| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|---|-------|--------------------------|
| | | | A. BUILDING: | | | |
| | | HAL077010 | B. WING | | 05/18 | 8/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET I | HOUSE | 632 FREEN | IAN MILL ROA | AD | | |
| TIANILLI | 10002 | HAMLET, N | IC 28345 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {D 000} | Initial Comments | | {D 000} | | | |
| | The Adult Care Licens follow up survey on M | sure Section conducted a lay 17 and 18, 2022. | | | | |
| {D 273} | 10A NCAC 13F .0902 | (b) Health Care | {D 273} | | | |
| | ` , | PHealth Care assure referral and follow-up and acute health care needs | | | | |
| | This Rule is not met a | • | | | | |
| | Based on these findin Violation was not aba | gs, the previous Type A2 ted. | | | | |
| | reviews, the facility fa care provider (PCP) for (#1 and #2) for compl of breath and heart pa resident not receiving days (#2) and for repe | ns, interviews and record iled to notify the primary or 2 of 5 sampled residents aints of increased shortness alpitations in addition to the a cardiac medication for 7 eated refusals of tes, pain, and electrolyte | | | | |
| | The findings are: | | | | | |
| | 05/04/22 revealed dia atrial fibrillation with ra hypertension, chronic | t #2's current FL-2 dated ignoses included dementia, apid ventricular response, obstructive pulmonary congestive heart failure | | | | |
| | (ED) report dated 04/ | 2's emergency department 30/22 revealed: ed to the FD with mild | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

PRINTED: 03/06/2023 FORM APPROVED

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | | , , | E SURVEY PLETED | |
|---|--|---|----------------------|---|--------------------------------------|--------------------------|
| | | | | | | R |
| | | HAL077010 | B. WING | | 05 | 5/18/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | ADDRESS, CITY, STATE | , ZIP CODE | | |
| | | 632 FRE | EMAN MILL ROAD | | | |
| HAMLET | HOUSE | HAMLET | Γ, NC 28345 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETE DATE |
| {D 273} | respiratory distress, to respirations), wheezing fibrillation (rapid but in the upper chambers of ventricular response heart). -The ED work up was probably high output meet the body's need pumped from the heart rate. Review of Resident # consult note dated 02-The resident's initial—He had not received (Diltiazem is used to high blood pressure.) -The resident was given Diltiazem before restant was given before resta | achypnea (increase ng, and found to be in atrial noomplete contractions of of the heart) with rapid (lower chambers of the se consistent with CHF, failure (not enough blood to despite the volume art) from the resident's rapid (2's hospital cardiology 4/30/22 revealed: heart rate was in the 140s. his Diltiazem for 3-4 days. treat atrial fibrillation and (2'en 2 intravenous doses of arting oral doses. 42's hospital discharge (4/22 revealed: ted to the ED on 04/30/22 palpitations and had run out as prior to admission to the cortness of breath and was at rate of 150 on admission. with an ejection fraction of of blood pumped from the less test (measures the lond to stress) and 40% on assound of the heart). erican Heart Association on is 50-75%.) | {D 273} | DE NOILL | | |
| | -For several days bef | fore he went to the hospital | 1 | | | |

Division of Health Service Regulation

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| Division of Health Service Regulation | | | | | | |
|---------------------------------------|--------------------------|--|----------------------------|--|------------------|------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLE | TED |
| | | | _ | | _ | |
| | | | D MANAGE | | R | |
| | | HAL077010 | B. WING | | 05/1 | 8/2022 |
| NAME OF PE | ROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, STA | TE ZIP CODE | | |
| | 10115211 011 001 1 21211 | | | • | | |
| HAMLET HOUSE | | MAN MILL ROA | AD . | | | |
| | | HAMLEI | NC 28345 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | | COMPLETE DATE |
| TAG | REGULATORT OR I | EGG IDENTIF TING INFORMATION) | TAG | DEFICIENCY) | MAIL | 5,2 |
| | | | + | | | |
| {D 273} | Continued From page | e 2 | {D 273} | | | |
| | (04/20/22) ha waa ha | aving difficulty broathing that | | | | |
| | | aving difficulty breathing that | | | | |
| | was increasingly notic | | | | | |
| | | they offered to send him to | | | | |
| | • ' | ranted to wait and see. | | | | |
| | - | edications with derivatives | | | | |
| | | regulate breathing because | | | | |
| | • | caring for a family member | | | | |
| | on hospice. | | | | | |
| | • | edication would help him to | | | | |
| | relax and breathe eas | | | | | |
| | | ot so bad he had to go to | | | | |
| | the hospital the night | | | | | |
| | | vas not getting the Diltiazem | | | | |
| | | d have gone immediately to | | | | |
| | the hospital. | | | | | |
| | | | | | | |
| | | nt #2 on 05/17/22 at 9:53am | | | | |
| | revealed: | | | | | |
| | | ng because he had multiple | | | | |
| | | ons including CHF, a heart | | | | |
| | valve problem, lupus | | | | | |
| | | e emergency medical | | | | |
| | | nat he was not getting his | | | | |
| | heart medication. | | | | | |
| | | | | | | |
| | | t #2's physician order | | | | |
| | | 22 at 6:05am revealed: | | | | |
| | | MA) documented the resident | | | | |
| | | eart palpitations through the | | | | |
| | night. | | | | | |
| | | nis morning medications | | | | |
| | usually helped him. | | | | | |
| | | encing the heart palpitations | | | | |
| | a couple of nights in a | | | | | |
| | -He also had anxiety. | | | | | |
| | | ry care provider (PCP) | | | | |
| | signed the notification | n on 05/04/22. | | | | |
| | | | | | | |
| | Review of Resident # | 2's physician order request | | | | |
| | dated 04/30/22 at 1:3 | 5am revealed: | | | | |

Division of Health Service Regulation

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| STATEMEN | F OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE | SURVEY LETED |
|--------------------------|---|--|---------------------|---|---------------------------------|--------------------------|
| | | | A. BUILDING: _ | | | |
| | | HAL077010 B. WING | | | R 18/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | | DDRESS, CITY, STAT | TE ZIP CODE | 1 00/ | 10/2022 |
| TWAME OF T | NOVIDEN ON OUT FEET | | EMAN MILL ROA | | | |
| HAMLET HOUSE | | | , NC 28345 | D | | |
| 0(1) 15 | CHMMADV CT | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF | CORRECTION | 0/5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| {D 273} | Continued From page | e 3 | {D 273} | | | |
| | -A MA documented the resident requested to go to the ED for heart palpitations, trouble breathing and stomach painThe resident's PCP signed the notification on 05/04/22. | | | | | |
| | progress notes reveal -On 04/29/22 at 10:46 resident was complained and chest discomfortThe resident refused and reported feeling to 04/29/22On 04/30/22 at 1:08 resident was sent to 1 -There was no docum reporting shortness of -There was no docum reporting shortness of -There was no docum and/or family membe. Telephone interview with 10:52 am revealed: -She was working the when Resident #2 condiscomfort and difficulting -He did not want to go because he thought it medication, he would -She checked on him and he said he was an -She notified the Resident was completed. | Spm, a MA documented the ning of shortness of breath I to be sent to the hospital petter later in the evening on am, a MA documented the the ED for heart palpitations. Inentation of Resident #2 f breath prior to 04/29/22. Inentation the resident's PCP is was called. With a MA on 05/18/22 at the evening shift on 04/29/22 implained of chest lty breathing. The oto the emergency room of the took his pain feel better. before the end of her shift | | | | |
| | provider (PCP). Telephone interview v 05/18/22 at 3:20pm re | the resident's primary care with a second MA on | | | | |

Division of Health Service Regulation

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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---|---|-------------------------------|--|
| | | | _ | | R | |
| | | HAL077010 | B. WING | | 05/18/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET I | HOUSE | 632 FREE | MAN MILL ROA | AD | | |
| | | HAMLET, | NC 28345 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE | |
| {D 273} | Continued From page | e 4 | {D 273} | | | |
| {D 273} | the end of her shift (1 times the week of 04/-The resident told her palpitations but said it took his morning med -She checked his vita 04/28/22 and 04/30/2 documented the vital -She faxed a physicia resident's PCP and comorning before she lead -Notifying the PCP and documented in her practice of the property of the | 1:00pm to 7:00am) 2-3 25/22. The was having heart to would go away when he lications. I signs on the night of 2 but she was not sure she signs. In's notification sheet to the alled the RCC early in the eff at 7:00am on 04/28/22. Ind RCC should have been logress note. I into 04/30/22 he "just did e sent him to the hospital. C on 05/18/22 at 12:04pm Resident #2's complaints of eithing, heart palpitations and 4/28/22 and 04/29/22 the ele resident, and he said he ele resident, and he said he ele resident, and he said he ele resident and he said he ele reside | {D 273} | | | |
| | -The resident was exp breath and increased days especially at nig | periencing shortness of arythmias over the past 3 ht. | | | | |
| | breath and fatigue when the was having meals endurance and a feel | s in his room due to low | | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 5 of 34

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | . , | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--|---|-------------------------------|--|
| | | | A. BOILDING. | | R | |
| | | HAL077010 | B. WING | | 05/18/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET I | HOUSE | 632 FREEN HAMLET, N | IAN MILL ROA IC 28345 | .D | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE | |
| {D 273} | 04/29/22 at 3:50pm re- The resident was har breath that on 04/29/2 -He required frequent due to shortness of breath rateHis heart rate increasminute and his blood sat) decreased to 829She reported the heashortness of breath to Second interview with 6:00pm revealed: -She did not know ab 04/28/22 and 04/29/2 -She had not seen the (05/18/22)The PT did not talk to symptoms during his -She did not know the with his breathing and days before he went to Interview with the Adr 6:10pm revealed: -He remembered see with the PT on 04/29/2 -Neither the PT nor st resident's complaints chest discomfort. | 2's PT visit note dated evealed: ving increased shortness of 22. rest periods during therapy reath and rapid increase in sed to 137 to 144 beats per oxygen saturation level (O2 %. art rate, O2 sat and o the RCC and MA on duty. In the RCC on 05/18/22 at out the PT visit notes dated 2. In notes before today In the rabout Resident #2's therapy on 04/29/22. In resident was having issues at chest discomfort several to the hospital. In ministrator on 05/18/22 at ing Resident #2 working | {D 273} | | | |
| | 05/18/22 at 11:35am | vith Resident #1's PCP on revealed: #2 had issues with anxiety | | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 6 of 34

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|----------------------------|--|-------------------------------|--|
| AND I EAN OF CONNECTION | IDENTIFICATION NOMBER. | A. BUILDING: | | COMI LETED | |
| | HAL077010 | B. WING | | R 05/18/2022 | |
| NAME OF PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET HOUSE | 632 FREEN HAMLET, N | MAN MILL ROA NC 28345 | AD. | | |
| PREFIX (EACH DEFICIENCY MU | MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE | |
| ED 273 Continued From page 6 but did not know he was I -Palpitations were not know history of palpitationsStaff may have contacted they did not call her regard chest discomfort, anxiety, difficulty breathing on 04/ Interview with the Administ 12:48pm revealed: -He was aware of Reside 04/28/22 documented by -Normally staff notified the then let him knowHe was made aware of the documented by staff on 00 reported to him the next reported to him the next reported to the PCP and of progress note by the MA. b. Review of Resident #2 03/09/22 revealed an ord extended release (ER) 24 used to treat atrial fibrillate pressure.) Review of Resident #2's medication administration revealed: -There was an entry for Data 8:00amThere was documentation administered from 04/01/2 on 04/26/22Doses of Diltiazem on 04/04/25/22, 04/27/22, 04/28/24 documented on holdOn 04/30/22 the Diltiazem | d her on-call office but riding Resident #2 having palpitations and /28/22 and 04/29/22. strator on 05/18/22 at ent #2's complaints on staff. e RCC and the RCC enteresident's complaints 04/29/22; he thought staff morning (04/30/22). oreathing, chest enteresident in a enteresident | {D 273} | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 7 of 34

| DIVISION | n nealth Service Regu | ialiuii | | | | |
|------------|--|---------------------------------------|----------------------------|---|------------------|------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLE | TED |
| | | | | | | |
| | | | | | R | |
| | | HAL077010 | B. WING | | 05/1 | 8/2022 |
| NAME OF D | ROVIDER OR SUPPLIER | STREET AP | DRESS, CITY, STA | TE ZID CODE | | |
| TWANE OF T | NOVIDER OR OUT FIER | | , , | , | | |
| HAMLET I | HOUSE | | MAN MILL ROA | AD. | | |
| | | HAMLET, | NC 28345 | | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | N | (X5) |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | | COMPLETE DATE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | RIATE | DATE |
| | | | | 22.10.2.10.7 | | |
| {D 273} | Continued From page | e 7 | {D 273} | | | |
| , , | . • | | ` ′ | | | |
| | because the resident | was hospitalized. | | | | |
| | | | | | | |
| | Interview with a medic | | | | | |
| | 05/18/22 at 10:44am | | | | | |
| | -She did not remembe | er why Resident #2's | | | | |
| | Diltiazem was held wh | hen she administered his | | | | |
| | morning medications | on 04/23/22 and 04/24/22. | | | | |
| | -She did not want to d | document the medication | | | | |
| | was refused when it v | vas not available from the | | | | |
| | pharmacy, so she doo | cumented the medication | | | | |
| | • | nedication was not in the | | | | |
| | building. | | | | | |
| | • | vas placed on hold, she | | | | |
| | contacted the pharma | | | | | |
| | | illed the pharmacy about | | | | |
| | Resident #2's Diltiaze | · · · · · · · · · · · · · · · · · · · | | | | |
| | remember what was s | | | | | |
| | | en an issue with the order. | | | | |
| | -She usually contacte | | | | | |
| | | ss note and reported to the | | | | |
| | RCC when a medicat | · | | | | |
| | | | | | | |
| | -The RCC usually cor | | | | | |
| | primary care provider -She did not see whe | | | | | |
| | | | | | | |
| | 1 0 | resident's electronic record | | | | |
| | for 04/23/22 or 04/24/ | 22. | | | | |
| | D | Ol- A 0000 -1 | | | | |
| | | 2's April 2022 electronic | | | | |
| | progress notes reveal | | | | | |
| | | n 04/05/22 at 8:47am, | | | | |
| | | and 04/26/22 at 2:25pm that | | | | |
| | cart audits had been o | • | | | | |
| | | nentation the resident was | | | | |
| | | n as a result of the audit. | | | | |
| | | entation the pharmacy | | | | |
| | and/or the resident's I | PCP were notified about | | | | |
| | Diltiazem. | | | | | |
| | | | | | | |
| | Telephone interview w | with Resident #1's PCP on | | | | |

Division of Health Service Regulation

05/18/22 at 11:35am revealed:

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| DIVISION | i Health Service Regu | | 1 | | | |
|-------------------|---------------------------|--|------------------|--|-------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLE | = IED |
| | | | | | R | , |
| | | HAL077010 | B. WING | | 1 | 8/2022 |
| | | HALOTTOTO | | | 05/1 | 0/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, STA | TE, ZIP CODE | | |
| | | 632 FREE | MAN MILL ROA | AD. | | |
| HAMLET I | HOUSE | HAMLET, | NC 28345 | | | |
| | OLIMANA DV OT | · | | DDO///DEDIO DI ANI OF CODDECTION | | |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| TAG | • | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPE | | DATE |
| | | | | DEFICIENCY) | | |
| (D 073) | 0 | - 0 | (D 272) | | | |
| {D 273} | Continued From page | 8 8 | {D 273} | | | |
| | -She knew the reside | nt needed refill orders for his | | | | |
| | Diltiazem, but she did | I not know he was out of the | | | | |
| | | 3/22 to 04/29/22 until he | | | | |
| | went to the hospital (0 | 04/30/22). | | | | |
| | | tiazem for atrial fibrillation | | | | |
| | and not taking the Dil | tiazem could increase his | | | | |
| | heart rate. | | | | | |
| | | ssing 7 days of Diltiazem | | | | |
| | caused the resident to | | | | | |
| | | tal for CHF and the rapid | | | | |
| | atrial fibrillation was a | | | | | |
| | atrial librillation was a | result of the Orn . | | | | |
| | Interview with the RC | C on 05/18/22 at 12:04pm | | | | |
| | revealed: | o on oo, 10,22 at 1210 .p | | | | |
| | | ner know Resident #2 was | | | | |
| | out of Diltiazem, she | found out while the resident | | | | |
| | was hospitalized. | | | | | |
| | - | that he was out of the | | | | |
| | | turned from the hospital | | | | |
| | (05/04/22). | • | | | | |
| | , | not received in the facility | | | | |
| | | s were supposed to notify | | | | |
| | her and she contacted | | | | | |
| | resident's PCP. | , | | | | |
| | | not included in the multidose | | | | |
| | | notified the pharmacy that | | | | |
| | | tion was not received within | | | | |
| | 1 day, the MA was su | | | | | |
| | r day, and mir mad da | ppeccu to mainy men. | | | | |
| | Interview with the Adr | ministrator on 05/18/22 at | | | | |
| | 12:48pm revealed: | | | | | |
| | • | esident #2 was out of | | | | |
| | | ore the resident returned | | | | |
| | from the hospital (05/ | | | | | |
| | • • • | to call the pharmacy and | | | | |
| | | sident's medications ran out. | | | | |
| | • | to document the contact | | | | |
| | | d the PCP in the progress | | | | |
| | notes. | a ale i di ili ale pieglese | | | | |
| | 110100. | | 1 | | | |

Division of Health Service Regulation

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PRINTED: 03/06/2023 FORM APPROVED

Division of Health Service Regulation

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--|--|-------------------------------|--|
| | | | 71. BOILBING. | | R | |
| | | HAL077010 | B. WING | | 05/18/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET I | HOUSE | 632 FREEN HAMLET, N | MAN MILL ROA NC 28345 | AD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE | |
| {D 273} | 2. Review of Residen 03/17/22 revealed: -Diagnoses included ineuropathyOrdered medications mg once a day, cyclo and sodium chloride (pioglitazone was use cyclobenzaprine was sodium chloride was experience of the cyclobenzaprine was refused of the cyclobenzaprine was refused by Resido 03/21, 03/22, 03/23, 03/28, 03/29, 03/24, 03/25, 03/26, 03/24, 03/25, 03/26, 03/27, 03/28, 03/29, 03/29, 03 | t #1's current FL-2 dated Type 2 diabetes and s included pioglitazone 45 benzaprine 5 mg at bedtime, 1 gm twice a day ed to control diabetes, used for pain control, and used for electrolytes). 1's March 2022 Medication d (eMAR) revealed: one 45 mg once a day was ed by Resident #1 on 03/20, 03/24, 03/25, 03/26, 03/27, and 03/31. nzaprine 5 mg at bedtime lent #1 on 03/22, 03/23, 03/27, 03/28, 03/29, 03/30, chloride 1 gm twice a day refused by Resident #1 on 03/23, 03/24, 03/25, 03/26, 03/30, and 03/31. 1's April 2022 eMAR one 45 mg once a day was ed by Resident #1 on 04/01, 04/05, 04/06, and 04/07. nzaprine 5 mg at bedtime lent #1 on 04/01, 04/02, and chloride 1 gm twice a day refused by Resident #1 on 04/01, 04/05, 04/06, and 04/07. nzaprine 5 mg at bedtime lent #1 on 04/01, 04/02, and chloride 1 gm twice a day refused by Resident #1 on and 04/04. | {D 273} | | | |
| | Review of Resident # progress notes did no | 1's March-May 2022 of reveal any documentation | | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 10 of 34

| DIVISION | n Health Service Negu | ialion | | | | |
|------------|-------------------------|-------------------------------|------------------|---|--------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SI | |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLE | ETED |
| | | | | | _ | |
| | | | B. WING | | R | |
| | | HAL077010 | D. WING | | 05/1 | 8/2022 |
| NAME OF PE | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE ZIP CODE | | |
| | | | | | | |
| HAMLET I | HOUSE | | MAN MILL ROA | ND | | |
| | | HAMLET, | NC 28345 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | ı | (X5) |
| PREFIX | , | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | | COMPLETE DATE |
| TAG | REGULATORT OR L | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | JAIL | DAIL |
| | | | | , | | |
| {D 273} | Continued From page | e 10 | {D 273} | | | |
| | | | | | | |
| | | ysician of Resident #1's | | | | |
| | refusals. | | | | | |
| | | | | | | |
| | Interview with a medic | | | | | |
| | 05/18/22 at 2:54pm re | evealed: | | | | |
| | -Resident #1 does no | t usually refuse her | | | | |
| | medications. | | | | | |
| | -The physician should | d have been notified of | | | | |
| | Resident #1's refusals | s after the third consecutive | | | | |
| | refusal. | | | | | |
| | -She had not notified | the physician of the | | | | |
| | refusals. | . , | | | | |
| | -Physician notification | n of refusals should be | | | | |
| | documented in the pr | | | | | |
| | | ny documentation that the | | | | |
| | | otified of Resident #1's | | | | |
| | refusals. | | | | | |
| | | y the physician had not | | | | |
| | been notified. | iy the physician had not | | | | |
| | been nouned. | | | | | |
| | Interview with a secon | ad NAA am 05/40/22 at | | | | |
| | | nd MA 011 05/16/22 at | | | | |
| | 3:08pm revealed: | | | | | |
| | | d have been notified of | | | | |
| | | t refused medications for 3 | | | | |
| | consecutive days. | | | | | |
| | | ation should have been | | | | |
| | documented in the pro- | ogress notes. | | | | |
| | | | | | | |
| | | nt #1 on 05/18/22 at 3:35pm | | | | |
| | | remember refusing those | | | | |
| | medications. | | | | | |
| | | | | | | |
| | | nt #1's primary care provider | | | | |
| | (PCP) on 05/18/22 at | 4:35pm revealed: | | | | |
| | | Resident #1 had refused her | | | | |
| | medications. | | | | | ļ |
| | -Resident #1 had diffi | culty controlling her blood | | | | |
| | | ded the pioglitazone for her | | | | |
| | " · · · | [3 | | | | |

Division of Health Service Regulation

-Resident #1 used the cyclobenzaprine for pain

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PRINTED: 03/06/2023 FORM APPROVED

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|--|---------------|-------------------------|
| | | | A. BUILDING: _ | A. BUILDING: | | |
| | | HAL077010 | B. WING | | R 05/18/20 |)22 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET I | HOUSE | 632 FREEN HAMLET, N | MAN MILL ROA | ND . | | |
| (V4) ID | SLIMMARY ST | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTION | J | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE CC | (X5) OMPLETE DATE |
| {D 273} | Continued From page | e 11 | {D 273} | | | |
| (= = - v) | control and she was elevels for possibly dis-Resident #1 needed supplement and that have increased conful. Interview with the Res (RCC) on 05/18/22 at -She was not aware or refusals. -There were no progribeen notified. | evaluating the resident's pain continuing the medication. the sodium chloride as a without it, Resident #1 could asion and muscle spasms. sident Care Coordinator to 5:54pm revealed: of Resident #1's medication ress notes that the PCP had motified after the third time a | | | | |
| | Interview with the Administrator on 05/18/22 at 5:57pm revealed the MAs should notify the RCC and the PCP when a resident refused their medications. | | | | | |
| | not being available fo #2. The facility's failur for 4 days treatment of day delay in notifying shortness of breath a coinciding with 7 days treat heart dysrhythm PCP was not notified. | in condition and medications or administration for Resident re resulted in hospitalization of heart failure following a 2 the PCP of increased nd heart palpitations is without a medication to itas (Diltiazem) for which the itas failure resulted in itas physical harm and | | | | |
| | The facility provided a accordance with G.S. this violation. | a plan of protection in . 131D-34 on 05/18/22 for | | | | |
| {D 358} | 10A NCAC 13F .1004 Administration | l(a) Medication | {D 358} | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 12 of 34

PRINTED: 03/06/2023 FORM APPROVED

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--------------------------|---|------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED |
| | | HAL077010 | B. WING | | R 05/18/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | |
| HAMLET | HOUSE | 632 FREEN HAMLET, N | IAN MILL ROA IC 28345 | D | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE |
| {D 358} | Continued From page | e 12 | {D 358} | | |
| | 10A NCAC 13F .1004 (a) An adult care hor preparation and admi prescription and non-by staff are in accorda (1) orders by a licens which are maintained (2) rules in this Section and procedures. This Rule is not met TYPE A2 VIOLATION Based on observation reviews, the facility fawere administered as practitioner for 4 of 5 #3 and #5) including a arythmias (#2), medic medication for chest prescription and some contents of the section of th | Medication Administration ne shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by: Ins, interviews and record illed to ensure medications ordered by the prescribing sampled residents (#1, #2, medications for cardiac cation for diabetes (#1), a pain (#5); and medications repertension, an antiviral | | | |
| | The findings are: | | | | |
| | 05/04/22 revealed: -Diagnoses included with rapid ventricular chronic obstructive puand congestive heart -An order for Diltiazer | m extended release (ER) m is used to atrial fibrillation | | | |
| | | 2's previous FL-2 dated d order for Diltiazem ER | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 13 of 34

| DIVISION | or rieditii Service Regu | | 1 | | 1 | |
|-------------------|--------------------------|------------------------------|------------------|---------------------------------|--------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SU | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLE | IED |
| | | | | | R | |
| | | HAL077010 | B. WING | | 1 | 3/2022 |
| | | TIALUTTO TO | | | 03/10 | 5/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, STA | TE, ZIP CODE | | |
| | | 632 FREE | MAN MILL ROA | AD | | |
| HAMLET | HOUSE | HAMLET, | NC 28345 | | | |
| (VA) ID | SLIMMARY ST | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTION | N. | (VE) |
| (X4) ID PREFIX | | Y MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPE | RIATE | DATE |
| | | | | DEFICIENCY) | | |
| {D 358} | Continued From page | . 12 | {D 358} | | | |
| (D 000) | Continued From page | . 13 | [[D 000] | | | |
| | Interview with Reside | nt #2 on 05/17/22 at 9:53am | | | | |
| | revealed: | | | | | |
| | -He ran out of a medi | cation for his heart for 4 | | | | |
| | days. | | | | | |
| | -A "real bad thing hap | ppened," he went to the | | | | |
| | hospital for a week. | | | | | |
| | -He was still recovering | ng because he had multiple | | | | |
| | chronic health conditi | ons including CHF, a heart | | | | |
| | valve problem, lupus | and osteoarthritis. | | | | |
| | -He found out from th | e emergency medical | | | | |
| | technicians (EMTs) th | at he was not getting his | | | | |
| | heart medication. | | | | | |
| | | | | | | |
| | Review of Resident # | 2's hospital cardiology | | | | |
| | consult note dated 04 | /30/22 revealed: | | | | |
| | -The resident's initial | heart rate was in the 140s. | | | | |
| | -He had not received | his Diltiazem for 3-4 days. | | | | |
| | -The resident was giv | en 2 intravenous doses of | | | | |
| | Diltiazem before resta | arting oral doses. | | | | |
| | | | | | | |
| | | 2's hospital discharge | | | | |
| | summary dated 05/04 | 1/22 revealed: | | | | |
| | | ted to the ED on 04/30/22 | | | | |
| | complaining of heart | palpitations and had run out | | | | |
| | of his Diltiazem 2 day | s prior to admission to the | | | | |
| | hospital. | | | | | |
| | -He complained of sh | ortness of breath and was | | | | |
| | found to have a heart | rate of 150 on admission. | | | | |
| | -He was also in CHF | with an ejection fraction of | | | | |
| | | f blood pumped from the | | | | |
| | | ss test (measures the | | | | |
| | | nd to stress) and 40% on | | | | |
| | echocardiogram (ultra | | | | | |
| | | erican Heart Association | | | | |
| | normal ejection fraction | on is 50-75%.) | | | | |
| | | | | | | |
| | | 2's March 2022 electronic | | | | |
| | medication administra | ation record (eMAR) | | | | |
| | revealed: | | | | | |
| | -There was an entry f | or Diltiazem ER 240mg daily | | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 14 of 34

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|--|---------------------|---|-------------------------------|
| | | | B. WING | | R |
| | | HAL077010 | B. WING | | 05/18/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | RESS, CITY, STA | | |
| HAMLET HOUSE | | | MAN MILL ROA | .D | |
| | OLUMBA DV OT | HAMLET, N | | | . |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE |
| {D 358} | Continued From page | e 14 | {D 358} | | |
| | | tation Diltiazem was /16/22 through 03/31/22. ad or refused doses of | | | |
| | Review of Resident #2's April 2022 eMAR revealed: -There was an entry for Diltiazem ER 240mg daily at 8:00am. -There was documentation Diltiazem was administered from 04/01/22 through 04/22/22 and on 04/26/22. -Doses of Diltiazem on 04/23/22, 04/24/22, 04/25/22, 04/27/22, 04/28/22 and 04/29/22 were documented on hold. -On 04/30/22 the Diltiazem was not administered because the resident was hospitalized. Review of Resident #2's May 2022 eMAR revealed: | | | | |
| | | | | | |
| | daily at 8:00am. -From 05/01/22 throu documentation Diltiaz due to hospitalization | es for Diltiazem ER 240mg gh 05/04/22 there was em was not administered . azem was documented on | | | |
| | progress notes revea -There were entries of 04/12/22 at 9:16am, a cart audits had been -There was no docum low or out of Diltiazen -There was no docum | n 04/05/22 at 8:47am, and 04/26/22 at 2:25pm that completed. hentation the resident was as a result of the audit. hentation the pharmacy or care provider (PCP) were | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 15 of 34

| DIVISION | n Health Service Negu | ialion | | | | |
|---------------|---|---|------------------|--|--------------|------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SU | IRVEY |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLE | TED |
| | | | | | 1 _ | |
| | | | B WING | | R | |
| | | HAL077010 | B. WING | | 05/18 | 3/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE. ZIP CODE | | |
| | | 632 EDEE | MAN MILL ROA | ND. | | |
| HAMLET I | HOUSE | HAMLET, | | | | |
| | | HAMILE I, | NC 20345 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | | COMPLETE DATE |
| ind | | , | IAG | DEFICIENCY) | | |
| | | | | | + | |
| {D 358} | Continued From page | e 15 | {D 358} | | | |
| | Interview with a medic | cation aide (MA) on | | | | |
| | 05/18/22 at 10:33am | , , | | | | |
| | | vere not available from the | | | | |
| | | ked a hold request order to | | | | |
| | | ider (PCP) or the Resident | | | | |
| | | CC) emailed the PCP the | | | | |
| | same day. | oo) challed the For the | | | | |
| | | ns were automatically filled | | | | |
| | on monthly cycle fills. | | | | | |
| | | own to 10 remaining doses, | | | | |
| | • | ned a refill request to the | | | | |
| | | ned a reilli request to the | | | | |
| | pharmacy. | ons were not available | | | | |
| | | | | | | |
| | | cy was late in delivering | | | | |
| | medications. | | | | | |
| | -She did not remember | - | | | | |
| | | d when she administered his | | | | |
| | morning medications | | | | | |
| | | nber if the Diltiazem was not | | | | |
| | available from the pha | armacy on 04/28/22. | | | | |
| | latamiaitha a acces | ad MA an OF/40/22 at | | | | |
| | Interview with a secon | nd MA on 05/18/22 at | | | | |
| | 10:44am revealed: | an why Danidant #01a | | | | |
| | -She did not remember | • | | | | |
| | | hen she administered his | | | | |
| | • | on 04/23/22 and 04/24/22. | | | | |
| | | document the medication | | | | |
| | , | documented the medication | | | | |
| | | nedication was not in the | | | | |
| | building. | | | | | |
| | When a medication vector contacted the pharma | vas placed on hold, she acy. | | | | |
| | | illed the pharmacy about | | | | |
| | Resident #2's Diltiaze | • | | | | |
| | remember what was | | | | | |
| | | en an issue with the order. | | | | |
| | -She usually contacte | | | | | |
| | | ss note and reported to the | | | | |
| | RCC when a medicat | | | | | |

Division of Health Service Regulation

-She did not document a progress note on the

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| | n rieaitii Service Regu | | 1 | | Т | |
|------------|-------------------------|--|------------------|--|-------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLI | = IED |
| | | | | | R | , |
| | | 1141 077040 | B. WING | | 1 | |
| | | HAL077010 | 3: | | 05/1 | 8/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| | | 632 EDEE | MAN MILL ROA | ND. | | |
| HAMLET I | HOUSE | | | | | |
| | | HAMLEI, | NC 28345 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | | COMPLETE DATE |
| TAG | REGULATORT OR E | ESCIDENTIF TING IN CRIMATION) | TAG | DEFICIENCY) | MAIL | 5,112 |
| | | | | | | |
| {D 358} | Continued From page | e 16 | {D 358} | | | |
| | | | | | | |
| | resident's electronic r | | | | | |
| | 04/24/22 regarding co | ontact with the pharmacy. | | | | |
| | | | | | | |
| | | with a third MA on 05/18/22 | | | | |
| | at 4:14pm revealed: | | | | | |
| | -She was not sure wh | | | | | |
| | Resident #2's Diltiaze | em. | | | | |
| | -She did not call the p | pharmacy about his | | | | |
| | Diltiazem. | | | | | |
| | -She did not tell the R | RCC the resident's Diltiazem | | | | |
| | was not available from | n the pharmacy. | | | | |
| | -She did not know if a | any other MA had contacted | | | | |
| | the pharmacy or talke | ed to the RCC. | | | | |
| | -There should have b | een a progress note if the | | | | |
| | pharmacy was contac | . • | | | | |
| | - | mented the Diltiazem was on | | | | |
| | - | 04/27/22 but administered | | | | |
| | | she may not have seen it | | | | |
| | on the cart and then o | | | | | |
| | on the sait and then t | and 555 h. | | | | |
| | Second interview with | n the first MA on 05/18/22 at | | | | |
| | | documented Resident #2's | | | | |
| | • | n 05/05/22 because she did | | | | |
| | not check the oversto | | | | | |
| | THOU CHECK THE OVERSTO | ock diawer. | | | | |
| | Interview with the PC | C on 05/18/22 at 9:08am | | | | |
| | revealed: | O 011 03/ 10/22 at 9.00a111 | | | | |
| | | acad on hold for various | | | | |
| | | aced on hold for various | | | | |
| | | iting for the medication to | | | | |
| | come from the pharm | | | | | |
| | | ication on hold when the | | | | |
| | | vailable for administration | | | | |
| | | ne PCP to sign an order to | | | | |
| | hold the medication. | | | | | |
| | | 0 05/40/00 15.55 | | | | |
| | | C on 05/18/22 at 9:36am | | | | |
| | | find a signed order from the | | | | |
| | PCP to hold Resident | | | | | |
| | 04/23/22 through 04/2 | 29/22. | | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 17 of 34

| DIVISION | n nealth Service Negu | lation | | | |
|-------------------|------------------------|----------------------------------|------------------|--|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED |
| | | | | | |
| | | 1141.077040 | B. WING | | R |
| | | HAL077010 | J | | 05/18/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, STA | TE, ZIP CODE | |
| | | 632 FREE | MAN MILL ROA | AD. | |
| HAMLET I | HOUSE | HAMLET, | | | |
| 040.15 | CLIMMADY CT | ATEMENT OF DEFICIENCIES | | DROVIDER'S DI AN OF CORRECTION | 1 0/5 |
| (X4) ID PREFIX | | Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | (- / |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | |
| | | | | DEFICIENCY) | |
| {D 358} | Continued From page | e 17 | {D 358} | | |
| ` , | | | ` , | | |
| | - | vith a pharmacist at the | | | |
| | • | harmacy on 05/18/22 at | | | |
| | 11:01am revealed: | | | | |
| | | ew admission to the facility | | | |
| | on 03/15/22. | D'II: | | | |
| | dated 03/15/22. | Diltiazem ER 240mg daily | | | |
| | | the pharmacy not dispense | | | |
| | any Diltiazem for the | | | | |
| | | est Diltiazem for the resident | | | |
| | as needed. | oot Billiazoni for the resident | | | |
| | | nsed 28 tablets of Diltiazem | | | |
| | for Resident #2 on 03 | | | | |
| | | not dispensed all at one | | | |
| | | ements in multidose packs | | | |
| | (MDPs). | · | | | |
| | • | rmacy dispensed 7 tablets | | | |
| | | ole pack and 7 tablets in a | | | |
| | MDP on 05/13/22. | | | | |
| | -MDP were processed | d by the pharmacy weekly. | | | |
| | -The pharmacy conta | cted the facility one week in | | | |
| | advance of needing a | | | | |
| | | l dispense an emergency | | | |
| | supply or a courtesy r | refill for life saving | | | |
| | medications. | | | | |
| | | at happened with Resident | | | |
| | #2's Diltiazem from 04 | | | | |
| | | nsed on 03/25/22 would | | | |
| | | o administer until 04/23/22 | | | |
| | or 04/24/22. | | | | |
| | | en a problem with the | | | |
| | | 2 because she was showing | | | |
| | | orders until 05/04/22. | | | |
| | | nsferred from a sister facility | | | |
| | | nat facility migrated with him | | | |
| | | he facility awaited new | | | |
| | signed orders from th | | | | |
| | | o treat high blood pressure | | | |
| | and cardiac issues ar | nd not taking it could result in | | | |

Division of Health Service Regulation

increased blood pressure.

STATE FORM 6899 G8HF12 If continuation sheet 18 of 34

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE S | |
|---|--|--|---|---|-------------|--------------------------|
| | | | | · | | 2 |
| | | HAL077010 | B. WING | | 05/1 | 8/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET | HOUSE | 632 FREE | MAN MILL ROA | AD. | | |
| TIANILLI | | HAMLET, I | NC 28345 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {D 358} | Continued From page | ÷ 18 | {D 358} | | | |
| | revealed: -The MAs did not let hout of Diltiazem, she four was hospitalizedShe completed a me found his Diltiazem in She did not remember medication cart audit has were responsible medications when the last row of a bubber of medications were rewithin 2 days, the MA herMDPs were automatified a medication was not rewas supposed to notified the pharm medication was not rewas supposed to notified the pharm medication was not rewas supposed to notified the pharm medication was not rewas supposed to notified the pharm medication was not rewas supposed to notified the pharm medication was not rewas supposed to notified the pharm medication was not rewas supposed to notified. Interview with the Adr 12:48pm revealed: -He became aware Roulitiazem the day before the hospital (05%)-The problem was best thoroughly check the DiltiazemHe did not know there hold the resident's Dil Refer to telephone introduced in the side (MA) on 05/18/22. Refer to telephone introduced in the side (MA) on 05/18/22. | and found the Diltiazem. le for re-ordering e medications were down to le pack. not received in the facility s were supposed to notify cally cycle filled each week. not included in the MDP, the nacy that day and if the eceived within 1 day, the MA fy her. ninistrator on 05/18/22 at esident #2 was out of ore the resident returned 03/22). cause the MA did not overstock drawer for the e was no signed order to tiazem. erview with a medication | | | | |

Division of Health Service Regulation

Refer to interview with the Administrator on

STATE FORM 6899 G8HF12 If continuation sheet 19 of 34

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------|---|-------------------------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | A. BUILDING: | |
| | | | | | R |
| | | HAL077010 | B. WING | | 05/18/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | ORESS, CITY, STA | TE, ZIP CODE | |
| LAMIET | HOUSE | 632 FREE | MAN MILL ROA | AD | |
| HAMLET HOUSE HAMLET, | | | NC 28345 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE |
| {D 358} | Continued From page | e 19 | {D 358} | | |
| | 05/18/22 at 12:48pm. | | | | |
| | | h the Administrator on | | | |
| | 03/09/22 revealed dia | t #3's current FL-2 dated agnoses included depressive disorder and | | | |
| | Review of Resident #3's April 2022 electronic progress notes revealed: -There were entries on 04/14/22 at 8:39am, 04/21/22 at 5:30pm, and 04/28/22 at 10:30pm that cart audits had been completed. -There was no documentation the resident was low or out of any medications as a result of the audit. -There was no documentation the pharmacy and/or the resident's primary care provider (PCP) were notified about medications that were not available from the pharmacy. | | | | |
| | progress notes revea -There was an entry of cart audit had been of the cart audit had been of the cart audit had been of the cart audit of any mediauditThere was no docum and/or the resident's were notified about may available from the phase. a. Review of Residen 03/09/22 revealed an | on 05/05/22 at 9:56pm that a completed. nentation the resident was lications as a result of the nentation the pharmacy primary care provider (PCP) nedications that were not | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 20 of 34

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | . , | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---|---|-------------------------------|--|
| | | | A. BUILDING | A. BUILDING. | | |
| | | HAL077010 | B. WING | | R 05/18/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET | HOUSE | 632 FREEN HAMLET, N | IAN MILL ROA IC 28345 | .D | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE | |
| {D 358} | Continued From page | 20 | {D 358} | | | |
| | | 3's physician's order review led an order for sertraline | | | | |
| | (RCC) on 05/18/22 at | sident Care Coordinator : 3:46pm revealed there or Resident #3's sertraline. | | | | |
| | Review of Resident #3's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for sertraline 25mg daily at 8:00am starting 03/15/22There was documentation sertraline was | | | | | |
| | administered from 03/ except 03/22/22. -There documentation sertraline on 03/22/22 | | | | | |
| | Review of Resident #3's April 2022 eMAR revealed: -There was an entry for sertraline 25ng daily at 8:00amThere was documentation sertraline was administered from 04/01/22 through 04/18/22 and 04/20/22 through 04/26/22Sertraline on 04/19/22 and 04/27/22 through 04/30/22 were documented as on hold. | | | | | |
| | 8:00amThere was document administered from 05, -There was document on 05/01/22 and 05/0 Telephone interview v | for sertraline 25mg daily at tation sertraline was /03/22 through 05/17/22. tation sertraline was on hold | | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 21 of 34

| ` ' | PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SI COMPLE | |
|---|---|------------------------|---|------------------------|--------------------------|
| | | A. BOILDING. | | R | |
| | HAL077010 | B. WING | | 1 | 8/2022 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDR | RESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET HOUSE | 632 FREEM HAMLET, N | AN MILL ROA C 28345 | D | | |
| PREFIX (EACH DEFICIENCY MUST | ENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| 4:47pm revealed: -The pharmacy dispensed 03/25/22 for Resident #3 w until 04/11/22The pharmacy did not hav additional sertraline tablets 03/25/22 and 05/06/22 who up on the multidose packs -The pharmacy dispensed in a bubble pack on 05/13/2 missing from the MDPs on Interview with the RCC on revealed: -She did not know Resident sertraline in April and May -The MAs should have let the 3 days of the medication not the pharmacy because she the issue with a phone call b. Review of Resident #3's 03/09/22 revealed an order 20mEq daily. (Potassium or replace low levels of potassi Review of Resident #3's photography daily. Interview with the Resident (RCC) on 05/18/22 at 3:46 were no hold orders for Rechloride. Review of Resident #3's M medication administration in revealed: -There was an entry for potatomEq daily at 7:30 am sta | which would have lasted we bill dates of s dispensed between en the resident was set (MDPs). 7 tablets of sertraline /22 because it was 1 05/06/22. 05/18/22 at 5:35pm Int #3 was out of 2022. her know at least after 1 to the pharmacy. Is current FL-2 dated 1 to the pharmacy. Is current FL-2 dated 1 to fro potassium chloride 1 chloride is used to 1 sium in the blood.) hysician's order review In order for potassium It Care Coordinator Improveded there 1 to the pharmacy It Care Coordinator Improveded there 1 to the pharmacy It Care Coordinator Improveded there 1 to the pharmacy It Care Coordinator Improveded there It care Coordinator | {D 358} | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 22 of 34

| | or riealth Service Regu | | | | T | |
|---------------|-------------------------|--|------------------|--|-------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED | |
| | | | 1 | | F | , |
| | | HAL077010 | B. WING | | 1 | 8/2022 |
| | | I HALUTTUIU | | | 1 05/1 | 0/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| | | 632 FREE | MAN MILL ROA | AD. | | |
| HAMLET I | HOUSE | | NC 28345 | - | | |
| | | <u>_</u> | 110 20040 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| PREFIX TAG | | SC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPR | | DATE |
| 1710 | | , | 1,710 | DEFICIENCY) | | |
| | | | + | | | |
| {D 358} | Continued From page | 22 | {D 358} | | | |
| | -There was document | tation potassium chloride | | | | |
| | was administered from | | | | | |
| | | | | | | |
| | 03/31/22 except 03/22 | | | | | |
| | -There documentation | | | | | |
| | potassium chloride or | า 03/22/22. | | | | |
| | | | | | | |
| | Review of Resident # | 3's April 2022 eMAR | | | | |
| | revealed: | | | | | |
| | -There was an entry f | or potassium chloride | | | | |
| | 20mEq daily at 7:30a | m. | | | | |
| | · | tation potassium chloride | | | | |
| | was administered from | | | | | |
| | 04/18/22 and 04/20/2 | <u> </u> | | | | |
| | -Potassium chloride o | • | | | | |
| | | | | | | |
| | through 04/30/22 wer | e documented as on hold. | | | | |
| | D : (D :1 | 01 14 0000 1445 | | | | |
| | Review of Resident # | 3's May 2022 eMAR | | | | |
| | revealed: | | | | | |
| | | for potassium chloride | | | | |
| | 20mEq daily at 7:30a | m. | | | | |
| | -There was document | tation potassium chloride | | | | |
| | was administered from | m 05/03/22 through | | | | |
| | 05/17/22. | - | | | | |
| | -There was document | tation potassium chloride | | | | |
| | was on hold on 05/01 | | | | | |
| | . ,,,, | | | | | |
| | Telephone interview v | vith a pharmacist at the | | | | |
| | | narmacy on 05/18/22 at | | | | |
| | 4:47pm revealed: | .aaoy 511 50/ 10/22 at | | | | |
| | • | need 7 notaceium obleride | | | | |
| | | nsed 7 potassium chloride | | | | |
| | tablets on 03/15/22 fo | n resident #3 and Z1 | | | | |
| | tablets on 03/25/22. | | | | | |
| | | of additional dispenses of | | | | |
| | potassium chloride fo | r the resident. | | | | |
| | | | | | | |
| | | vith Resident #3's PCP on | | | | |
| | 05/18/22 at 3:10pm re | evealed she was not | | | | |
| | concerned with Resid | lent #3 missing doses of | | | | |
| | | 04/19/22 04/23/22 through | | | | |

Division of Health Service Regulation

04/30/22, 05/01/22 and 05/02/22.

STATE FORM 6899 G8HF12 If continuation sheet 23 of 34

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE S COMPLI | |
|--------------------------|---|---|---------------------|--|-----------------------|--------------------------|
| | | | 7 20.25 | | R | } |
| | | HAL077010 | B. WING | | 1 | 8/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET | HOUSE | | MAN MILL ROA | AD | | |
| | T | HAMLET, I | NC 28345 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {D 358} | Continued From page | ⊋23 | {D 358} | | | |
| | revealed: -She did not know Repotassium chloride or 04/30/22, 05/01/22 ar -The MAs should hav 3 days of the medicate the pharmacy because the issue with a phone. C. Review of Residen 03/09/22 revealed and aily. (Atripla is used Review of Resident # dated 04/27/22 revealed tablet daily. Interview with the Resident are the companient of the companient | in 04/19/22, 04/23/22 through and 05/02/22. The let her know at least after tion not being available from see she could have resolved to call to the pharmacy. It #3's current FL-2 dated to order for Atripla 1 tablet to treat viral infections.) It is physician's order review alled an order for Atripla 1 It is ident Care Coordinator to 3:46pm revealed there for Resident #3's Atripla. It is is March 2022 electronic action record (eMAR) If or Atripla 1 tablet daily at 7/22. Itation Atripla was 1/17/22 through 03/31/22. It is is April 2022 eMAR If or Atripla 1 tablet daily at 7/32 is April 2022 eMAR If or Atripla 1 tablet daily at 7/32 is April 2022 eMAR If or Atripla 1 tablet daily at 7/32 is April 2022 eMAR | | | | |

Division of Health Service Regulation

04/21/22, 04/22/22, 04/27/22 and on 04/28/22.

STATE FORM 6899 G8HF12 If continuation sheet 24 of 34

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|--------------------------|--|----------|--------------------------|
| ANDILAN | or Connection | IDENTIFICATION NOWIBER. | A. BUILDING: | | OOWII EE | ILD |
| | | HAL077010 | B. WING | B. WING | | 3/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET I | HOUSE | 632 FREE HAMLET, | MAN MILL ROA NC 28345 | AD | | |
| 0/0.15 | SLIMMADV ST | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTIO | N | 0/5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {D 358} | Continued From page | 24 | {D 358} | | | |
| | -Doses of Atripla on 04/19/22, 04/20/22, 04/23/22, 04/24/22, 04/25/22, 04/26/22 and 04/29/22 were documented on hold. -There was documentation Atripla was not administered on 04/01/22 and 04/02/22 because the resident refused. Review of Resident #3's May 2022 eMAR revealed: -There was an entry for Atripla 1 tablet daily at 8:00am. -There was documentation Atripla was administered from 05/01/22 through 05/17/22. -There were no missed or refused doses of Atripla documented. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/18/22 at 4:47pm revealed the pharmacy dispensed 30 Atripla tablets on 03/11/22 at Resident #3's previous facility and 30 tablets on 05/01/22. Telephone interview with Resident #3's PCP on 05/18/22 at 3:10pm revealed: -She was concerned about the resident missing doses of Atripla which was why she ordered a viral load which was still undetectable. -Missing doses of Atripla could cause an increased viral load in the blood. Interview with the RCC on 05/18/22 at 5:35pm revealed: -She did not know Resident #3 was out of Atripla in April 2022. -The MAs should have let her know at least after 3 days of the medication not being available from the pharmacy because she could have resolved the issue with a phone call to the pharmacy. | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | d. Review of Residen | t #2's physician order dated | | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 25 of 34

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE | (X3) DATE SURVEY | | |
|---|--|--|---------------------|---|------------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: _ | | COMPLETED | |
| | | HAL077010 | B. WING | | R 05/18/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE. ZIP CODE | |
| | | | MAN MILL ROA | | |
| HAMLET | HOUSE | HAMLET, N | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE |
| {D 358} | Continued From page | ÷ 25 | {D 358} | | |
| | 03/30/22 revealed an order for Exforge 1 tablet daily. (Exforge is used to treat high blood pressure.) | | | | |
| | Review of Resident #3's physician's order review dated 04/27/22 revealed an order for Exforge 1 tablet daily. | | | | |
| | Interview with the Resident Care Coordinator (RCC) on 05/18/22 at 3:46pm revealed there were no hold orders for Resident #3's Exforge. | | | | |
| | medication administrate revealed: | | | | |
| | -There was an entry f 8:00am starting 03/30 -There were no doses | | | | |
| | administeredOn 03/31/22 there was Exforge was disconting | as documentation the nued. | | | |
| | Review of Resident # revealed: | 3's April 2022 eMAR | | | |
| | 8:00am. | for Exforge 1 tablet daily at | | | |
| | 04/22/22 through 04/3 | /04/22 through 04/18/22 and 30/22. | | | |
| | | tation Exforge was not 1/22 through 04/02/22 refused. | | | |
| | facility's contracted pt 4:47pm revealed the tablets of Exforge on | vith a pharmacist at the narmacy on 05/18/22 at pharmacy dispensed 8 03/30/22, 7 tablets on ets on 04/22/22 for Resident | | | |

Division of Health Service Regulation

STATE FORM 6899 G8HF12 If continuation sheet 26 of 34

| DIVISION | n nealth Service Regu | ialion | | | | |
|---|--------------------------|--|-----------------|--|-----------|------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | |
| | | | | | | |
| | | | | | R | |
| | | HAL077010 | B. WING | | 05/18 | 3/2022 |
| | | | • | | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| | | 632 FREEN | MAN MILL ROA | AD. | | |
| HAMLET I | HOUSE | HAMLET, N | IC 28345 | | | |
| | OLIMANA DV OT | · | | PROVIDENIA DI ANI CE CORRECTION | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) | | (X5) COMPLETE |
| PREFIX TAG | | LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPR | | DATE |
| IAG | | , | IAG | DEFICIENCY) | | |
| | | | | | | |
| {D 358} | Continued From page | e 26 | {D 358} | | | |
| | . • | | | | | |
| | - | vith Resident #3's PCP on | | | | |
| | 05/18/22 at 3:10pm re | evealed Resident #3 missing | | | | |
| | doses of Exforge from | n 04/19/22 through 04/21/22 | | | | |
| | was not concerning. | ŭ | | | | |
| | mae net concerning. | | | | | |
| | Interview with the PC | C on 05/18/22 at 5:35pm | | | | |
| | revealed: | O 011 00/ 10/22 at 3.33piii | | | | |
| | | . 1 . 1 . 10 | | | | |
| | -She did not know Re | | | | | |
| | Exforge from 04/19/22 | 2 through 04/21/22. | | | | |
| | -The MAs should hav | e let her know at least after | | | | |
| | 3 days of the medicat | ion not being available from | | | | |
| | - | se she could have resolved | | | | |
| | | e call to the pharmacy. | | | | |
| | the 1990e with a phone | e can to the pharmacy. | | | | |
| | Defer to talenhane int | tonuious with a madication | | | | |
| | = | terview with a medication | | | | |
| | aide (MA) on 05/18/22 | 2 at 4:14pm. | | | | |
| | | | | | | |
| | Refer to telephone int | terview with Resident #1's | | | | |
| | and Resident #3's PC | CP on 05/18/22 at 3:10pm. | | | | |
| | | | | | | |
| | Refer to interview with | h the Administrator on | | | | |
| | 05/18/22 at 12:48pm. | | | | | |
| | 00/10/22 at 12.10pin. | | | | | |
| | Defer to intervious with | h the Administrator on | | | | |
| | | in the Administrator on | | | | |
| | 05/18/22 at 6:10pm. | | | | | |
| | | | | | | |
| | Telephone interview v | vith a medication aide (MA) | | | | |
| | on 05/18/22 at 4:14pr | n revealed: | | | | |
| | -When she noticed a | medication barcode strip | | | | |
| | | om the package, she knew | | | | |
| | | een reordered from the | | | | |
| | pharmacy. | 55136146164 Holli tilo | | | | |
| | | not received offer are day. | | | | |
| | | s not received after one day, | | | | |
| | | nacy and the primary care | | | | |
| | provider (PCP) if a ne | ew order was needed. | | | | |
| | | | | | | |
| | Telephone interview v | vith Resident #1's and | | | | |
| | Resident #3's PCP or | | | | | |
| | revealed. | | | | | |

Division of Health Service Regulation

-The facility was having problems getting

STATE FORM 6899 G8HF12 If continuation sheet 27 of 34

| * * | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---|---|-------------------------------|--|
| | | | _ | | R | |
| HAL077010 | | B. WING | | 05/18/2022 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET I | HOUSE | 632 FREEN | IAN MILL ROA | AD. | | |
| HAWLETT | 1003L | HAMLET, N | IC 28345 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE | |
| {D 358} | Continued From page | 27 | {D 358} | | | |
| {D 330} | medication in a timely pharmacyStaff had made her a issuesShe did not know wh Resident #3 staff had was reportedWhen a medication with pharmacy the staff fair which also constitutedMas were expected notify the PCP if a resident year expected with the pharmacy an notesTypically, when medithe medication on hold the hold orderThere should be som medications were not pharmacy rather than medication was held. Interview with the Adr 6:10pm revealed: -Medication cart audit random residents by similar medication care | ware of "a lot" of medication sich specific medications for reported to her or when it was not available from the ked her a hold order request d notification. ministrator on 05/18/22 at to call the pharmacy and sident's medications ran out. to document the contact d the PCP in the progress ications ran out staff placed d and the PCP signed off on the way for staff to document available from the documenting the ministrator on 05/18/22 at the way for staff to document available from the documenting the | {D 330} | | | |
| | completed quarterly a medicationsHe had a compliance ensure orders were in medications were in the issue causing a | e report that he reviewed to place and residents' | | | | |

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needing re-education on checking the overstock

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | |
|--|---|--|---------------------|--|-------------|
| | | 71. BOILBING. | | R | |
| | | HAL077010 | B. WING | | 05/18/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | |
| HAMLET I | HOUSE | | MAN MILL ROA | AD. | |
| | | <u> </u> | NC 28345 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE |
| {D 358} | Continued From page | e 28 | {D 358} | | |
| | drawer and follow up when needed. | with the pharmacy and RCC | | | |
| | 03/17/22 revealed: | t #1's current FL-2 dated | | | |
| | -Diagnoses included neuropathy. | | | | |
| | -Ordered medications included Trulicity 1.5mg injection once a week on Mondays (Trulicity is used to control diabetes). Review of Resident #1's March 2022 Medication Administration Record (eMAR) revealed an entry | | | | |
| | | | | | |
| | for Trulicity 1.5mg inje | ection once a week on ented as administered on | | | |
| | Review of Resident # revealed: | 1's April 2022 eMAR | | | |
| | -An entry for Trulicity 1.5mg injection once a week on Mondays was documented as administered on 04/04, 04/11, and 04/18. | | | | |
| | -There was document on 04/25. | tation that Trulicity was held | | | |
| | Review of Resident # revealed: | • | | | |
| | -An entry for Trulicity 1.5mg injection once a week on Mondays was documented as administered on 05/09 and 05/16. | | | | |
| | -There was document on 05/02. | tation that Trulicity was held | | | |
| | | 1's March 2022-May 2022 of reveal any documentation n was held. | | | |
| | | s/22 at 2:54pm revealed: es of Trulicity 1.5mg in the | | | |

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facility for Resident #1.

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|----------------------------|---|-------------------------------|--|
| | | | A. BUILDING: _ | | | |
| | | HAL077010 | B. WING | | R 05/18/2022 | |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| HAMLET I | HOUSE | 632 FREE | MAN MILL ROA | ND . | | |
| | | HAMLET, | NC 28345 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE | |
| {D 358} | Continued From page | 29 | {D 358} | | | |
| | -The prescription label on one pen indicated it was one of four pens dispensed on 03/01/22The prescription label on the other pen indicated it was one of three pens dispensed on 03/16/22There were no other injection pens in the facility. Interview with a medication aide (MA) on 05/18/22 at 2:54pm revealed: -Resident #1 was compliant with taking her medicationsShe did not know why the medication was held. Interview with Resident #1 on 05/18/22 at 3:35pm revealed she did not remember not receiving her shot those days. Interview with the Resident Care Coordinator (RCC) on 05/18/22 at 5:54pm revealed: -Trulicity was held on 04/25 and 05/02 because the MA thought there was none availableShe did not realize the medication was kept in the refrigeratorThe pharmacy had dispensed 4 doses on 03/01 and 3 doses on 03/16 and each injection pen was one doseNine doses should have been given since | | | | | |
| | would have run out a | d mean the medication nd been refilled before the | | | | |
| | 05/09 dose could hav | e been given. y the number of doses | | | | |
| | | er of doses on hand, and the | | | | |
| | number of doses documented as administered did not add up to the amount dispensed by the pharmacy. Telephone interview with the facility's contract pharmacist on 05/18/22 at 3:55pm revealed: -Trulicity was used for blood sugar and diabetic controlThe pharmacy had dispensed 4 doses on 03/01 | | | | | |
| | | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|---|------------------------|
| | | A. | | | |
| | | HAL077010 | B. WING | | R 05/18/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, STA | TE, ZIP CODE | |
| HAMLET I | HOUSE | 632 FREE | MAN MILL ROA | ND. | |
| | | HAMLET, | NC 28345 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE |
| {D 358} | Continued From page | e 30 | {D 358} | | |
| | and 3 doses on 03/16 and each injection pen was one doseThere was no refill request from the facility since 03/16/22. | | | | |
| | -The last dose should 04/25/22. | have been given on | | | |
| | -Trulicity was used for blood sugar management and Resident #1 was at risk of high blood sugars and a coma if diabetic medications were missed. Telephone interview with Resident #1's primary care provider on 05/18/22 at 4:35pm revealed Resident #1 took Trulicity for blood sugar management and needed it weekly to avoid having high blood sugars. 4. Review of Resident #5's current FL-2 dated 02/28/22 revealed: -Diagnoses included hypertension, Type 2 diabetes, and chronic obstructive pulmonary disease. -Orders included nitroglycerin 0.4mg one pill under the tongue as needed for chest pain. Observation of Resident #5's medications on hand on 05/18/22 at 2:48 pm revealed no supply of nitroglycerin was available for Resident #5. Interview with a Medication Aide (MA) on 05/18/22 at 2:51pm revealed: -There was no nitroglycerin available for Resident #5. -The medication may have expired and was discarded. -Medications should be reordered 1-3 days before expiration. | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | 05/18/22 at 5:33pm re | sident Care Coordinator on evealed medications should ately so it could be delivered | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE (A. BUILDING: | (X3) DATE SURVEY COMPLETED | | | |
|---|--|--|-------------------------------|--|------------------------|--|
| | | | 7.1. 50.25.1.(6 | | | |
| | | HAL077010 | B. WING | | R 05/18/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, STAT | E, ZIP CODE | | |
| HAMLET | HOUSE | | EMAN MILL ROAL |) | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | Γ, NC 28345 | PROVIDER'S PLAN OF CORRE | CTION (X5) | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE COMPLETE | |
| {D 358} | Continued From page | e 31 | {D 358} | | | |
| | the same day. | | | | | |
| | pharmacist on 05/18/ -There was a current 0.4mg one pill under chest painThe pharmacy had la medication on 10/01/ -The facility had not r -The pharmacy had s facility that had not be care provider on 05/1 | 21. equested it be refilled. eent refill requests to the een addressed. with Resident #5's primary 8/22 at 4:35pm revealed: y her patient for 3 weeks. of him not having | | | | |
| The facility failed to administer medications as ordered by the prescribing practitioner for 4 of 5 residents including Resident #2 who did not receive Diltiazem used to treat cardiac arhythmias for 7 days. The facility's failure to administer Diltiazem as ordered for Resident #2 resulted in the resident being hospitalized for atrial fibrillation with rapid ventricular response (rapid heart rate) and congestive heart failure. This failure resulted in substantial risk of serious harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/18/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 17, 2022. | | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | |
|---|--|---|--|---|-----------|--------------------------|
| | | HAL077010 | B. WING | B. WING | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | . ZIP CODE | | 5/18/2022 |
| | | | EMAN MILL ROAD | , | | |
| HAMLET | HOUSE | HAMLET | , NC 28345 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| {D912} | Continued From page | e 32 | {D912} | | | |
| {D912} | G.S. 131D-21(2) Dec | laration of Residents' Rights | {D912} | | | |
| | Every resident shall h 2. To receive care an adequate, appropriate | ration of Residents' Rights have the following rights: nd services which are e, and in compliance with state laws and rules and | | | | |
| | This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and medication administration. | | | | | |
| | The findings are: | | | | | |
| | reviews, the facility fa care provider (PCP) for (#1 and #2) for compl of breath and heart pa resident not receiving days (#2) and for repo medications for diabe imbalances (#1) [Refe | ions, interviews and record liled to notify the primary for 2 of 5 sampled residents laints of increased shortness alpitations in addition to the la cardiac medication for 7 leated refusals of letes, pain, and electrolyte letes are to Tag 273 10A NCAC Care (Unabated Type A2) | | | | |
| | reviews, the facility fa were administered as practitioner for 4 of 5 #3 and #5) including rarrythmias (#2), medi | ions, interviews and record illed to ensure medications ordered by the prescribing sampled residents (#1, #2, medications for cardiac cation for diabetes (#1), a pain (#5); and medications | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | | X3) DATE SURVEY COMPLETED | | | |
|---|--|--|--------------------------|--|------------------------------|--------------------------|--|--|
| , | | 152.11.11.10.11.10.11.10 | A. BUILDING: | A. BUILDING: | | | | |
| | | HAL077010 | B. WING | | 05/1 | R 8/2022 | | |
| NAME OF PROVIDER OR S | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | |
| HAMLET HOUSE | | | MAN MILL ROA NC 28345 | AD | | | | |
| PREFIX (EAC | CH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE | | |
| for depres medication 358 10A N | n and a sup ICAC 13F . | e 33 //pertension, an antiviral oplement (#3) [Refer to Tag 1004(a) Medication A2 Violation)]. | {D912} | | | | | |

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