STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034090	A. BUILDING: _____ B. WING _____	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS VILLAGE I	6401 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 and follow-up survey on August 5-6, 2025.	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 administer medications as ordered by a licensed practitioner for 1 of 5 sampled residents (#5) including a medication used to increase thyroid hormone levels (#1). The findings are: 1. Review of Resident #5's current FL2 dated 08/07/24 revealed: -Diagnoses included dementia, atrial fibrillation, diverticulitis, anxiety, depression and syncopal episodes. -There was an order for levothyroxine (used to increase thyroid hormone levels) 50mcg to be administered every morning. Review of Resident #5's physicians' orders dated 06/23/25 revealed there was an order to decrease levothyroxine from 50mcg to 35mcg, 1 tablet every morning.	D 358		

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D 358	Continued From page 1 Review of Resident #5's June 2025 electronic medication administration record (eMAR) from 06/24/25 through 06/30/25 revealed: -There was an entry for levothyroxine 50mcg one tablet every morning. -Levothyroxine 50mcg was documented as administered 06/24/25 through 06/30/25. Review of Resident #5's July 2025 eMAR from 07/01/25 through 07/31/25 revealed: -There was an entry for levothyroxine 50mcg 1 tablet every morning. -Levothyroxine 50mcg was documented as administered 07/01/25 through 07/31/25. Review of Resident #5's August 2025 eMAR from 08/01/25 through 08 /05/25 revealed: -There was an entry for levothyroxine 50mcg. 1 tablet every morning. -Levothyroxine 50mcg was documented as administered 08/01/25 through 08/05/25. Observation of Resident #5's medications on hand on 08/06/25 at 8:30am revealed: -There was a multi-dose blister pack, which included levothyroxine 50 mcg, available for administration. -There was no levothyroxine 35 mcg available for administration. Telephone interview with Resident #5's primary care provider (PCP) on 08/06/25 at 9:00am revealed: -Resident #5 had a current order for levothyroxine 35mcg 1 tablet every morning. -She expected the facility to administer Resident #5's levothyroxine as ordered. -She was not concerned of adverse effects because she was trying to decrease the amount	D 358		

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D 358	Continued From page 2 of medication Resident #5 took. Telephone interview with the pharmacist from the facility's contracted pharmacy on 08/06/25 at 11:10am revealed: -There was an active order for levothyroxine 50mcg. -A new order to decrease levothyroxine from 50mcg to 35mcg had not been received from the facility or Resident #5's PCP. Interview with a medication aide (MA) on 08/06/25 at 11:51am revealed: -When new orders were received from a resident's physician, the new order was faxed to the facility's contracted pharmacy and the resident's family was notified. -Whichever MA receives the new order was the one responsible for verifying the physician orders and faxing the order to the facility's contracted pharmacy. -She was not aware that Resident #5 had a new order to decrease their levothyroxine medication. Interview with the Resident Care Director (RCD) on 08/06/25 at 12:00pm revealed: -When a physician changes an order, whoever received the changed order was the person responsible for faxing the order to the facility's contracted pharmacy. -A confirmation page, confirming the new order was received by the facility's contracted pharmacy, was put into the patient's file. -The facility's contracted pharmacy was responsible for updating the eMAR when new orders were received. -Chart audits were done at least once every month. -She was not aware that Resident #5 had a new order to decrease their levothyroxine medication.	D 358		

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D 358	Continued From page 3 Interview with the Administrator on 08/06/25 at 12:30pm revealed: -Whichever staff member received a new order from a physician, was the person responsible for faxing the new order to the facility's contracted pharmacy. -Chart audits were done monthly. -She was not aware that Resident #5 had a new order to decrease their levothyroxine medication. -She was not aware the eMAR did not reflect the current physicians' orders for Resident #5's levothyroxine medication. -She expected new orders to be implemented as ordered by the physician.	D 358		