Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034062	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS VILLAGE II	6441 HOLDER ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 03/31/26 through 04/01/26.	D 000		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#1) including errors for a medication used to treat elevated blood pressure (BP). The findings are: Review of Resident #1's current FL2 dated 08/14/25 revealed: -Diagnoses included hypertensive chronic kidney disease, fracture of facial bones, dysphagia, atherosclerotic heart disease, anxiety, and mild cognitive impairment. -There was an order for metoprolol (used to treat hypertension) 50mg take one tablet once daily. Review of Resident #1's signed physician order dated 03/09/26 revealed an order for metoprolol 50mg 1 tablet twice a day, hold for systolic blood pressure (SBP) less than 100 and hold for heart rate (HR) less than 65.	D 358	A refresher training for all Medication Technician's (MT's) is scheduled for 4/17/26. The training will be conducted by the RCD and facility RN, with focus on responsibilities of staff regarding all physician orders that require additional actions based on physician ordered parameters for holding and contacting the ordering physician. The Med Tech LHPS check off sheet that is conducted by the facility RN has been revised to reflect physician ordered parameter responsibilities. The RN will include training and discussion during the individual MT's new hire training and skills check off. Daily, for the next 4 weeks, the RCD and RN will monitor the Vital Signs Report from QMAR. Each vitals order with physician ordered parameters will be compared to the MAR and chart notes to assure compliance. Additional training will be provided as identified. After 4 weeks, the RCD and RN will continue the above monitoring weekly for four weeks. Then, monthly thereafter.	4/17/26 4/6/26 5/8/26 6/5/26 on-going as part of monthly QA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: K-1 Kim Bridgeman — TITLE: Campus Executive Director — (X6) DATE: 4/14/26

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D 358	Continued From page 1 Review of Resident #1's January 2026 electronic medication administration record (eMAR) from 01/01/26 to 01/31/26 revealed: -There was an entry for metoprolol 50mg tablet take one tablet once daily at 8:00am from 01/01/26 through 01/31/26, hold for SBP less than 100 and hold for HR less than 65. -There was documentation metoprolol was administered when it should have been held, with examples as follows for 4 of 31 opportunities: -On 01/05/26 Resident #1's HR value was documented as 56 at 8:00am. -On 01/06/26 Resident #1's HR value was documented as 60 at 8:00am. -On 01/13/26 Resident #1's HR value was documented as 64 at 8:00am. -On 01/23/26 Resident #1's HR value was documented as 62 at 8:00am. Review of Resident #1's February 2026 eMAR from 02/01/26 to 02/28/26 revealed: -There was an entry for metoprolol 50mg tablet take one tablet once daily at 8:00am from 02/01/26 through 02/28/26, hold for SBP less than 100 and hold for HR less than 65. -There was documentation metoprolol was administered when it should have been held, with examples as follows for 5 of 28 opportunities: -On 02/05/26 Resident #1's HR value was documented as 62 at 8:00am. -On 02/21/26 Resident #1's HR value was documented as 60 at 8:00am. -On 02/23/26 Resident #1's HR value was documented as 62 at 8:00am. -On 02/26/26 Resident #1's HR value was documented as 58 at 8:00am. -On 02/27/26 Resident #1's HR value was documented as 64 at 8:00am.	D 358		

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D 358	Continued From page 2 Review of Resident #1's March 2026 eMAR from 03/01/26 to 03/30/26 revealed: -There was an entry for metoprolol 50mg tablet take one tablet once daily at 8:00am from 03/01/26 through 03/30/26, hold for SBP less than 100 and hold for HR less than 65. -There was documentation metoprolol was administered when it should have been held, with examples as follows for 13 of 31 opportunities: -On 03/01/26 Resident #1's HR value was documented as 60 at 8:00am. -On 03/02/26 Resident #1's HR value was documented as 64 at 8:00am. -On 03/04/26 Resident #1's HR value was documented as 63 at 8:00am. -On 03/06/26 Resident #1's HR value was documented as 60 at 8:00am. -On 03/10/26 Resident #1's HR value was documented as 58 at 8:00am. -On 03/11/26 Resident #1's HR value was documented as 60 at 8:00am. -On 03/12/26 Resident #1's HR value was documented as 54 at 8:00am. -On 03/14/26 Resident #1's HR value was documented as 56 at 8:00am. -On 03/16/26 Resident #1's HR value was documented as 63 at 8:00am. -On 03/18/26 Resident #1's HR value was documented as 64 at 8:00am. -On 03/21/16 Resident #1's HR value was documented as 62 at 8:00am. -On 03/26/26 Resident #1's HR value was documented as 64 at 8:00am. -On 03/27/26 Resident #1's HR value was documented as 62 at 8:00am. Review of Resident #1's heart rate values revealed the facility documented a heart rate value of 75 on 03/31/26 at 8:00am.	D 358		

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D 358	Continued From page 3 Observation of the medications on hand for Resident #1 on 04/01/26 at 10:55am revealed there were 7 tablets remaining of 7 tablets dispensed on 04/01/26 in a bubble pack labeled as metoprolol 50mg one tablet once daily, hold for SBP less than 100 and hold for HR less than 60. Interview with Resident #1 on 04/01/26 at 12:05pm revealed: -The medication aides (MA) obtained his BP and HR readings in the mornings. -He was not sure if he had ever gone without any of his medications. -He denied any current issues with heart rate levels or having experienced symptoms related to dizziness with getting weak. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/01/26 at 1:24pm revealed: -Resident #1 had a current order on file for metoprolol 50mg take one tablet once daily at 8:00am, hold for SBP less than 100 and hold for HR less than 60. -Metoprolol 50mg was dispensed for Resident #1 on 03/24/26 for 7 tablets and on 04/01/26 for 7 tablets. Interview with Resident #1's primary care provider (PCP) on 04/01/26 at 1:31pm revealed: -She did not know there were errors with Resident #1's metoprolol administration in January 2026, in February 2026 and in March 2026. -She had no concerns related to low blood pressure or low heart rates for Resident #1 but she expected the facility staff to administer Resident #1's metoprolol as she had ordered according to the HR values.	D 358		

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D 358	Continued From page 4 Interview with a MA on 04/01/26 at 11:18am revealed: -She administered medications to Resident #1 and she followed the medication orders in the eMAR system when administering medications to residents. -She knew there was a parameter to hold Resident #1's metoprolol if his HR was lower than "some" number but she was not sure of the exact parameter number. -She was not aware Resident #1's metoprolol had been documented as administered when it should have been held according to Resident #1's ordered parameters in January 2026, February 2026, and March 2026. -The Resident Care Director (RCD) and the Nurse were responsible for reviewing the eMAR audits but she had not been informed of any medication errors. Interview with another MA on 04/01/26 at 11:32am revealed: -He administered medications to Resident #1 and he followed the medication orders in the eMAR system when administering medications to residents. -He knew there was a parameter to hold Resident #1's metoprolol if his HR was below 65. -He was not aware Resident #1's metoprolol had been documented as administered when it should have been held according to Resident #1's ordered parameters in January 2026, February 2026, and March 2026 until today (04/01/26). -The RCD and the Nurse were responsible for reviewing the eMAR audits but he had not been informed of any medication errors. Interview with the RCD on 04/01/26 at 1:57pm revealed:	D 358		

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D 358	Continued From page 5 -She did not know Resident #1's metoprolol was administered when it should have been held from for 4 times in January 2026, 5 times in February 2026, and 13 times in March 2026. -The MA administering medications would be responsible to hold Resident #1's metoprolol if it should be held. -She and the Nurse were responsible for reviewing the eMAR audits but she was not sure why Resident #1's metoprolol was documented as administered when the MAs should have held the medication. Interview with the Nurse on 04/01/26 at 2:05pm revealed: -She was not aware Resident #1's metoprolol was administered when it should have been held from for 4 times in January 2026, 5 times in February 2026, and 13 times in March 2026. -She and the RCD were responsible for completing eMAR audits daily but the occurrences with Resident #1's metoprolol were overlooked. -She expected the MAs to follow provider orders and MAs were responsible to hold Resident #1's metoprolol if it should be held. Telephone interview with the Administrator on 04/01/26 at 2:26pm revealed: -She did not know Resident #1's metoprolol was administered when it should have been held in January 2026, February 2026, and March 2026. -The RCD and the Nurse were responsible for completing eMAR audits and both were usually auditing the eMARs daily. -She expected the MAs to follow provider orders and MAs were responsible to hold Resident #1's metoprolol if it should be held. -She expected the RCD and the Nurse to review the eMAR audits to identify medication errors.	D 358		

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