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
	HAL077010	A. BUILDING: _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMLET HOUSE	632 FREEMAN MILL ROAD HAMLET, NC 28345

(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 February 25-27, 2025.	D 000	Response to cited deficiencies do not costitute an admission or agreement by the facility of the truth of the facts alleged or the conclusios set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.	
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (MA) who administered medications to residents had the required documentation of the state approved 5-hour and 10-hour or 15-hour medication administration training for adult care homes (Staff B). The findings are: Review of Staff B's personnel record on 02/27/25 revealed: -Staff B was hired on 11/04/22. -Staff B passed the medication aide (MA) examination on 01/24/23. -There was a non-state approved certificate for completion of a 15-hour medication technician manual dated 11/12/22. -There was a medication administration clinical	D 125	Clinical Nurse Consultant (CNC) in-serviced all Med Techs on their annual training for Qualifications of Medication Staff which included the 15-hour medication administration training. Business Office Manager (BOM) completed an audit on all Med Aide files. There will be quarterly audits conducted. Executive Director/ or Designee conducted an audit on the Med Aide files. An audit will be completed monthly to ensure that all Med Aide Staff are in compliance.	3/12/25 3/7/25 3/1/25 3/7/25

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Cassie Beard, D 3-20-25

Reviewed and acknowledged on 03/24/25 by JL

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skills checklist dated 11/18/22.
-There was no state approved certificate of completion for the 5-hour, 10-hour, or 15-hour medication administration training for adult care homes.

Interview with the Business Office Manager (BOM) on 02/27/25 at 11:30am revealed:
-Staff B had been previously hired on 04/25/22 as a personal care aide (PCA) and then left around July 2022.
-Staff B returned as a rehire on 11/04/22 with the understanding that he would complete the requirements to become a MA.
-He completed the MA training and clinical skills checklist on 11/18/22.
-She was not aware that the completed certificate in Staff B's employee file was not acceptable for documentation of the completion of the 5-hour and 10-hour or 15-hour medication administration training for adult care homes.
-She had seen the acceptable form in other employees' files but had never been told that the certificate generated by the facility's training program was not acceptable.
-She thought the Registered Nurse (RN) who completed the training and signed the certificates would know which certificates met the state compliance requirements.
-The RN was no longer employed by the company.
-She was not sure how to contact her.

Interview with the Administrator on 02/27/25 at 12:15pm revealed:
-The BOM completed the personnel file audits.
-She had seen the 15-hour medication administration training certificates in some of the employee files.
-The MAs should have the required 15-hours of

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D 125	Continued From page 2 medication administration training prior to completion of their medication administration clinical skills checklist. -She thought the 15-hour training certificate currently used by the facility met the state requirements because the certificate and training program were implemented by the facility's corporate office. -The Clinical Nurse Consultant (CNC) was a RN who was responsible for completing the 5-hour, 10-hour, and 15-hour medication administration training. -The facility had recently hired a new CNC. -She was not sure if the new CNC had been made aware of the correct state approved certificate or not. Attempted telephone interview with Staff B on 02/27/25 at 11:50am was unsuccessful.	D 125		
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 2 of 3 residents observed during the medication pass (#1, #6)	D 358	Clinical Nurse Consultant (CNC) in-serviced all Med Aides on Medication Administration. Clinical Nurse Consultant (CNC) in-serviced all Med Techs on 6 rights of medication. Executive Director/ or Designee conducted an audit on the Med Aides which will be completed twice a month. Resident Care Coordinator (RCC) conducted a weekly med pass observations to ensure medications are being passed properly.	3/12/25 3/12/25 3/07/25 3/13/25

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D 358	Continued From page 3 including a medication used to treat seizure disorder (#1), a medication used to treat indigestion (#1), a medication used to treat pain (#1), and a medication used to treat respiratory conditions (#6). The findings are: The medication error rate was 14% as evidenced by 4 errors out of 27 opportunities during the 8:00am medication pass on 02/26/25. 1. Review of Resident #1's current FL2 dated 01/28/25 revealed diagnoses included dehydration, seizure disorder, hypertension, general weakness, dysphagia, unintended weight loss, and paroxysmal atrial fibrillation. a. Review of Resident #1's current FL2 dated 01/28/25 revealed: -There was an order for Levetiracetam 500mg 1 tablet twice daily (Levetiracetam is a medication used to treat or prevent seizures). -There was no order for Resident #1's medications to be crushed. Observation of the 8:00am medication pass on 02/26/25 from 7:06am to 7:24am revealed: -The medication aide (MA) opened a blister pack containing Resident #1's 8:00am medications. -The MA took a spoon and removed a capsule from the blister pack and placed the capsule in a plastic medication cup. -The MA took the remaining 4 tablets in the blister pack, including Levetiracetam 500mg, and emptied the tablets into a plastic pouch. -The MA inserted the plastic pouch into the pill crushing device and crushed the tablets. -The MA emptied the crushed tablets into the plastic cup containing the capsule and added	D 358	Clinical Nurse Consultant (CNC) conducted a random Med Aide observations during med passes to ensure at least 2 observations per month are completed during site visits. This will check compliance with giving medications correctly. Hospice Provider updated pill crushing order. Clinical Nurse Consultant (CNC) in-serviced the Resident Care Coordinator (RCC) on the Bucket System to ensure orders are being followed up on. Resident Care Coordinator (RCC)/ or Designee followed up on bucket system daily to ensure are being followed up on. Resident Care Coordinator (RCC)/ or Designee monitored Medication Administration Reports daily to ensure orders are being followed per Provider orders and compliance with adminstration. Weekly cart audits were completed by Resident Care Coordinator (RCC) and Med Aides to check for the QA compliance of the medication cart.	3/20/25 2/28/25 3/12/25 3/13/25 3/13/25 3/13/25

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D 358	Continued From page 4	D 358	Follow up given to the ED to be reviewed. Report was reviewed in management meeting and will be reviewed daily with the ED, and all concerns will immediately be follow up on. Once addressed and corrected the ED and RCC will sign off on them.	3/13/25

pudding to the cup.
-The MA mixed the crushed medications and capsule in the pudding.
-The MA entered Resident #1's room and administered her medications at 7:14am.

Review of Resident #4's February 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Levetiracetam 500mg 1 tablet twice daily scheduled for 8:00am and 8:00pm.
-Levetiracetam 500mg was documented as administered at 8:00am from 02/01/25 to 02/26/25 and at 8:00pm from 02/01/25 to 02/25/25.
-There was no entry for Resident #1's medications to be crushed.

b. Review of Resident #1's current FL2 dated 01/28/25 revealed:
-There was an order for Famotidine 20mg 1 time daily (Famotidine is a medication used to treat or prevent indigestion).
-There was no order for Resident #1's medications to be crushed.

Observation of the 8:00am medication pass on 02/26/25 from 7:06am to 7:24am revealed:
-The medication aide (MA) opened a blister pack containing Resident #1's morning medications.
-The MA took a spoon and removed a capsule from the blister pack and placed the capsule in a plastic medication cup.
-The MA took the remaining 4 tablets in the blister pack, including Famotidine 20mg, and emptied the tablets into a plastic pouch.
-The MA inserted the plastic pouch into the pill crushing device and crushed the tablets.
-The MA emptied the crushed tablets into the

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plastic cup containing the capsule and added pudding to the cup.
-The MA mixed the crushed medications and capsule in the pudding.
-The MA entered Resident #1's room and administered her medications at 7:14am.

Review of Resident #4's February 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Famotidine 20mg 1 tablet daily scheduled for 8:00am.
-Famotidine 20mg was documented as administered at 8:00am from 02/01/25 to 02/26/25.
-There was no entry for Resident #1's medications to be crushed.

c. Review of Resident #1's current FL2 dated 01/28/25 revealed:
-There was an order for Acetaminophen 325mg 2 tablets twice daily (Acetaminophen is medication used to treat pain).
-There was no order for Resident #1's medications to be crushed.

Observation of the 8:00am medication pass on 02/26/25 from 7:06am to 7:24am revealed:
-The medication aide (MA) opened a blister pack containing Resident #1's morning medications.
-The MA took a spoon and removed a capsule from the blister pack and placed the capsule in a plastic medication cup.
-The MA took the remaining 4 tablets in the blister pack, including Acetaminophen 325mg 2 tablets, and emptied the tablets into a plastic pouch.
-The MA inserted the plastic pouch into the pill crushing device and crushed the tablets.
-The MA emptied the crushed tablets into the plastic cup containing the capsule and added

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pudding to the cup.
-The MA mixed the crushed medications and capsule in the pudding.
-The MA entered Resident #1's room and administered her medications at 7:14am.

Review of Resident #4's February 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Acetaminophen 325mg 2 tablets twice daily scheduled for 8:00am and 8:00pm.
-Acetaminophen 325mg 2 tablets was documented as administered at 8:00am from 02/01/25 to 02/26/25 and at 8:00pm from 02/01/25 to 02/25/25.
-There was no entry for Resident #1's medications to be crushed.

Interview with Resident #1 on 02/26/25 at 8:21am revealed:
-Sometimes the facility staff administered her medicines crushed and mixed with pudding and sometimes her medications were administered whole.
-She did not take many medications, so she did not think her medications were too difficult to swallow.
-She had some difficulty swallowing food or liquids at times but was able to swallow her medications whole because the tablets were small.

Interview with the MA on 02/26/25 at 1:23pm revealed:
-She checked the residents' eMAR and followed the directions on the eMAR when administering medications.
-If a resident had an order for their medications to be crushed, the crush medications order was on

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the residents' eMAR.
-She thought Resident #1 had an order to crush her medications.
-She did not see instructions to crush Resident #1's medications on Resident #1's current eMAR.
-She crushed Resident #1's medications because she thought Resident #1 still had an order for her medications to be crushed.

Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 1:34pm revealed:
-MAs should check the instructions on the residents' eMAR when administering medications.
-If a resident had an order for their medications to be crushed, there would be an entry to crush their medications on their eMAR.
-The resident's primary care provider (PCP) had to give the facility an order for the resident's medications to be crushed.
-She thought Resident #1 had an order for her medications to be crushed at one time but did not see the order on Resident #1's current eMAR.
-It was important to have a PCP's order for medications to be crushed because there were some medications that could not be crushed.

Interview with the Administrator on 02/26/25 at 2:00pm revealed:
-MAs should be following the instructions on the eMAR when administering residents' medications.
-Residents who needed their medications crushed should have an order from their PCP to crush their medications.
-Resident #1's medications should not have been crushed without an order to crush medications.
-If MAs noticed a resident having issues with taking their medications, they should notify the residents' PCP.

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D 358	Continued From page 8 Telephone interview with a registered nurse (RN) from Resident #1's hospice agency on 02/26/25 at 2:30pm revealed: -Resident #1 was hospitalized in June 2024 and was readmitted to hospice services on 07/01/24. -Resident #1 did not have a current order to crush her medications. -She had not received any reports of Resident #1 having difficulty swallowing her medications. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/26/25 at 12:50pm revealed: -The pharmacy did not have an order for Resident #1's medications to be crushed. -When the pharmacy received an order for a resident's medication to be crushed, the order was added to the resident's eMAR. -Residents who need their medications crushed must have an order from their PCP for the facility staff to crush their medications. -There were some medications that could not be crushed, so it was important to have an order from the resident's PCP so the pharmacy could identify medications on the resident's medication list that could not be crushed. Telephone interview with Resident #1's PCP on 02/27/25 at 11:20am revealed: -Resident #1 was able to take medications without difficulty. -She had not received any reports from the facility that Resident #1 was having difficulty taking medications. -Resident #1 occasionally had difficulty swallowing food or liquids. -The facility staff should not crush Resident #1's medications without an order. -Crushing some medications changed the way	D 358		

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D 358	Continued From page 9 the medication was absorbed in the body, so it was important to have an order for medications to be crushed. 2. Review of Resident #6's current FL2 dated 01/28/25 revealed: -Diagnoses included schizophrenia, anxiety disorder, essential hypertension, chronic obstructive pulmonary disease, type 2 diabetes mellitus, and hyperlipidemia. -There was an order for Advair Diskus 250-50mcg inhale 1 puff by mouth twice daily, rinse mouth and spit out after use (Advair Diskus is an inhaled medication used to treat respiratory conditions). Observation of the 8:00am medication pass on 02/26/25 from 7:06am to 7:24am revealed: -The medication aide (MA) prepared Resident #6's oral medications and administered the medications with a cup of water at 7:20am. -The MA removed Resident #6's Advair Diskus from the medication cart for administration and prompted Resident #6 to inhale a deep breath from the Advair Diskus inhaler at 7:21am. -The MA asked Resident #6 if she wanted a drink of water but did not prompt Resident #6 to rinse her mouth after administering the Advair Diskus inhaler. -Resident #6 replied she did not need any more water. -The MA continued administering Resident #6's medications and completed administering Resident #6's medications at 7:24am. Review of Resident #6's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Advair Diskus 250-50mcg inhale 1 puff by mouth twice daily, rinse mouth	D 358	Clinical Nurse Consultant (CNC) in-serviced all Med Techs on how to properly administer the Advair Diskus Inhaler.	3/12/25

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and spit out after use.
-Advair Diskus 250-50mcg was documented as administered at 8:00am from 02/01/25 to 02/26/25 and at 8:00pm from 02/01/25 to 02/25/25.

Interview with Resident #6 on 02/27/25 at 8:12am revealed:
-She used 2 different inhalers because she had some shortness of breath.
-The staff did not ask her to rinse her mouth after she used her Advair Diskus inhaler.
-Sometimes the staff offered her an extra cup of water because she took a lot of medications but did not give her a cup of water to use for rinsing her mouth.
-She was not aware that not rinsing her mouth after using Advair Diskus inhaler could cause thrush (Thrush is a fungal infection of the mouth).
-She had not experienced any mouth irritation.

Interview with the MA on 02/26/25 at 1:23pm revealed:
-MAs received annual medication administration training.
-She could not remember having any recent training on administering inhalers.
-She followed the instructions on the residents' eMAR when she administered medications.
-She saw the instructions on Resident #6's Advair Diskus to rinse her mouth and spit after using the inhaler.
-She asked Resident #6 if she wanted some water to drink after her Advair Diskus inhaler this morning, 02/26/25, but Resident #6 did not want any water.
-Sometimes she offered residents water to rinse their mouths out after using their inhalers and they refused to rinse their mouths.

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Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 1:34pm revealed:
-MAs received annual medication administration training, which included how to administer inhalers.
-MAs should follow instructions on the eMAR when administering medications.
-If the eMAR had instructions for a resident to rinse their mouth after using an inhaler, the MA should offer the resident some water and explain to the resident to rinse their mouth.
-The MA should offer the resident water for rinsing their mouth after using the inhaler and ask the resident to drink the water.
-The purpose of rinsing the mouth after using an inhaler kept the mouth from becoming irritated.

Interview with the Administrator on 02/26/25 at 2:00pm revealed:
-MAs had quarterly training on medication administration.
-MAs should follow the instructions on the residents' eMAR when administering medications.
-If Resident #6's eMAR had instructions for Resident #6 to rinse her mouth after the inhaler was administered, the MA should prompt Resident #6 to rinse her mouth.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/26/25 at 12:50pm revealed:
-Advair Diskus contained an anti-inflammatory medication which sometimes left a residue in the mouth.
-The residue from the Advair Diskus could cause thrush if the mouth was not rinsed after use.
-The MAs at the facility should follow the instructions on the residents' eMARs and prompt the residents to rinse their mouths after using

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D 358	Continued From page 12 inhalers if indicated. Telephone interview with Resident #6's primary care provider (PCP) on 02/27/24 at 10:11am revealed: -Resident #6 was prescribed Advair Diskus for chronic obstructive pulmonary disease (COPD). -Resident #6 should rinse her mouth after using Advair Diskus because the medication could cause thrush in the mouth. -Thrush could cause irritation, discomfort, dry mouth, and difficulty swallowing, so it was important to rinse the mouth after using Advair Diskus to avoid these complications.	D 358		