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 06/12/2023

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 and Annual and Follow Up survey on 06/09/23 and 06/12/23.	C 000		
C 021	10A NCAC 13G .0302 (a) Design And Construction 10A NCAC 13G .0302 Design And Construction (a) Any building licensed for the first time as a family care home shall meet the applicable requirements of the North Carolina State Building Code. All new construction, additions and renovations to existing buildings shall meet the requirements of the North Carolina State Building Code for One and Two Family Dwellings and Residential Care Facilities, if applicable. All applicable volumes of The North Carolina State Building Code, which is incorporated by reference, including all subsequent amendments, may be purchased from the Department of Insurance Engineering Division located at 322 Chapanoke Road, Suite 200, Raleigh, North Carolina 27603 at a cost of three hundred eighty dollars ($380.00). This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the building met the North Carolina Building Code requirements for non-ambulatory residents as	~~C 021~~ C 022 10A NCAC 13G .0302 (b) Design and Construction		

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 06/12/2023

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 021	Continued From page 1	C 021		

evidenced by 1 of 4 residents (Resident #2) who was physically impaired, residing in the facility and being unable to evacuate the facility independently without verbal or physical assistance.

The findings are:

Review of the facility's current license effective 01/01/23 revealed the facility was licensed for a capacity of four ambulatory residents.

Observation of the facility front entrance on 06/09/23 at 8:35am revealed:
-There was not a ramp at the threshold of the front entry/exit door that led to the front porch landing.
-The was a ramp that connected to the front porch that led to the ground.

Review of Resident #2's current FL2 dated 03/26/22 revealed:
-Diagnoses included athetoid cerebral palsy, unspecified dementia without behavioral disturbance.
-There was no information on Resident #2's orientation.

Review of Resident #2's care plan dated 06/01/22 revealed:
-Ambulation was documented as limited range of motion with both arms and legs.
-There was no documentation on Resident #2's activities of daily living (ADL).

Review of Resident #2's Licensed Health Professional Service dated 04/07/22 revealed Resident #2 used a wheelchair as an assistive device.

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 06/12/2023

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 021	Continued From page 2 Observation of a fire drill on 06/09/23 at 2:33pm revealed: -There were three residents present during the fire drill. -Resident #2 used a wheelchair as an assistive device. -The Administrator used a long stick to set off the alarm from a smoke detector -One resident who was seated on their bed was prompted to exit the facility. -Resident #2 could not get his wheelchair over the threshold of the front entrance. -Resident #2 stood up and tried unsuccessfully to move his wheelchair over the threshold. -Resident #2 was assisted by the supervisor in charge (SIC) and another resident in getting over the threshold. -Resident #2 was able to ambulate down the ramp that was connected to the porch of the facility. -All three residents exited the facility with 2 minutes. Interview with Resident #2 on 06/09/23 at 5:22pm revealed: -He would get someone to open and hold the front door for him. -Staff or another resident would place the wheelchair outside for Resident #2 when he needed to leave the facility or go outside. -There had not been a ramp placed at the threshold, but it would help with his rolling in and out of the facility if there was a ramp. Interview with Resident #2's primary care physician (PCP) on 06/12/23 at 3:38pm revealed: -Resident #2 was last seen on 10/24/22. -Resident #2 had difficulty walking. -Because Resident #2 had not been seen in 10 months his mobility to get in and out of the facility	C 021		

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 06/12/2023

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 021	Continued From page 3 on his own could not be assessed. Interview with the SIC on 06/09/23 at 5:32pm revealed: -She assisted Resident #2 during the fire drill on 06/09/23 because she was standing at the door. -She had assisted Resident #2 in the past with getting over the threshold. -Resident #2 had not had any issues getting out of the facility. Interview with the Administrator on 06/09/23 at 2:25pm revealed: -Resident #2 was admitted to the facility with a wheelchair. -Resident #2 could stand and walk on his own. -Resident #2 had not complained of needing assistance getting around or in and out of the facility. -She would have a ramp installed at the front threshold. Observation of the facility's front entrance on 06/09/23 at 6:23 pm revealed there had been a ramp installed at the front door entrance. _____ The facility failed to be equipped and maintained in a manner to ensure the safety of 1 of 4 sampled residents who had physical impairments and utilized a wheelchair and could not evacuate independently in an emergency. The facility's failure was detrimental to the 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 06/09/23 for this violation. CORRECTION DATE FOR THE TYPE B	C 021		

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 06/12/2023

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 021	Continued From page 4 VIOLATION SHALL NOT EXCEED JULY 27, 2023.	C 021		
C 097	10A NCAC 13G .0316 (b) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (b) The building shall be provided with smoke detectors as required by the North Carolina State Building Code and U.L. listed heat detectors connected to a dedicated sounding device located in the attic and basement. These detectors shall be interconnected and be provided with battery backup. This Rule is not met as evidenced by: Based on interviews, observations, and record reviews the facility failed to ensure a smoke detector had an operable battery. The findings are: Review of the Inspection of Residential Care Facility dated 06/08/23 revealed: -An inspection was completed on 06/08/23. -The facility code status was an A with 15 demerits. -There was no documentation relating to the smoke detectors. Observation of the facility on 06/09/23 from 8:35am to 2:33pm revealed: -The was a loud beeping sound coming from a smoke detector within the home.	C 097		

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 06/12/2023

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 097	Continued From page 5 -There was one smoke detector installed in the hallway ceiling. -The smoke detector in the hallway was beeping. -There was one smoke detector that had been removed from the hallway ceiling. -There was one smoke detector in a resident room that was alightly hanging. Interview with a resident on 06/09/23 at 1:18pm revealed: -The smoke detector in the hallway had been beeping nonstop for several months. -The smoke detector sounds all day and all night long. -The sound had bothered him. -He had asked staff to change the battery (date and time not provided), but his request was ignored. Interview with a second resident on 06/09/23 at 1:33pm revealed: -He heard the smoke detector beeping for about 2 to 3 weeks. -The beeping had not bother him because it was not in his room. Interview with a third resident on 06/09/23 at 2:37pm revealed: -The smoke detector "chirped" all night long. -She did not know how long the smoke detector had been chirping. -She had not reported the chirping to staff. Interview with a fourth resident on 06/09/23 at 4:54pm revealed: -The smoke detector was beeping when she first came to the facility in May 2023. -The smoke detector would beep all night long. -She had not reported to staff about the smoke detector beeping all night long.	C 097		

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 06/12/2023

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 097	Continued From page 6 Interview with the Administrator on 06/09/23 at 9:27pm revealed: -The county inspector had completed an inspection on 06/08/23 and requested the battery be changed in the smoke detector. -The smoke detector had been beeping for a couple of days and she was waiting for the handyman to come and replace the battery. -The battery would be changed on 06/09/23. -The smoke detector was in the attic and there was an issue with the wiring of the smoke detector.	C 097		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 residents sampled (Residents #2) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are:	C 202		

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 06/12/2023

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 202	Continued From page 7 Review of Resident #2's current FL2 dated 03/26/22 revealed: -Diagnoses included athetoid cerebral palsy, unspecified dementia without behavioral disturbance. -There was no information on Resident #2's orientation. Review of Resident's #2 Resident Register revealed, Resident #2 was admitted to the facility on 04/01/22. Review of Resident #2's record revealed there was documentation of TB test for Resident #2 was read on 06/04/22. Interview with Resident #2 on 06/09/23 at 1:22pm revealed he could not remember if he had a TB test. Interview with Resident #2 legal guardian on 06/09/23 at 12:41pm revealed Resident #2 had completed a TB test when he was admitted to the facility in April 2022. Interview with Resident #2's primary care provider (PCP) on 06/12/23 at 3:38pm revealed Resident #2 did not have TB testing results on file. Interview with the Administrator on 06/12/23 at 3:52pm revealed: -Resident #2 had completed a TB test on 06/04/22. -Resident #2 had resided at another facility and she thought that TB test was in his record. -The supervisor in charge (SIC) was responsible for scheduling TB testing appointments. -The SIC responsible for ensuring all TB tested had been completed.	C 202		

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 06/12/2023

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 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an assessment approved by the Department based on a form containing at least the same information as required on the established assessment. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure residents' FL2 was updated annually for 1 of 3 sampled residents (#2). The findings are: Review of Resident #2's current FL2 dated 03/26/22 revealed: -Diagnoses included athetoid cerebral palsy and unspecified dementia without behavioral	~~C 231~~ C 203 10A NCAC 13G .0702(b) Tuberculosis Test and Medical Examination		

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 06/12/2023

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 231	Continued From page 9	C 231		

disturbance.
-There was no information on Resident #2's orientation.
-The diet order was not documented on the FL2.

Review of Resident #2's Resident Register revealed Resident #2 was admitted to the facility on 04/01/22.

Review of Resident #2's record revealed there was not a subsequent diet order in the record.

Interview with Resident #2's primary care provider (PCP) on 06/12/23 at 3:38pm revealed:
-Resident #2 last visit was on 10/24/22.
-Resident #2 had a regular diet with no restrictions.
-There was not a current FL2 on file.

Interview with the Supervisor in Charge (SIC) on 06/09/23 at 9:50am revealed:
-Resident #2 had a PCP visit in March 2023 (date not provided) and the FL2 was to be completed at that time.
-She forgot to take the FL2 to the appointment but fazed the form back to the PCP.
-The FL2 had not been received.
-She had not called the PCP to follow up on the FL2 for Resident #2.

Interview with the Administrator on 06/09/23 9:47am revealed:
-Resident #2 had seen his PCP in March 2023 (date not provided) and his updated FL2 was completed but she had not received a copy of the FL2.
-She called the PCP on 06/09/23 to request a copy of Resident #2's FL2.
-She completed an assessment of all residents prior to accepting them into the facility.

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 06/12/2023

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 231	Continued From page 10 -She completed a checklist for all required documents to include the FL2 prior to admission. -She was responsible for ensuring residents had an FL2 upon admission and annual FL2s.	C 231		
C 237	10A NCAC 13G .0802 (b) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (b) The care plan shall be revised as needed based on further assessments of the resident according to Rule .0801 of this Subchapter This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure residents' care plan was completed annually for 1 of 3 sampled residents (#2). The findings are: Review of Resident #2's current FL2 dated 03/26/22 revealed: -Diagnoses included athetoid cerebral palsy, unspecified dementia without behavioral disturbance. -There was no information on Resident #2's orientation. Review of Resident #2's resident register revealed Resident #2 was admitted to the facility on 04/01/22. Review of Resident #2's care plan on 06/01/22 revealed: -The most recent care plan was completed by the Resident #2's primary care physician on 06/01/22.	~~C 237~~ C 231 10A NCAC 13G .0801(b) Resident Assessment		

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 06/12/2023

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 237	Continued From page 11 -The activities of daily living was not completed on the care plan for Resident #2. Interview with Resident #2's primary care provider (PCP) on 06/12/23 at 3:38pm revealed: -Resident #2 last visit was on 10/24/22. -There was not a current care plan on file. -Resident #2 was not scheduled for any upcoming appointments. Interview with the Administrator on 06/12/23 at 2:25pm revealed: -Resident #2 had a completed care plan on 06/01/22. -Care plans were completed when residents were admitted to the facility. -Resident #2 did not have any upcoming appointments with his PCP. -She was responsible for ensuring the care plans for residents were completed annually.	C 237		
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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure health care referral and follow up for 1 of 3 residents sampled (#3) who were receiving psychiatric services. The findings are: Review of Resident #3's current FL2 dated	C 246		

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 06/12/2023

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 246	Continued From page 12 06/02/23 revealed diagnoses included asthma, major depression disorder, hypertension, obesity, iron deficiency, gastroesophageal reflux disease (GERD) and seasonal allergies. Review Resident #3's Resident Register dated 05/01/23 revealed Resident #3 was admitted to the facility on 05/01/23. Review of Resident #3's record on 06/09/23 revealed there was not a FL2 completed at the time of admission to the facility on 05/01/23. Interview with Resident #3 on 06/09/23 at 4:54pm revealed: -She had resided at the facility for at least a month. -Her psychiatrist was in another city. -She had not seen her psychiatrist since residing at the facility. -She had not taken the haloperidol and benztropine because she felt she did not need the medication. Telephone interview with Resident #3's Primary Care Physician (PCP) on 06/09/23 at 3:11pm revealed: -Resident #3 was last seen on 06/02/23. -The facility had not contacted the PCP since Resident #3's visit on 06/09/23. -Resident #3 was prescribed haloperidol and benztropine (Cogentin) from another provider. -Resident #3 sought psychiatric services from another provider. Telephone interview with Resident #3's mental health provider on 06/12/23 at 12:31pm revealed: -The facility called on the morning of 06/12/23 and scheduled an appointment for 06/15/23. -Resident #3 was last seen on 03/25/23.	C 246		

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 06/12/2023

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 246	Continued From page 13 -On the 03/25/23 visit, Resident #3 was seen due to hitting another resident at the previous facility where she lived. -Resident #3 was seen on 02/16/23 and questioned why she had to take the medication but had not complained of side effects. -Resident #3 was seen monthly for medication management. -Resident #3 was prescribed haloperidol 5mg 1 tablet at bedtime and benztropine 1mg tablet at bedtime. Interview with the supervisor in charge (SIC) on 06/09/23 at 2:04pm revealed: -She had not contacted Resident #3's mental health provider to schedule a follow up appointment because she did not have the mental health provider's contact number. -Resident #3 had not displayed inappropriate behavior towards staff or other residents. -She was responsible for making all health appointments. Interview with the Administrator on 06/09/23 at 6:35pm revealed: -She had not contacted Resident #3's mental health provider to schedule a follow up appointment. -Resident #3 had not displayed any signs or concerns of behavior issues. -The SIC was responsible for making all appointments for the residents. _____ The facility failed to ensure to follow up with mental health services to meet the mental health care needs of 1 of 3 sampled residents (#3) who was prescribed psychiatric medication. The facility failure were detrimental to the health, safety and welfare of the residents and	C 246		

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 06/12/2023

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 246	Continued From page 14 constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 06/09/23. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 27, 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: Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 3 sampled residents (#3) with orders for finger stick blood sugar (FSBS) checks once daily. The findings are: Review of Resident #3's current FL2 dated 06/02/23 revealed: -Diagnoses included asthma, major depression disorder, hypertension, obesity, iron deficiency, gastroesophageal reflux disease (GERD) and seasonal allergies. -Collection and testing of fingerstick blood glucose (FSBS) samples were once daily	C 249		

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 06/12/2023

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 249	Continued From page 15 Review of Resident #3's record on 06/09/23 revealed there was not a Licensed Health Professional Support (LHPS) completed. Review of Resident #3's record on 06/09/03 revealed there were not an Electronic Medication Administration Record (eMAR) on site for May 2023 and June 2023. Observation of Resident #3's glucometer on 06/09/23 at 2:06pm revealed: -There was one reading on 09/25 (year not stated) at 1:15pm of 115. -There was one reading on 09/20 (year not stated) at 1:32pm of 110. -There was one reading on 09/19 (year not stated) at 1:11pm of 49. Observation of Resident #3's FSBS on 06/09/23 at 5:10pm revealed: -She completed her own FSBS. -The glucometer read with a date of 09/25 (year not stated) at 5:10pm of 147. Interview with Resident #3 on 06/09/23 at 4:54pm revealed: -She completed her own FSBS twice a day. -She had watched staff put the results in the computer but had not seen them write down the results. -She did not know what her normal range were. -Her sugar had been high at times, but she did not know when the last time her sugar was high. -She did not know her glucometer was registering an incorrect date and time. -She had used the same glucometer for a long time (timeframe not provided). Telephone interview with Resident #3's PCP on	C 249		

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 06/12/2023

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 249	Continued From page 16 06/09/23 at 3:11pm revealed: -Resident #3 was last seen on 06/02/23. -Resident #3 was to have her FSBS checked once daily. -Resident #3 was not taking diabetic medication because her blood sugar was normal. -Resident #3's blood sugar was controlled by diet. -The facility had not contacted the PCP since Resident #3's visit on 06/02/23. -The facility was accepted to contact the PCP if Resident #3's blood sugar was too high or low. Interview with the supervisor in charge (SIC) on 06/09/23 at 2:04pm revealed: -Resident #3 checked her own FSBS at least once daily. -She did not know if Resident #3 had parameters. -She did not know Resident #3's glucometer was not reading the correct date and time. -She had not contacted the pharmacy to request another glucometer. -Resident #3 completed her FSBS in the SIC presence. -Resident #3's FSBS results were reviewed but were not documented. -Resident #3's FSBS were within normal range. Interview with the Administrator on 06/09/23 at 6:35pm revealed Resident #3 FSBS were not documented because she did not have an Electronic Medical Administration Record (eMAR).	C 249		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a	C 254		

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 06/12/2023

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 254	Continued From page 17 registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed quarterly for 1 of 3 sampled residents (#3) with LHPS task of fingerstick blood sugar (FSBS) checks. The findings are: Review of Resident #3's current FL2 dated 06/02/23 revealed: -Diagnoses included asthma, major depression disorder, hypertension, obesity, iron deficiency, gastroesophageal reflux disease (GERD) and seasonal allergies. -Collection and testing of fingerstick blood	C 254		

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 06/12/2023

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 254	Continued From page 18 glucose (FSBS) samples were once daily. Review Resident #3's Resident Register dated 05/01/23 revealed Resident #3 was admitted to the facility on 05/01/23. Review of Resident #3's record revealed there was not a LHSP available for review. Interview with Resident #3 on 06/09/23 at 4:54pm revealed she checked her own FSBS twice daily. Telephone interview with the facility's local Pharmacist on 06/09/23 at 12:20pm revealed: -There was a Nurse who completed the LHPS for the facility. -There was no a LHPS for Resident #3 available for review. Telephone interview with Resident #3's local pharmacy on 06/09/23 at 3:39pm revealed Resident #3 did not have a LHPS available for review. Telephone interview with Resident #3's Primary Care Physician (PCP) on 06/09/23 at 3:11pm revealed: -Resident #3 was last seen on 06/02/23. -Resident #3's FSBS were to be completed once daily. Interview with the Administrator on 06/09/23 at 9:55am revealed: -There was a local pharmacy used to complete and update the LHPS. -The LHPS were completed at admission and every three months if there were tasks identified. -She was responsible for checking the residents' records to ensure the LHPS reviews were completed.	C 254		

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 06/12/2023

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 254	Continued From page 19 -She had not checked the residents record since the start of COVID-19.	C 254		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents, (#1) related to vitamin deficiency, asthma, allergy and birth control medications and two psychotropic medications. The findings are: Review of Resident #3's current FL2 dated 06/02/23 revealed: -Diagnoses included asthma, major depression disorder, hypertension (HTN), obesity, iron deficiency, gastroesophageal reflux disease (GERD) and seasonal allergies. -There was an order for vitamin B-12 1000mg 1 tablet daily. -There was an order for albuterol HFA 90mcg/actuation inhaler 1 to 2 puffs as needed (prn).	C 330		

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 06/12/2023

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 330	Continued From page 20 -There was an order for Advair 100-50mcg one puff daily. -There was an order for Mili 0.25-0.035 1 tablet daily. -The orders for haloperidol and benztropine was not documented on the FL2. Review Resident #3's Resident Register dated 05/01/23 revealed Resident #3 was admitted to the facility on 05/01/23. Review of Resident #3's record on 06/09/03 revealed there were not an Electronic Medication Administration Record (eMAR) on site for May 2023 and June 2023. Review of Resident #3's Primary Care Provider (PCP) after-visit summary dated 05/24/23 revealed: -The after-visit summary was electronically signed by the PCP. -There was an order for loratadine 10mg 1 tablet daily for high blood pressure documented on the medication list. -There was an order for Mili .025-35mg-mcg 1 tablet daily for birth control documented on the medication list. -There was an order for haloperidol 10mg 1 tablet at night for anxiety documented on the medication list. -There was an order for benztropine 1mg 1 tablet at night for depression and side effects for muscle control documented on the medication list. Interview with Resident #3 on 06/09/23 at 4:54pm revealed: -She had resided at the facility for at least a month. -Her psychiatrist was in another city.	C 330		

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 06/12/2023

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 330	Continued From page 21 -She had not seen her psychiatrist since residing at the facility. -She had been out of some of her medications (could not name the medications). -She used two inhalers to treat her asthma and took medication for HTN. -She had not taken the haloperidol and benztropine because she felt she did not need the medication. Telephone interview with Resident #3's PCP on 06/09/23 at 3:11pm revealed: -Resident #3 was last seen on 06/02/23. -The facility had not contacted the PCP since Resident #3's visit on 06/02/23. -Resident #3 was no longer taking diabetic medication because her blood sugar was normal. -Resident #3's blood sugar was controlled by diet. -Resident #3 had an order for losartan 50mg 1 tablet daily for blood pressure. Review of Resident #3's Primary Care Physician (PCP) after-visit summary dated 06/09/23 revealed: -The after-visit summary was signed electronically by the PCP. -There was an order for albuterol HFA 90 mcg/actuation inhaler 1 to 2 puffs prn to treat asthma was documented on the medication list. -There was an order for budesonide-foremother (Symbicort) 160-4.5 mcg inhaler 2 puffs twice daily to treat asthma was documented on the medication list. -There was an order for losartan 50mg 1 tablet daily to treat allegories was documented on the medication list. -There was an order for loratadine 10mg 1 tablet daily to treat HTN was documented on the medication list. -There was an order for Mili .025-35mg-mcg 1	C 330		

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 06/12/2023

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 330	Continued From page 22	C 330		

tablet daily to treat birth control was documented on the medication list.
-There was an order for an order haloperidol 10mg 1 tablet at night to treat anxiety was documented on the medication list.
-There was an order benztropine 1mg 1 tablet at night to treat depression and side effects for muscle control was documented on the medication list.
-The order for vitamin b-12 1,000mg 1 tablet daily to treat vitamin deficiency was documented as discontinued on the medication list.

Second telephone interview with Resident #3's PCP on 06/12/23 at 2:05pm revealed:
-The staff visited the office on 06/09/23 to request refills on Resident #3's medication.
-The Mili .025-35mg-mcg 1 tablet daily, albuterol HFA 90 mcg/actuation inhaler 1 to 2 puffs as needed (prn), and Symbicort 160-4.5 mcg inhaler 2 puffs twice daily was sent to Resident #3's local pharmacy to be filled on 06/09/23.
-The haloperidol and benztropine was not submitted for a refill because the medications were prescribed by another health care provider.

Telephone interview with Resident #3's mental health provider on 06/12/23 at 12:31pm revealed:
-The facility called on the morning of 06/12/23 and scheduled an appointment for 06/15/23.
-Resident #3 was last seen on 03/25/23.
-On the 03/25/23 visit, Resident #3 questioned her need to take the haloperidol and benztropine but had not complained about side effects.
-Resident #3 was last seen on 03/20/23 due to reports of her hitting another resident at her previous facility.
-Resident #3 medications were haloperidol 5mg 1 tablet in the morning and haloperidol 10mg 1 tablet at bedtime and benztropine 1mg 1 tablet at

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 06/12/2023

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 330	Continued From page 23 bedtime. -The facility called the provider on the morning of 06/12/23 and scheduled an appointment on 06/15/23 at 9:15am. -Resident #3 was resistant to taking her medications because of paranoia and not due to reports of side effects. -The facility had not contacted the mental health provider prior to 06/12/23 to request refills on medication an order would have been sent to the Resident #3's new pharmacy. -There was a concern of Resident #3 decompensating due to not having her medication for a long as two weeks. -The psychiatrist had not recommended prescribing the medications as needed because the facility did not have a Registered Nurse (RN) staffed at the facility. Observation of Resident #3's medication on hand on 06/09/23 at 4:20pm revealed: -There was a bubble pack of APAP (Tylenol) 325mg prn with 1 tablet in the packet with a dispense date on 12/20/22 for 15 tablets. -There were two empty bubble packs of haloperidol 10mg 1 tablet at night with a dispense date on 04/26/23 for 30 tablets each pack. -There was an empty bubble pack of losartan 50mg 1 tablet once daily with a dispense date on 04/26/23 for 31 tablets. -There was an empty bubble pack of loratadine 10mg 1 tablet daily with a dispense date of 04/26/23 for 31 tablets. -There was an empty bubble pack of vitamin B-12 1000mcg 1 tablet daily with a dispense on 04/26/23 for 31 tablets. -There was an empty bubble pack of benztropine 1mg 1 tablet at bedtime with a dispense date on 04/26/23 for 31 tablets.	C 330		

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 06/12/2023

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 330	Continued From page 24 Observation of Resident #3's medication on hand 06/09/23 at 6:26pm revealed: -There was losartan 10mg 1 tablet daily 90 tablets with a dispense date of 06/02/23 with 83 tablets on hand. -There was Mili .025-35mg-mcg (Sprintec) 1 tablet daily of 28 tablets on hand with a dispense date of 06/09/23. -The Mili .025-35mcg 1 tablet daily had not been administered to Resident #3. -There was an albuterol HFA 90 mcg/actuation inhaler 1 to 2 puffs as needed (prn) with a dispense date of 06/09/23. -The albuterol HFA 90 mcg/actuation inhaler had not been administered to Resident #3. -There was an Symbicort 160-4.5 mcg inhaler 2 puffs twice daily with a dispense of 06/09/23. -The Symbicort 160-4.5 mcg inhaler had not been administered to Resident #3. Telephone interview with Resident #3's local Pharmacist on 06/12/23 at 1:54pm revealed: -Losartan 50mg 1 tablet daily was filled on 06/02/23 for 90 tablets. -Mili .025-35mg-mcg (Sprintec) 1 tablet daily filled on 06/09/23 for 84 tablets. -Loratadine 10mg 1 tablet daily 06/09/23 for 90 pills. -Albuterol HFA 90 mcg/actuation inhaler 1 to 2 puffs prn filled 06/09/23. -Symbicort 160-4.5 mcg inhaler 2 puffs twice daily filled 06/09/23. Review of Resident #3's previous pharmacy's dispense log dated 06/13/23 revealed: -There was documentation of haloperidol 10mg 1 tablet at night for 39 dispensed on 03/20/23. -There was documentation of benztropine 1mg 1 tablet at night for 26 dispensed on 03/20/23.	C 330		

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 06/12/2023

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 330	Continued From page 25 Interview with the supervisor in charge (SIC) on 06/09/23 at 2:04pm revealed: -Resident #3 was not receiving mental health services. -Resident #3 did not have any medications on site. -Resident #3 did not have an eMAR on site. -She had not documented administering medications for Resident #3. -She had not contacted Resident #3's PCP to request medication refills. -She did not know when Resident #3 had run out of her medications. -She was responsible for all medication orders. Second interview with the SIC on 06/12/23 at 3:49pm revealed: -She had taken Resident #3 to her PCP who had sent new orders for -Mili .025-35mg-mcg (Sprintec), Albuterol HFA 90 mcg/actuation inhaler and Symbicort 160-4.5 mcg inhaler to Resident #3's new pharmacy on 06/09/23. -She made a mental health appointment on today for Resident #3's for 06/15/23. -She had not made the mental health appointment prior today because she did not have a contact number. Interview with the Administrator on 06/09/23 at 6:35pm revealed: -Resident #3 could not get an appointment until 06/02/23. -She had not contacted the PCP for a follow up appointment. -She had not contacted Resident #3's previous pharmacy to request refills on the haloperidol and benztropine. -The staff had not documented when Resident #3 took her medication because an eMAR was not sent with the medications.	C 330		

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 06/12/2023

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 330	Continued From page 26 -She had not requested an eMAR from the pharmacy. -The SIC was responsible for following up with all residents' medication orders. _____ The facility failed to ensure to follow up were medications administered to 1 of 3 sampled residents (#3) who had vitamin deficiency, allergies, birth control prevention and behavior issues for more than two weeks. The facility failure were detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 06/09/23. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 27, 2023.	C 330		