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 _____	R-C 08/01/2022

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 a follow up survey and complaint investigation on July 28-29, 2022 and August 1, 2022. The complaint investigation was initiated by the County Department of Social Services on June 20, 2022.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions 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 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure staff immediately responded to an emergency for 1 of 6 sampled residents related to not providing cardiopulmonary resuscitation (CPR) on a resident that had full code orders (Resident #6). The findings are: Review of facility Accident/Falls/Disaster & Fire Safety policy dated 09/2021 revealed: When an accident or an emergency occurs, staff should:	D 271	Hamlet House shall ensure staff responds immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. Area Clinical Director(ACD) immediately began in-servicing staff on the policy for Emergency Training and CPR, ensuring they understand that if a resident does not have a "Do-Not-Resusitate" order that a person person that is CPR certified is to initiate CPR and not cease until EMS arrives and takes over the scene. The staff was also educated that they are to remain with the resident until released by EMS.	7/29/22
			Executive Director(ED)/ Resident Care Manager (RCM) established a consistent system for staff to quickly identify residents' code status. Resident's that are DNR status will have a Red awareness symbol placed on their name-plate outside of their door.	7/30/22
			RCM in-serviced staff on Awareness Emblems, and continues to re-educate staff upon hire. This is to ensure staff can quickly identify a resident's code status without delay in cases of emergency.	8/31/22
			ACD re-inserviced care staff on the importance of quality resident care and rounding on residents; what to do when a resident is having difficulty swallowing or is choking; and the importance of effective CPR by certified staff members.	8/9/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nathaniel Franklin TITLE: Executive Director (X6) DATE: 9/7/22

Reviewed and acknowledged. 12 September 2022

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D 271	Continued From page 1 -Determine if the resident was breathing, conscious and check for pulse. -Administer cardiopulmonary resuscitation (CPR) as appropriate (first check for do-not-resuscitate (DNR) status). -Continue emergency intervention until Emergency Medical Services (EMS) arrives. Review of Resident #6's most recent FL-2 dated 05/12/22 revealed: -Diagnoses included dementia, heart failure, hypertension, atherosclerotic heart disease, diabetes, chronic kidney disease, and gastroesophageal reflux disease. -He was intermittently disoriented and non-ambulatory. -He had orders for a full code (all resuscitation measures were to be attempted). Review of Resident #6's Resident Register (undated) revealed: -Resident #6 was originally admitted to the facility 08/31/1999. -He had significant memory loss and must be directed. Review of Facility Death Report dated 05/23/22 revealed: -Resident #6 was found unresponsive in his room on 05/21/22 at 4:30pm. -The Medication Aide (MA) checked for his pulse and found he had no pulse. -The MA called for help and dialed 911. -The MA started chest compressions until EMS arrived. -EMS arrived, checked the resident, and pronounced his time of death at 4:35pm. Telephone interview with the MA on 07/29/22 at 3:10pm revealed:	D 271	ED in-serviced staff on identifying a resident's code status; the importance of reporting incidents and accidents; and what it means when a resident is a "DNR". ED will ensure newly hired staff are also in-serviced on these items upon hire.	8/31/22
			RCM completed an audit of all residents' code status to ensure it is accurately reflected, and all MD orders as well as advanced directives are in place appropriately.	8/31/22
			ACD will continue to review the policy for Emergency Training and CPR, responding to emergencies reporting incidents and accidents with current staff as well as new staff upon hire.	8/31/22
			RCM has established an assignment sheet that identifies staff members on duty that are CPR certified.	8/31/22
			RCM will bring incident reports to daily management meeting for review with the ED to ensure appropriate actions have been taken, and appropriate interventions are in place.	8/31/22
			RCM will ensure to collect advanced directive information on all new admissions and ensure awareness emblem has been placed on the resident's nameplate outside of their door for rapid staff identification.	8/31/22
			RCM will update awareness emblems and educate staff when a resident's code status is changed. RCM will also discuss any updated advanced directives or code status changes with ED in daily management meeting to ensure appropriate interventions are in place.	8/31/22
			ED/RCM will include responding to emergencies as education topic in staff meetings at a minimum of quarterly to ensure that newly hired staff as well as seasoned staff are receiving the training on a regular basis.	8/31/22

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D 271	Continued From page 2 -She worked with Resident #6 that day. -She had obtained his vital signs at approximately 3:00pm that day. -Resident #6 was not ready for the evening meal that day, which was unusual, so she went to his room to look for him. -She found Resident #6 unresponsive in his room. -He was laying on his bed with his legs elevated and his arm over his face. -He had vomit on his face. -His skin was yellow. -He was starting to stiffen up. -She telephoned the Resident Care Director (RCD) who instructed her to call 911. -She called 911 and reported Resident #6's condition. -The MA told the 911 operator that although her certification had expired, she would be able to start CPR if necessary. -The 911 operator told her not to start CPR. -She did not want to start CPR because she did not want to move Resident #6's arm and possibly break it. -A Personal Care Aide (PCA) came to the room. -The PCA did not know what to do. -The PCA did not start CPR. -Other staff were keeping other residents away from the room. -EMS arrived but did not start CPR. -She spoke with the Executive Director the next business day about the death. -He was completing a death report and had written that she had begun CPR and continued until EMS arrived. -She was uncomfortable and said that was not accurate, she had never begun CPR. Telephone interview with the PCA on 07/29/22 at 3:50pm revealed:	D 271		

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D 271	Continued From page 3 -She had worked with the MA and Resident #6 that day. -She had last checked on Resident #6 at approximately 2:30pm that afternoon. -He had not been feeling well that day but was responsive. -She had a current CPR certification. -The MA told her that Resident #6 was found unresponsive in his room. -She went to his room and he was laying on his bed and had vomit on his face. -The MA told the PCA she had attempted CPR but that it did not help the resident. -The PCA did not initiate CPR but went to get a washcloth to clean him up. -When she began to clean Resident #6, she had moved his arm from his head and he was not stiff. -The PCA did not see the MA do CPR at any time. -Normally she would have initiated CPR when a resident was found unresponsive but did not because the MA stated she had started CPR and it was ineffective -None of the staff were performing CPR when EMS arrived. Review of EMS Patient Record dated 05/21/22 revealed: -The MA had called 911 at 4:24pm. -EMS arrived at Resident #6's bedside at 4:34pm. -Resident #6 was laying on his back in the bed. -He had vomit on his face and mouth. -Staff were present in the room. -Staff had found the resident unconscious, pulseless, and not breathing. -Staff reported CPR had been attempted but had stopped prior to EMS arrival as they believed resuscitation attempts to be futile. -EMS found him to have flaccid arms and legs, no breath, and was cool, dry and pale.	D 271		

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D 271	Continued From page 4 -Resident #6 was found deceased at the scene. Interview with the Emergency Medical Technician (EMT) on 07/29/22 at 12:13pm revealed: -The 911 call was received and coded as a Priority 2 Heart Attack and the patient was already deceased. -They received the call at 4:24pm and were at the facility at 4:33pm. -He was pronounced dead at 4:35pm. -He was told staff had attempted CPR but stopped prior to EMS arrival. -Staff were not performing CPR when EMS arrived. -Resident #6 was completely flaccid, meaning his arms and legs were not stiff and could easily be moved. Second telephone interview with MA on 08/01/22 at 9:37am revealed: -When she walked into Resident #6's room and found him unresponsive, she froze. -When she called 911, she told the operator that a resident had died, had no pulse, and was not breathing. -The MA told the 911 operator that she was able to do CPR but did not currently have certification. -The 911 operator did not say anything about starting CPR so she assumed performing CPR was not necessary. -Resident #6 did not have a DNR order, though she was not 100% sure when she was on the phone with the 911 operator. -She did not start CPR because she was not sure if she was allowed to touch him. Interview with the RCD on 08/01/22 at 1:38pm revealed: -She received a phone call from the MA who said Resident #6 was unresponsive.	D 271		

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D 271	Continued From page 5 -She instructed the MA to immediately call 911 and start CPR. -She expected staff to start CPR immediately and to call EMS. -Staff should continue CPR until EMS arrived and took over. -If one staff member stopped CPR, a second staff member should continue CPR (chest compressions). Interview with the Executive Director on 08/01/22 at 1:57pm revealed: -He received a phone call from the RCD that Resident #6 was found unresponsive. -He understood the MA was performing CPR and EMS was called. -If staff found a resident unresponsive, it was expected staff would check for a pulse and call 911. -If the resident was lifeless, staff should initiate CPR and call out for other staff to help. -Staff were to continue CPR until EMS arrived. -If the first staff says CPR was not helping, a second staff member should come and continue CPR until EMS arrived. Attempted telephone interview with Resident #6's primary care physician on 08/01/22 at 1:12pm was unsuccessful. The facility failed to ensure the initiation of CPR immediately for a resident with a full code order who was found in his bed unresponsive and without a pulse, in accordance with the facility's policy, and was subsequently pronounced dead when EMS arrived. The facility's failure resulted in serious neglect of Resident #6 which constitutes a Type A1 Violation. The facility provided a plan of protection in	D 271		

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D 271	Continued From page 6 accordance with G.S. 131D-34 on 07/29/22 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 31, 2022.	D 271		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of mental and physical abuse, neglect, and exploitation related to personal care and supervision. The findings are: Based on interviews and record reviews, the facility failed to ensure staff immediately responded to an emergency for 1 of 6 sampled residents related to not providing cardiopulmonary resuscitation (CPR) on a resident that had full code orders (Resident #6) [Refer to Tag 271 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A1 Violation)].	D914	See above POC Response.	

Washington, Bynithia T

From: Hamlet House, ED - Peterkin, Nathaniel <director@hamletseniors.com>
Sent: Wednesday, September 7, 2022 7:13 PM
To: Washington, Bynithia T
Cc: Reka Green; Rakishia Peterson
Subject: [External] Hamlet House - Plan Of Correction
Attachments: Plan Of Correction 9-7-22.pdf

Hi Bynithia

Please see the attached plan of correction for your review and records.

Nate Peterkin, Executive Director
Hamlet House Assisted Living | director@hamletseniors.com
(Phone) 910-582-0082 |(Fax) 910-582-8567