm because

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C 100	Continued From page 5	C 100		

he thought the Administrator was just testing the alarms.
-He knew to go outside and wait at the end of the driveway because he had practiced fire drills at another facility where he lived before, he moved to this facility.
-He had not received any education from staff at the facility of what he should do when he heard the fire alarm.
-He had not participated in a fire drill since he had been admitted to the facility.

Interview with the Administrator on 10/05/23 at 7:20pm revealed:
-She and facility staff were responsible for conducting fire drills four times a year, but they usually did them more often.
-She did not understand why the residents did not get up when they heard the fire drill.
-She had reviewed the fire drill process with all residents at the facility and they should have known to exit the facility as soon as they heard the fire alarm.
-She used a number code for the description of each fire drill, the last three fire drills she listed "2" as the description code.
-The "2" description code meant staff conducted a fire drill rehearsal of evacuation without leaving the building.
-She thought that practicing the fire drill by reviewing the process and residents not actually exiting the building counted as a fire drill for the facility.
-She did not realize that the residents were required to participate in a fire drill by exiting the building.

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The facility failed to ensure fire drills were conducted at least four times yearly. This resulted in 3 of 3 residents not being aware of what to do

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C 100	Continued From page 6 during a fire drill and all 3 residents required verbal instruction in order to evacuate a fire drill. The facility's failure was detrimental to the resident's health, safety, and welfare and constitutes a Type B Violation. __________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/06/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 20, 2023.	C 100		
{C 246}	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the Previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 residents (#1) attended appointments with her internal medicine physician for hypertension after two visits to the local emergency department (ED) two days in a row with a diagnosis of high blood pressure and failed to ensure the resident attended a follow up appointment with a plastic surgeon. The findings are:	{C 246}		

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{C 246}	Continued From page 7	{C 246}		

Review of Resident #1's current FL-2 dated 06/15/23 revealed diagnosis included hypertension and obesity.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 05/01/23.

a. Review of a hospital discharge summary for Resident #1 dated 08/05/23 revealed:
-The resident was seen at the local emergency department (ED) for high blood pressure and a headache.
-The resident's discharge diagnosis was hypertensive urgency.
-Discharge instructions included a follow up with the resident's internal medicine physician and keep a log of the resident's blood pressure readings.
-A follow up appointment with the resident's internal medicine physician was scheduled for 08/14/23.

Review of a hospital discharge summary for Resident #1 dated 08/06/23 revealed:
-The resident was seen at the local ED for high blood pressure.
-The resident's discharge diagnosis was elevated blood pressure reading.
-Discharge instructions included a follow up with the resident's internal medicine physician in 24 to 48 hours.

Review of an after visit summary for Resident #1 dated 08/14/23 revealed:
-Resident #1 was seen by a physician for a follow up visit for essential hypertension.
-There was a physician's note that the resident's blood pressure remained uncontrolled.

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{C 246}	Continued From page 8 -There was a physician order to order blood pressure cuff for Resident #1 and to keep a log of the resident's blood pressure readings. -There was an appointment listed on the after visit summary for a follow up appointment with the resident's internal medicine physician on 09/13/23. Telephone interview with a receptionist at Resident #1's internal medicine physician's office on 10/06/23 at 9:03am revealed: -Resident #1 had an appointment with her internal medicine physician on 09/13/23 but the resident was a no show. -Resident #1's appointment for 09/13/23 was rescheduled for 09/20/23 and the resident was a no show. -There were no future appointments scheduled for Resident #1 with her internal medicine physician. Interview with Resident #1 on 10/05/23 at 3:44pm revealed: -She had a very bad headache when she went to the local ED for high blood pressure in early August 2023. -She would ask the Administrator or the medication aide (MA) about any upcoming appointments she had scheduled. -She asked about any upcoming appointments at least once a week. -She had never refused to go to an appointment that was scheduled with a physician. Telephone interview with Resident #1's legal guardian at Department of Social Services on 10/06/23 at 11:01am revealed: -She had not received documentation that Resident #1 had been to the local ED on 08/05/23 or 08/06/23.	{C 246}		

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{C 246}	Continued From page 9	{C 246}		

-There was no documentation that the facility had communicated with the legal guardian regarding Resident #1's high blood pressure.
-The facility had not notified the legal guardian that the resident had missed two appointments with her internal medicine physician.
-The legal guardian could have assisted if needed to transport the resident to the two appointments that the resident missed.
-It was important for the facility to communicate with the legal guardian to ensure the resident attended all medical appointments.
-The resident was at risk of a stroke or heart attack due to her hypertension and needed to attend all follow up appointments with physicians to ensure her safety.

Telephone interview with the medication aide (MA) on 10/06/23 at 11:32am revealed:
-She missed taking Resident #1 to her appointments with her internal medicine physician and must have overlooked the appointment dates.
-She usually placed appointment dates on the facility calendar but missed the two appointments for Resident #1.
-She did not remember canceling Resident #1's appointments with her internal medicine physician.
-She should have called to reschedule the resident's appointments because it was important to follow up with her healthcare needs.
-The resident had never refused to attend a physician appointment.

Interview with the Administrator on 10/05/23 at 5:30pm revealed:
-She was not aware that Resident #1 missed two follow up appointments with her internal medicine physician.

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{C 246}	Continued From page 10 -She expected the MA to contact her if staff were unable to transport a resident to an appointment so that other arrangements could be made to ensure the resident kept all appointments. -The MA kept a calendar of any upcoming appointments on the facility schedule. -She expected the MAs to document any follow up appointments on the calendar after they returned to the facility from a physician's appointment. -Resident #1 should not have missed two appointments with her internal medicine physician because she needed assistance with controlling her high blood pressure. Attempted telephone interview with Resident #1's internal medicine physician on 10/06/23 at 9:03am was unsuccessful. b. Review of an after visit summary for Resident #1 dated 07/18/23 revealed: -Resident #1 was seen by a plastic surgeon for a follow up visit for treatment of a keloid on the resident's right breast and right side of her back. -The resident had a follow up appointment scheduled with a plastic surgeon on 09/19/23. Observation of Resident #1's keloid on 10/06/23 at 5:32pm revealed: -There was a keloid on the resident's right side of her back. -The keloid on the right side of the resident's back was an oblong shape that was 1 ½ inches in width, and 3 inches in length. -The keloid on the resident's right breast was a 2 ½ inches in width, and 2 inches in length. Observation of Resident #1 at the dining room table on 10/05/23 at 3:44pm revealed: -The resident was sitting at the dining room table	{C 246}		

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{C 246}	Continued From page 11	{C 246}		

talking to the Administrator.
-The resident informed the Administrator that she was getting a rash under her breasts and the scar on her right breast was uncomfortable.
-The Administrator told the resident that she would get her an appointment scheduled.

Interview with Resident #1 on 10/06/23 at 5:32pm revealed:
-She had not seen the plastic surgeon for her keloid since June 2023 or July 2023.
-She was not sure why she had not been taken by facility staff to her follow up appointment with the plastic surgeon in September.
-She never refused to go to appointments and usually asked the facility staff about her upcoming appointments at least once a week.
-The plastic surgeon helped her keloids feel better when she had her last visit, she had less itching.
-She hoped the Administrator would schedule her an appointment with her plastic surgeon because the keloid on her right breast had started to itch again and was uncomfortable.

Telephone interview with a receptionist at Resident #1's plastic surgeons office on 10/06/23 at 1:45pm revealed:
-Resident #1 had a follow up appointment with the plastic surgeon on 09/19/23 but the resident was a no show.
-There were no future appointments scheduled for Resident #1.

Telephone interview with the medication aide (MA) on 10/06/23 at 11:32am revealed:
-She missed taking Resident #1 to her follow up appointment with her plastic surgeon
-She was not sure how she missed taking Resident #1 to her appointment with her plastic

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surgeon; she usually placed appointment dates for residents on the facility calendar.

Interview with the Administrator on 10/06/23 at 2:55pm revealed:
-She was not sure why Resident #1 missed her follow up appointment with the plastic surgeon in September.
-She assumed the medication aide (MA) had transported the resident to her appointment.
-The MA placed all appointments for residents on the facility calendar to ensure transportation to appointments.
-If facility staff were not able to transport the resident to an appointment, staff would contact the resident's legal guardian to assist with coordinating transportation.

Attempted telephone interview with Resident #1's internal medicine physician on 10/06/23 at 9:03am was unsuccessful.

____

The facility failed to ensure a resident (#1) who had two visits on 08/05/23 and 08/06/23 at a local emergency department for hypertension attended a follow up appointment as ordered within 24-48 hours after the 2nd ED visit; the resident also had an appointment scheduled with a plastic surgeon to address her keloids which she did not attend, and this resulted in itching and discomfort. These failures were detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/06/23 for this violation.

THE CORRECTION DATE FOR THE TYPE B

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{C 246}	Continued From page 13 VIOLATION SHALL NOT EXCEED NOVEMBER 20, 2023.	{C 246}		
{C 249}	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physician orders were implemented for 1 of 3 sampled residents by ensuring an order to check a resident's blood pressure daily and record the blood pressure readings was implemented after the resident was seen at the local emergency department (ED) for hypertension on 08/05/23 and 08/06/23 (#1). The findings are: Review of Resident #1's current FL-2 dated 06/15/23 revealed: -Diagnoses included hypertension, asthma, major depression, and obesity. -There was an order to check blood pressure daily. Review of Resident #1's Resident Register	{C 249}		

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{C 249}	Continued From page 14	{C 249}		

revealed the resident was admitted to the facility on 05/01/23.

Review of a hospital discharge summary for Resident #1 dated 08/05/23 revealed:
-The resident was seen at the local emergency department (ED) for high blood pressure and a headache.
-The resident's discharge diagnosis was hypertensive urgency.
-Discharge instructions included to follow up with the resident's physician with internal medicine within 3 days and keep a log of the resident's blood pressure readings.
-There was an order for Amlodipine 5mg, take one tablet once a day (Amlodipine is a medication used to treat high blood pressure).
-A follow up appointment with the resident's physician with internal medicine was scheduled for 08/14/23.

Review of a second hospital discharge summary for Resident #1 dated 08/06/23 revealed:
-The resident was seen at the local ED for high blood pressure.
-The resident's discharge diagnosis was elevated blood pressure reading.
-Discharge instructions included to follow up with the resident's physician with internal medicine in 24 to 48 hours.

Review of an after visit summary for Resident #1 dated 08/14/23 revealed:
-Resident #1 was seen by a physician for a follow up visit for essential hypertension.
-There was a physician's note that the resident's blood pressure remains uncontrolled.
-There was a physician order to order blood pressure cuff for Resident #1, keep a log of the resident's blood pressure readings, and return in

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two weeks.
-There was an order to discontinue Losartan 50mg, take one tablet once a day; and to start Losartan 75mg take one and ½ tablet once a day (Losartan is a medication used to treat high blood pressure).

Observation of a notebook with blood pressure readings for Resident #1 revealed:
-There was a handwritten page with daily blood pressure readings for Resident #1 from 07/31/23 to 08/18/23.
-There was a handwritten heading for the week of 08/19/23 to 08/26/23, but there were no blood pressure readings documented.

Interview with Resident #1 on 10/05/23 at 3:44pm revealed:
-She had a very bad headache when she went to the local ED for high blood pressure in early August 2023.
-The staff at the facility had never checked her blood pressure.
-She did not check her own blood pressure.

Telephone interview with Resident #1's legal guardian at Department of Social Services on 10/06/23 at 11:01am revealed:
-The facility was expected to implement a blood pressure reading log as ordered by the physician.
-It was important for the facility to document the resident's blood pressure readings per the physician's order because the resident could be at risk of having a stroke or a heart attack.

Telephone interview with the medication aide (MA) on 10/06/23 at 11:32am revealed:
-When the facility had a new admission, she followed all orders.
-Resident #1 checked her blood pressure once a

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{C 249}	Continued From page 16 week and reported her blood pressure reading to facility staff, who then documented the blood pressure readings in a notebook. -She explained that there was no way that the resident's blood pressure readings were not checked daily because she documented the blood pressure readings in a notebook daily. -She started documenting the resident blood pressure readings in a notebook on 07/13/23. -She transported the resident to her follow up appointment for the resident's two visits to the local ED for high blood pressure. -When she was at the residents follow appointment on 08/14/23 the physician told her to keep a blood pressure log daily for the resident for two to three weeks. -She did not realize that she was supposed to continue to check the resident's blood pressure readings daily and record it in a log. -She thought since the physician started the resident on a new medication for high blood pressure that she did not need to keep recording the resident's daily blood pressure readings. -The resident had torn a blood pressure cuff because it did not fit her arm correctly. -The resident knew she was supposed to check her own blood pressure readings, however, became angry when the blood pressure cuff did not work correctly, and the resident tore the cuff off her arm. -She realized that as a MA she was responsible for checking the resident's blood pressure readings daily and maintaining a log of the readings per the physician order. -She thought there was an order for the resident to check her own blood pressure readings daily and record them, she should have realized that it was her responsibility to check the resident's blood pressure daily per physician orders. -She should have followed the physician's order	{C 249}		

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and made a mistake.
-She should have followed the physician's order to check the resident's blood pressure daily and maintain a log with the blood pressure readings.
-It was important to check the resident's blood pressure because she could have a stroke, heart attack, or die from high blood pressure.

Observation of the Administrator on 10/05/23 at 5:23pm revealed:
-The state surveyor asked the Administrator to demonstrate taking Resident #1's blood pressure.
-The Administrator gave the blood pressure cuff to Resident #1 and told her to take her blood pressure.
-The resident attempted to put the blood pressure cuff on herself and attempted to place the blood pressure cuff over her sleeve.
-The state surveyor explained to the Administrator that she needed to observe the Administrator take the resident's blood pressure.
-The Administrator took the resident's blood pressure and there was a reading of 143/86.

Interview with the Administrator on 10/05/23 at 5:30pm revealed:
-The facility purchased a new blood pressure cuff for Resident #1 after her physician visit on 08/14/23.
-The only log she was aware of for Resident #1's blood pressure readings was the handwritten log from 07/31/23 to 08/18/23.
-She expected staff to follow physician orders to ensure the residents' safety.
-She did not know why staff had not implemented the physician order to record the residents blood pressure readings after the visits to the ED.
-Staff should have checked the resident's blood pressure and maintained a log to take to any of her physician appointments to help control her

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{C 249}	Continued From page 18 high blood pressure. -She was partly at fault because when she picked up the resident from a group home to admit her to their facility, staff told her that the resident checked her own blood pressure. -She should have reviewed the discharge summary from the local ED and the physician order at the resident's follow up appointment and followed the physician orders to check and record the resident's blood pressure. -It was her responsibility to ensure that any orders for a resident were implemented and the MAs understood they are expected to follow physician orders. ______________________________ The facility failed to ensure a resident order to check a resident's blood pressure daily and maintain a log of the resident's blood pressure readings was implemented after the resident was seen at a local ED on 08/05/23 and 08/06/23 for severe hypertension. This 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. 131D-34 on 10/05/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 20, 2023.	{C 249}		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the	C 341		

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medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure documentation of administration of medications to 1 of 3 sampled residents (#3) including medications to treat schizophrenia, high blood pressure, blood clots, high cholesterol, and depression.

The findings are:

Review of Resident #3's current FL-2 dated 09/25/23 revealed:
-Diagnoses included paranoid schizophrenia, hypertension, coronary artery disease, diabetes, acute kidney injury, high cholesterol and history of pulmonary embolism and deep vein thrombosis.
-There was an order for Amlodipine 5mg, take 1 tablet once a day (Amlodipine is a medication used to treat high blood pressure).
-There was an order for Atorvastatin 10mg, take 1 tablet once a day (Atorvastatin is a medication used to treat high cholesterol).
-There was an order for Carvedilol 12.5mg, take 1 tablet twice a day (Carvedilol is a medication used to treat high blood pressure).
-There was an order for Divalproex SOD ER 500mg, take 3 tablets in the morning (Divalproex is a medication used to treat bipolar disorder).

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-There was an order for Eliquis 5mg, take 1 tablet twice a day (Eliquis is a medication used to prevent blood clots).
-There was an order for Ferrous Sulfate 325mg, take 1 tablet once a day (Ferrous Sulfate is a medication used to treat low levels of iron in the blood).
-There was an order for Hydrochlorothiazide 25mg, take 1 tablet once a day (Hydrochlorothiazide is a medication used to treat high blood pressure).
-There was an order for Levetiracetam 500mg, take 1 tablet twice a day (Levetiracetam is a medication used to treat seizures).
-There was an order for Risperidone 2mg, take 1 ½ tablet in the morning (Risperidone is a medication used to treat schizophrenia).
-There was an order for Risperidone 2 mg, take 2 tablets at bedtime.
-There was an order for Sertraline HCL 50mg, take 1 tablet in the morning (Sertraline HCL is a medication used to treat depression).
-There was an order for Trazadone 100mg, take 1 tablet in the morning (Trazadone is a medication used to treat depression).
-There was an order for Vitamin C 500mg, take 1 tablet in the morning.
-There was an order for Vitamin D-3 2,000 units, take 1 tablet in the morning (Vitamin D-3 is used to prevent and treat bone disorders).
-There was an order for Melatonin 5mg, take 1 tablet at bedtime as needed for sleep.
-There was an order for Acetaminophen 500mg, take 2 tablets as needed for pain.

Review of Resident #1's Resident Record revealed the resident was admitted to the facility on 09/21/23.

Review of a signed medication release form from

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C 341	Continued From page 21 the assisted living facility where the resident was transferred from to the current facility for Resident #3 dated 09/05/23 revealed: -There was documentation that 14 Amlodipine 5mg tablets were provided to the facility. -There was documentation that 14 Atorvastatin 10mg tablets were provided to the facility. -There was documentation that 28 Carvedilol 12.5mg tablets were provided to the facility. -There was documentation that 42 Divalproex SOD ER 500mg. tablets were provided to the facility. -There was documentation that 28 Eliquis 5mg tablets were provided to the facility. -There was documentation that 7 Ferrous Sulfate 325mg tablets were provided to the facility. -There was documentation that 14 Hydrochlorothiazide 25mg tablets were provided to the facility. -There was documentation that 28 Levetiracetam 500mg tablets were provided to the facility. -There was documentation that 28 Risperidone 2mg tablets were provided to the facility. -There was documentation that 14 Sertraline HCL 50mg tablets were provided to the facility. -There was documentation that 14 Trazadone 100mg tablets were provided to the facility. -There was documentation that 7 Vitamin C 500mg tablets were provided to the facility. -There was documentation that 14 Vitamin D-3 2,000 units were provided to the facility. -There was documentation that 14 Melatonin 5mg tablets were provided to the facility. -There was documentation that 42 Acetaminophen 500mg tablets were provided to the facility. Observation of Resident #3's medication on hand on 10/05/23 at 11:30am revealed: -There was a medication card containing 28	C 341		

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C 341	Continued From page 22 tablets of Amlodipine 5mg dispensed on 10/02/23. -There was a medication card containing 27 tablets of Atorvastatin 10mg dispensed on 10/02/23. -There was a medication card containing 54 tablets of Carvedilol 12.5mg dispensed on 10/02/23. -There was a medication card containing 82 tablets of Divalproex SOD ER 500mg dispensed on 10/02/23. -There was a medication card containing 56 tablets of Eliquis 5mg dispensed on 10/02/23. -There was a medication card containing 27 tablets of Ferrous Sulfate 325mg dispensed on 10/02/23. -There was a medication card containing 27 tablets of Hydrochlorothiazide 25mg dispensed on 10/02/23. -There was a medication card containing 55 tablets of Levetiracetam 500mg dispensed on 10/02/23. -There was a medication card containing 27 tablets (2mg) and 27 half tablets (2mg tablets cut in half) of Risperidone 3mg dispensed on 10/02/23. -There was a medication card containing 56 tablets of Risperidone 2mg dispensed on 10/02/23. -There was a medication card containing 27 tablets of Sertraline HCL 50mg dispensed on 10/02/23. -There was a medication card containing 27 tablets of Trazadone 100mg dispensed on 10/02/23. -There was a medication card containing 27 tablets of Vitamin C 500mg dispensed on 10/02/23. -There was a medication card containing 27 tablets of Vitamin D-3 2,000 units dispensed on	C 341		

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10/02/23.
-There was a medication card containing 30 tablets of Melatonin 5mg tablets dispensed on 09/21/23.
-There was a medication card containing 170 tablets of Acetaminophen 500mg tablets dispensed on 09/21/23.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/05/23 at 10:00am revealed:
-Resident #3's medications had not been uploaded into the eMAR system.
-The pharmacist was able to upload Resident #3's medications into the eMAR system.
-The facility's contracted pharmacy was not aware that Resident #3's eMAR was not uploaded until the Administrator called on 10/05/23 at 9:58am to request the resident's medications in the eMAR system to be activated.

Interview with Resident #3 on 10/05/23 at 5:30pm revealed:
-He was admitted to the facility from an assisted living facility.
-He had not missed any medications that he was aware of and had not experienced any symptoms of missing his medications.

Interview with a medication aide (MA) on 10/05/23 at 10:35am revealed:
-Resident #3's medications were not in the eMAR system, and she did not use a paper MAR to document the administration of the resident's medications.
-She administered the resident his medications by comparing the medication card with a copy of his prescriptions.
-She should have notified the Administrator that the resident's medications were not in the eMAR

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C 341	Continued From page 24 system. -She had not thought of using a paper MAR for documentation of the resident's medications. -She administered the resident's medications based on the directions on each medication card and compared the medication card with a copy of his prescriptions. Second interview with a MA on 10/05/23 at 2:52pm revealed: -She always verified that the medication she was administering was the correct medication for the correct resident. -When she administered medications to a resident, she compared the resident's eMAR with the medication card, she then removed the medication from the medication card, placed in a medication cup, documented the medication was administered on the eMAR, and observed the resident take the medication. -She had to be careful that she did not administer the wrong medication to a resident because it could cause an allergic reaction which could cause a resident to die. Interview with the Administrator on 10/05/23 at 10:45am revealed: -She should have contacted the facility's contracted pharmacy to inform them that Resident #3's medications were not active in the eMAR system. -She should have implemented a paper MAR for staff to use to document the administration of medications for Resident #3 until the eMAR could be updated. -She was not sure why the facility's contracted pharmacy had not uploaded Resident #3's medications into the eMAR system. -It was her responsibility to contact the facility's contracted pharmacy to notify them that Resident	C 341		

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C 341	Continued From page 25 #3's medications were not on the eMAR system. -She was the only staff that had access the eMAR system to approve medications entered by the facility's contracted pharmacy. -She was the only person that could enter the eMAR system to approve the medications. -Once she accessed the eMAR system, it was her responsibility to approve the medications entered on the eMAR by the facility's contracted pharmacy. -She had forgotten to approve Resident #3's medications in the eMAR system. -She completed medication cart audits at least once a month. -She expected MAs to document on the eMAR or a paper MAR when medications were administered. -She should have realized that the MAs were not documenting the administration of Resident #3's medications. Attempted telephone interview with Resident #3's primary care physician (PCP) on 10/05/23 at 12:32pm was unsuccessful.	C 341		
C 448	10A NCAC 13G .1213 (e) Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for	C 448		

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emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to notify the county department of social services (DSS) who was the legal guardian for 1 of 3 sampled residents (#1) after the resident was treated at a local emergency department (ED) two days in a row for high blood pressure.

The findings are:

Review of Resident #1's current FL-2 dated 06/15/23 revealed diagnosis included hypertension and obesity.

Review of Resident #1's Resident Record revealed the resident was admitted to the facility on 05/01/23.

Review of Resident #1's record revealed there was documentation that appointment of guardian of person was granted to the DSS on 06/10/15.

Review of a hospital discharge summary for Resident #1 dated 08/05/23 revealed:
-The resident was seen at the local emergency department (ED) for high blood pressure and a headache.
-The resident's discharge diagnosis was hypertensive urgency.

Review of a hospital discharge summary for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL074041	A. BUILDING: ___ B. WING ___	R 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMIE'S FAMILY CARE HOME II	110 PEARL DR GREENVILLE, NC 27834

(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
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Resident #1 dated 08/06/23 revealed:
-The resident was seen at the local ED for high blood pressure.
-The resident's discharge diagnosis was elevated blood pressure reading.

Telephone interview with Resident #1's legal guardian at DSS on 10/06/23 at 11:01am revealed:
-DSS was legal guardian of Resident #1.
-There was no documentation that Resident #1's legal guardian was notified of the resident's visits to a local ED on 8/05/23 or 08/06/23.
-The facility was expected to communicate with the legal guardian about any medical emergencies.
-The legal guardian needed to know the resident went to the local ED because the legal guardian needed to follow up with the hospital about the resident's medical needs.
-The local DSS had recently contracted with an outside agency to provide case management for the resident.
-The legal guardian should have received information about the resident's local ED visits so it could be communicated with the new case management company.

Telephone interview with the MA on 10/06/23 at 11:32am revealed:
-She did not notify Resident #1's legal guardian about her visits to the local ED because she did not communicate with DSS, the Administrator usually communicated with DSS.
-She did not know that she needed to communicate with Resident #1's legal guardian when she had a medical emergency.

Interview with the Administrator on 10/06/23 at 11:45am revealed:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
C 448	Continued From page 28 -She was not aware that the facility needed to contact Resident #1's legal guardian if the resident went to the hospital or had a medical emergency. -She would call 911 if a resident had an emergency and 911 would contact the on call social worker for the resident. -She thought that the dispatcher with 911 or the emergency medical service (EMS) informed the social worker on call about any emergencies for the resident. -She did not notify Resident #1's legal guardian that the resident was seen at the local ED on 08/05/23 and 08/06/23.	C 448		