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MOCKSVILLE SENIOR LIVING & MEMORY CARE	337 HOSPITAL STREET MOCKSVILLE, NC 27028

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation survey via desk and onsite review on 04/23/20 through 05/01/20 with an exit conference via telephone on 05/01/20.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision in accordance with the resident's assessed needs and current symptoms for 1 of 5 sampled residents (Resident #5) related to supervision required during meals to prevent choking. The findings are: Review of Resident #5's current FL2 dated 10/23/19 revealed: -Diagnoses included vascular dementia with behavioral disturbance and forgetfulness. -The level of care was SCU (Special Care Unit). -Resident #5's orientation was constantly	D 270		

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disoriented.
-There was a diet order for "regular chopped."

Review of Resident #5's diet order dated 10/09/19 revealed the description for a chopped diet was mechanical soft, meats only chopped.

Review of Resident #5's physician's orders dated 01/26/20 revealed an order for "no bacon."

Review of Resident #5's initial resident assessment plan dated 11/07/19 revealed:
-Resident #5 was always disoriented.
-Resident #5 was forgetful and needed reminders.
-Resident #5 required limited assistance with eating.

Review of Resident #5's resident profile and care plan dated 12/20/19 revealed:
-Resident #5 fed self after set up for meals and snacks.
-Interventions for eating were to assist as needed.

Review of Resident #5's Speech and Language Pathologist (SLP) encounter note dated 01/27/20 revealed:
-Resident #5 completed a modified barium swallow study (MBSS) on 11/05/19 with diet recommendations for mechanical soft consistencies and thin liquids.
-Resident #5's family member contacted the SLP on 01/27/20 and stated Resident #5 had difficulty with eating bacon at her facility and requested a report be sent to the facility with diet recommendations.

Review of Resident #5's SLP's procedure note dated 02/14/20 revealed:

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D 270	Continued From page 2 -Resident #5 had a repeat MBSS on 02/14/20 due to increased coughing with eating and drinking as well as episodic choking incidents. -Resident #5 exhibited mild oral and mild to moderate pharyngeal deficits. -The SLP recommended a mechanically altered/ground diet. -The SLP recommended Resident #5 have one to one assistance with feeding and supervision with meals. -The SLP recommended Resident #5 eat/feed slowly; take small, single bites/sips; multiple swallows per bite/sip; and alternate foods and liquids. -Assistance/Supervisory needs were documented as 24/7 supervision/full time direct. Telephone interview with the SLP on 04/29/20 at 1:44pm revealed: -She saw Resident #5 for a MBSS on 11/05/19 after receiving a referral from the resident's gastrointestinal physician. -The result of Resident #5's MBSS on 11/05/19 was "mild oral pharyngeal dysphagia likely exacerbated at times by Resident #5's advanced cognitive deficits with distractibility." -Her recommendations included a diet for mechanically altered foods with a finely chopped consistency. -Her recommendations also included one to one assistance and full supervision during meals. -She provided a report with all her recommendations to Resident #5's family member and sent a report to the referring gastrointestinal physician. -On 01/27/20, Resident #5's family member contacted her via phone requesting she fax her recommendations from the 11/05/19 MBSS to the facility because Resident #5 had a recent choking episode with bacon.	D 270		

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-She faxed her recommendations to the facility on 01/27/20 at 10:08am.
-She saw Resident #5 again on 02/14/20 for another MBSS after receiving a referral from the resident's primary care provider (PCP).
-The result of Resident #5's MBSS on 02/14/20 was "mild oral and mild to moderate pharyngeal deficits."
-Her recommendations included a diet for mechanically altered foods with a ground consistency.
-Her recommendations, again, included one to one assistance and full supervision during meals.
-She faxed a report with all her recommendations to the facility on 02/14/20 at 3:54pm and provided a copy to Resident #5's family member.
-Her expectations for supervision included "keeping close eyes" on Resident #5 to ensure she was served only mechanically ground consistency foods, she took only small bites, and she alternated between taking a bite of food and then taking a sip of drink.
-Resident #5 required close supervision due to her cognitive issues putting her at risk for choking.

Review of Resident #5's accident/incident report dated 01/26/20 revealed:
-Resident #5 had a witnessed choking incident in the dining room on 01/26/20 at 8:28am.
-First aid administered was documented as Heimlich.
-Resident #5's level of consciousness was documented as able to state name and answer questions.
-Resident #5 was transported to the Emergency Department (ED) via ambulance.

Review of Resident #5's progress note dated 01/26/20 at 9:27am revealed:

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D 270	Continued From page 4 -Resident #5 "started choking at breakfast." -The medication aide (MA) and the personal care aide (PCA) had to "give Heimlich maneuver, it didn't work resident still choking." -The MA had to "finger swipe to try to get the food out." -911 was called and the resident was transported to the ED. Review of Resident #5's ED provider notes dated 01/26/20 revealed: -Resident #5 was "reportedly choking for approximately 8 minutes and lost consciousness but did not have CPR (cardio-pulmonary resuscitation)." -"The facility attempted the Heimlich maneuver multiple times but were not able to remove the foreign body." -By the time Resident #5 arrived at the ED, she was no longer choking and was speaking clearly. -A chest x-ray was performed and showed no aspiration (food inhaled into the airway). -Resident #5 was discharged back to the facility. Review of Resident #5's Home Health (HH) SLP progress notes revealed: -Resident #5 was initially seen on 02/05/20 for a dysphagia (difficulty with swallowing) evaluation. -During the evaluation, Resident #5 demonstrated overt signs and symptoms of aspiration after swallowing thin water and an impaired oral phase of swallowing. -The HH SLP recommended a MBSS and speech therapy (ST) treatment to address dysphagia. -On 02/10/20, Resident #5 was seen during her morning meal, and the HH SLP recommended alternating liquids and solids during meals and oral care after each meal. -On 02/18/20, the MBSS had been completed with a recommendation for a mechanical soft diet.	D 270		

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D 270	Continued From page 5 Telephone interview with Resident #5's HH SLP on 04/27/20 at 10:24am revealed: -Resident #5's start of care date for HH ST services was 02/05/20 after receiving a referral due to a recent choking incident with bacon. -She recommended a mechanical soft diet and was told by facility staff that was already Resident #5's diet order. -Bacon and raw fruits, including orange slices, were not allowed on a mechanical soft diet. -During her breakfast meal observation on 02/10/20, Resident #5 was not served bacon or orange slices. -Resident #5 did not require physical assistance with eating, but she did recommend close supervision during meals due to her advanced dementia. -On 02/05/20, after her initial evaluation of Resident #5, she provided a 4-page written document with her recommendations to the Memory Care Coordinator (MCC). -The MCC told her she would share her recommendations with the care staff. -When she observed Resident #5 during her breakfast meal on 02/10/20, she had to continually encourage her to take small bites. Review of Resident #5's accident/incident report dated 02/22/20 revealed: -Resident #5 had a witnessed choking incident in the dining room on 02/22/20 at 8:00am. -First aid administered was documented as Heimlich, finger sweep, and CPR. -Resident #5's level of consciousness was documented as unresponsive. -Resident #5 was transported to the emergency department (ED) via ambulance. Review of Resident #5's progress note dated	D 270		

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02/22/20 at 10:07am revealed:
-Resident #5 "started choking on eggs and oranges this morning."
-A MA performed the Heimlich maneuver.
-When the Heimlich maneuver "was not working, another MA assisted and did finger sweep because MA seen that there was eggs in resident's mouth, but when both MAs seen that wasn't what resident was choking on, MA called 911."
-"911 advised us to start CPR because resident became unconscious and stopped breathing."
-"MA did CPR until paramedics arrived and took over."
-Resident #5 was transported to the hospital.

Review of Resident #5's emergency medical services (EMS) report dated 02/22/20 revealed:
-EMS was dispatched to the facility in reference to "a choking" with CPR in progress.
-EMS arrived on the scene at 8:20am and reached Resident #5 at 8:25am to find facility staff performing chest compressions.
-EMS staff checked Resident #5's pulse and there was "no carotid noted."
-EMS staff immediately began chest compressions.
-Resident #5 was unable to be ventilated with a bag valve mask (BVM), "no air would exchange."
-"A staff member appeared stating patient choked on an orange."
-"With much effort, an orange wedge was removed from deep in oral pharynx" using forceps.
-Resident #5 was then able to be ventilated with the BVM.
-"iGel prepped and placed with good breath sounds." (iGel is an airway device).
-Time of first CPR was documented as 8:16am.
-There was documentation CPR was

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discontinued at 8:29am due to "return of spontaneous circulation (ROSC) with pulse or BP (blood pressure) noted."
-Resident #5 was transported to the ED via ambulance.

Telephone interview with an Emergency Medical Technician (EMT) on 04/27/20 at 2:19pm revealed:
-He responded to the facility on 02/22/20 during Resident #5's choking incident.
-He arrived on the scene at 8:20am.
-He reached Resident #5 at 8:25am and found facility staff performing chest compressions.
-He saw three staff, including 2 staff working with Resident #5, and 1 staff who helped him into the locked SCU door.
-He "assessed the environment" and all the residents' meal trays he saw had raw orange slices on them.
-A facility staff told him "I think she (Resident #5) has choked on an orange slice."
-Resident #5 did not have a pulse when he arrived.
-He used forceps to remove an orange slice from deep within Resident #5's throat.
-The peel had been removed from the orange slice found in Resident #5's throat.
-CPR was performed for about 10 minutes.
-Once EMS staff were able to obtain a pulse for Resident #5, they transported her to the hospital.

Review of Resident #5's ED provider notes dated 02/22/20 revealed:
-Resident #5 arrived at the ED by ambulance after having a witnessed cardiac arrest at the facility.
-"Food was removed as this was thought to be a choking episode."
-On arrival to the ED, Resident #5 was

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nonresponsive and required intubation (the process of inserting a tube through the mouth and into the airway, used when one is unable to breathe on their own).
-Resident #5 was admitted to the intensive care unit (ICU).
-"Targeted temperature management was initiated given her inability to follow commands status post cardiac arrest." (Targeted temperature management is a treatment used to minimize brain injury after cardiac arrest).
-"Intervention was immediately required due to the risk of substantial deterioration, and included treating her respiratory failure, optimizing her hemodynamics, and managing her temperature to minimize cerebral injury from her cardiac arrest."

Review of Resident #5's hospital procedure notes revealed:
-On 02/23/20 from 3:53am-8:00am, an electroencephalogram (EEG) was performed. The physician documented "This EEG is indicative of a severe encephalopathy (brain damage)." (An EEG is a test that detects electrical activity in the brain).
-02/23/20 from 8:00am to 02/24/20 at 8:00am, a long-term monitoring (LTM) EEG was performed. The physician documented "This LTM is consistent with severe encephalopathy with myoclonus (involuntary muscle jerks) ...LTM will continue."
-On 02/24/20 from 8:00am to 12:57pm, a LTM EEG was performed. The physician documented "This LTM is consistent with severe encephalopathy with myoclonus. The family decided on comfort care and LTM will be discontinued."

Review of Resident #5's hospital history and

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physical dated 02/25/20 revealed:
-Resident #5's documented assessment included cardiac arrest secondary to respiratory failure due to aspiration/foreign body obstruction.
-Resident #5 choked on an orange slice at her facility with subsequent PEA (pulseless electrical activity) arrest.
-CPR was performed for 10 minutes.

Review of Resident #5's hospital discharge summary dated 02/26/20 revealed:
-Resident #5 was brought to the ED via EMS on 02/22/20 after a witnessed cardiac arrest at the facility.
-When EMS arrived, they found Resident #5 to be in PEA.
-EMS removed food from Resident #5's upper airway and placed an airway device with subsequent ventilation.
-Approximate CPR time was 10 minutes.
-Upon arrival to the ED, the iGel was exchanged to an endotracheal tube for ventilation.
-Resident #5 was "initiated on targeted temperature management as she had a poor neurological exam after ROSC."
-Resident #5 was admitted to the ICU.
-Resident #5's hospital stay was complicated by myoclonic jerking (muscle jerking), an LTM EEG was started, and neurology was consulted.
-On 02/24/20, goals of care discussions were had with the critical care team and family, and the decision was made to transition to DNR (do not resuscitate) with comfort measures only.
-"Compassionate extubation afternoon of 2/24."
-Resident #5 transitioned to Hospice in place on 02/25/20 with a plan to transfer her to a Hospice facility on 02/26/20.

Review of the facility's census history revealed Resident #5 expired on 02/27/20.

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D 270	Continued From page 10 Telephone interview with a MA on 04/24/20 at 1:51pm revealed: -Resident #5 was in the dining room eating breakfast on 02/22/20 and started coughing. -The MA went over to check on her, and Resident #5 began pointing to her throat. -The MA performed a finger sweep and was able to remove some scrambled eggs, but Resident #5 continued choking. -The MA initiated the Heimlich maneuver and asked the PCA to go to the assisted living (AL) side of the building to get another MA. -When the second MA arrived, she took over performing the Heimlich maneuver, and the first MA called 911. -The 911 dispatcher instructed facility staff to begin CPR, so the second MA began chest compressions until EMS arrived. -EMS staff used "tongs" to remove an orange slice from Resident #5's throat. -Resident #5 began breathing again and was transported to the hospital. -Total estimated time from when Resident #5 began choking and EMS arrived was around 8-10 minutes. -Resident #5 had a previous choking incident with bacon approximately 1-2 months prior. -Resident #5 routinely ate orange slices with no issue. -Resident #5 did not require feeding assistance or supervision during meals. -Normally, both she and a PCA were in the dining room together during meals. -She had stepped out of the dining room "for maybe a minute," and when she returned, Resident #5 began coughing. -Resident #5 was receiving ST services and had been placed on a ground meat diet with no bacon.	D 270		

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D 270	Continued From page 11 Telephone interview with a PCA on 04/24/20 at 3:23pm revealed: -Resident #5 had a choking episode between 8:00am and 9:00am on 02/22/20. -Resident #5's tray arrived from the kitchen with raw orange slices on it. -Resident #5 had issues in the past with trying to place whole orange slices in her mouth so she removed the bowl of orange slices and placed them in the center of Resident #5's table. -Resident #5 would "do okay if you sat with her and encouraged her to take small bites of the orange slice." -She did not know Resident #5 had eaten an orange slice until EMS staff reported that was what she choked on. -She did not know if Resident #5 had been able to reach her removed bowl of orange slices, or if she had taken orange slices off her neighbor's plate. -She (the PCA) was alone in the dining room for a short time while the MA went to her medication cart to get something. -She was feeding a resident at another table. -She had just scanned the room and asked the residents if they were doing okay and Resident #5 had replied "yes." -Within a minute after, the MA returned to the dining room and she heard the MA ask Resident #5 if she was okay. -When she heard the MA ask Resident #5 if she was okay, it caught her attention. -She looked at Resident #5 and she was shaking her head "no" to indicate she was not okay. -The MA did a finger sweep and performed the Heimlich maneuver for approximately 5 minutes. -The finger sweep removed some scrambled eggs from Resident #5's mouth, but she still began to turn "gray."	D 270		

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-That was when the MA instructed her go to the AL side of the building and get a second MA.
-It did not take her long to return with the second MA because she ran the entire way to get her.
-The second MA took over the Heimlich maneuver while the first MA called 911.
-She then stepped out to take residents to their rooms and to open the locked unit's door for EMS when they arrived.
-She did not return to the dining room prior to EMS transporting Resident #5 to the hospital.
-She had been told by other staff, Resident #5 had a "couple" choking incidents prior to her coming to work at the facility in December 2019.
-Resident #5 was on a ground meat diet with no bacon.

Telephone interview with a second MA on 04/28/20 at 11:45am revealed:
-On 02/22/20, the SCU PCA came over to the AL side of the facility to get her because Resident #5 was choking.
-She immediately went to the SCU dining room and took over performing the Heimlich maneuver for the first MA.
-She was not able to get any food to eject when doing the Heimlich.
-The first MA left the dining room to get her phone and called 911.
-The 911 dispatcher instructed them to start CPR, so she did.
-She completed approximately 3 sets of chest compressions until EMS arrived and took over CPR.
-EMS staff used "tongs" to remove an orange slice "wedged deep down" in Resident #5's throat.
-She then left the dining room to check on the other residents.
-Total time from when EMS arrived to when they left to transport Resident #5 to the hospital was

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approximately 10-15 minutes.
-Resident #5 had a diet order for either chopped or ground meats (she could not remember which) with no bacon.
-She did not know Resident #5 had any difficulty in the past with eating orange slices.
-She was not sure if Resident #5 had been served orange slices or if she had taken them off another resident's plate.

Telephone interview with a facility cook on 04/27/20 at 11:38am revealed:
-She was not working on 02/22/20 when Resident #5 had a choking incident with an orange slice.
-Resident #5's diet order was chopped meats with no bacon.
-She had never been told Resident #5 had any issues with eating orange slices.
-Fresh fruit, either orange slices or bananas, were served to residents daily for breakfast.
-Orange slices were routinely served to Resident #5.
-The oranges were raw and cut into four slices with the peel left on.
-Meals were plated in the kitchen by kitchen staff and taken to the SCU in a cart.

Telephone interview with the Dietary Manager (DM) on 04/28/20 at 1:07pm revealed:
-She was working as the cook on 02/22/20 when Resident #5 had a choking incident with an orange slice.
-She did not witness the choking incident.
-She prepared Resident #5's plate in the kitchen with scrambled eggs, ground sausage, orange slices, and either toast or pancakes.
-The oranges were raw and cut into 4-5 slices with the peel left on.
-She delivered Resident #5's plate to the SCU dining room for the MA and PCA to serve.

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D 270	Continued From page 14 -She was told after the choking incident, the care staff had removed the orange slices from Resident #5's plate because "she couldn't have them." -She routinely plated Resident #5's plate with orange slices because no one had ever told her Resident #5 could not have orange slices. -Resident #5's diet order was ground meat with no bacon. Telephone interview with Resident #5's family member on 05/01/20 at 9:46am revealed: -She accompanied Resident #5 to her swallow study on 11/05/19. -When she brought Resident #5 back to the facility after her swallow study, she provided a written copy of the SLP's recommendations to the MCC. -After Resident #5's choking episode on 01/26/20, she requested the SLP fax another copy of the recommendations to the facility on 01/27/20. -She accompanied Resident #5 to her swallow study on 02/14/20. -When she brought Resident #5 back to the facility after her swallow study, she provided a written copy of the SLP's recommendations to an evening shift MA. -The family never refused for the facility to implement any of the SLP's recommendations. Telephone interview with the MCC on 04/28/20 at 9:06am revealed: -She provided oversight to the care staff in the SCU. -Capacity of the SCU was 19, and their census typically remained at 19. -She worked night shift, and had already left for the day, so she was not working at the time of Resident #5's choking incident on 02/22/20.	D 270		

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-She received a phone call from the MA reporting Resident #5 had choked on scrambled eggs and EMS staff had removed an orange slice wedged in her throat.
-She thought Resident #5 was on a mechanical soft ground meat diet and orange slices were not allowed to be served to her.
-Staff reported Resident #5 was not served orange slices, and that she must have gotten them from another resident's plate.
-Resident #5 did not require feeding assistance.
-Resident #5 required supervision with her meals.
-"Everyone in the SCU required supervision with meals."
-Supervision at meals meant a staff always had to be in the dining room during meals.
-She never saw the recommendations from Resident #5's SLP for one to one assistance.
-Typically, there were always 2 staff in the dining room during meals.
-She was not sure how Resident #5 was able to take an orange slice off another resident's plate, peel the orange slice, and swallow it whole if proper supervision was being provided.

Telephone interview with Resident #5's PCP's family nurse practitioner (FNP) on 04/29/20 at 11:21am revealed:
-Her last visit with Resident #5 was a well care visit on 11/14/19.
-She was on leave from 12/31/19-03/20/20.
-Resident #5 had been referred for a MBSS in November 2019 due to dysphagia.
-She could not speak to Resident #5's physical or cognitive abilities at the time of her choking incident on 02/22/20, but when she saw her on 11/14/19, Resident #5 did not require physical assistance with eating.
-Resident #5 was admitted to the SCU in October 2019 because she required increased supervision

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D 270	Continued From page 16 with all activities of daily living, including eating. Telephone interview with the Administrator in Charge (AIC) on 04/29/20 at 4:05pm revealed: -She was not working on the day of Resident #5's choking incident on 02/22/20. -Staff initially thought Resident #5 had choked on scrambled eggs until EMS staff removed an orange slice from her throat. -No one had communicated to her Resident #5 had ever had issues with eating orange slices. -Orange slices were allowed on Resident #5's diet, but she was not sure if she had been served orange slices on the day of her choking incident. -She always expected at least one staff person to be in the facility's dining rooms during meals. -One staff was responsible for providing feeding assistance to residents who required it, and a second staff person was responsible for supervising the other residents in the dining room. -She expected both staff to remain in the dining room until the residents requiring feeding assistance had finished their meals, and at that time, one staff person could leave the dining room to take residents back to their rooms while the other stayed behind to supervise the remaining residents. -She did not know if the facility had received the SLP's recommendations for Resident #5 to have one to one assist and full supervision at meals. -She was aware of Resident #5's previous choking incident on 01/26/20. -Interventions put into place after Resident #5's choking incident on 01/26/20 included HH ST and an addition to her diet order for no bacon. -Supervision for Resident #5 was not increased after the choking incident on 01/26/20. -One to one assistance was never provided to Resident #5 because "she did not require	D 270		

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D 270	Continued From page 17 physical assistance with feeding." -Staff "kept their eyes on her (Resident #5) at all times." Telephone interview with the Administrator on 04/30/20 at 2:51pm revealed: -She expected all care staff (MAs and PCAs) in the dining rooms during meals. -Any resident requiring feeding assistance was expected to have one to one assistance. -There should always be 2 PCAs in the dining room and a MA nearby for supervising. -There should be 1 PCA at the table with residents requiring feeding assistance and a second PCA roaming the dining room to supervise the other residents. -She was told after Resident #5's choking incident, there was a period of time that only 1 staff person was in the dining room during the breakfast meal on 02/22/20. -She did not know why only 1 care staff was in the dining room when Resident #5 ate an orange slice and subsequently choked, but this was not her expectation. _____ The facility failed to ensure Resident #5, who resided in the Special Care Unit (SCU) with a diagnosis of vascular dementia, a history of dysphagia, and a previous choking episode, was properly supervised at meals which led to her choking on a whole orange slice, going into cardiac arrest with no pulse for at least 10 minutes, suffering severe brain damage, and resulted in her death. Failure to ensure proper supervision resulted in serious physical harm and death of a resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/28/20 for	D 270		

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D 270	Continued From page 18 this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 31, 2020.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute healthcare needs for 1 of 5 sampled residents (Resident #5) related to diet order recommendations to prevent choking. The findings are: Review of Resident #5's current FL2 dated 10/23/19 revealed: -Diagnoses included vascular dementia with behavioral disturbance and forgetfulness. -The current level of care was documented as SCU (Special Care Unit). -Resident #5's orientation was documented as constantly disoriented. -There was a diet order for "regular chopped." Review of Resident #5's diet order description dated 10/09/19 revealed: -There was a category of diets titled "Mechanical Soft" with a description "this modification is	D 273		

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ordered for residents who have difficulty chewing but are able to tolerate more texture than a pureed diet offers. This diet is modified in consistency only. This modification can be limited to a portion of the meal, such as "Meats Only," or can apply to the "Entire Meal."
-Under the category of Mechanical Soft, there were two options; one was "Entire Meal" and the second option was "Meats Only."
-Next to the "Meats Only" option, there was a choice of "chopped" or "ground."
-There were check marks for the Mechanical Soft category and check marks for the "Meats Only" option and "chopped" choice.
-There was no check mark for the "Entire Meal" option.

Review of Resident #5's physician's orders dated 01/26/20 revealed an order for "no bacon."

Review of Resident #5's accident/incident report dated 02/22/20 revealed:
-Resident #5 had a witnessed choking incident in the dining room on 02/22/20 at 8:00am.
-First aid administered was documented as Heimlich, finger sweep, and CPR (cardiopulmonary resuscitation).
-Resident #5's level of consciousness was documented as unresponsive.
-Resident #5 was transported to the emergency department (ED) via ambulance.

Review of Resident #5's accident/incident report dated 01/26/20 revealed:
-Resident #5 had a witnessed choking incident in the dining room on 01/26/20 at 8:28am.
-First aid administered was documented as Heimlich.
-Resident #5's level of consciousness was documented as able to state name and answer.

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D 273	Continued From page 20 -Resident #5 was transported to the ED via ambulance. Review of Resident #5's Speech and Language Pathologist (SLP) encounter note dated 01/27/20 revealed: -Resident #5 completed a modified barium swallow study (MBSS) on 11/05/19 with diet recommendations for mechanical soft consistencies and thin liquids. -Resident #5's family member contacted the SLP on 01/27/20 and stated Resident #5 had difficulty with eating bacon at her facility and requested a report be sent to the facility with diet recommendations. Review of Resident #5's SLP's procedure note dated 02/14/20 revealed: -Resident #5 had a repeat MBSS on 02/14/20 in the setting of increased coughing with eating and drinking as well as episodic choking incidents. -Resident #5 exhibited mild oral and mild to moderate pharyngeal deficits. -The SLP recommended a mechanically altered/ground diet. Review of Resident #5's Home Health (HH) SLP progress notes revealed: -Resident #5 was initially seen on 02/05/20 for a dysphagia (difficulty with swallowing) evaluation. -During the evaluation, Resident #5 demonstrated overt signs and symptoms of aspiration after swallowing thin water and an impaired oral phase of swallowing. -The HH SLP recommended a MBSS and speech therapy (ST) treatment to address dysphagia. -On 02/18/20, there was documentation the MBSS had been completed with a recommendation for a mechanical soft diet.	D 273		

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Review of Resident #5's progress notes dated 02/18/20 revealed there was documentation by a MA, Resident #5 had been seen by her HH SLP and "she (the HH SLP) reported Resident #5 should have a mechanical diet, regular liquids, and absolutely no straws."

Telephone interview with a MA on 04/24/20 at 1:51pm revealed:
-Resident #5 had a choking incident while eating breakfast on 02/22/20 and lost consciousness.
-EMS was called to the facility.
-EMS staff used "tongs" to remove an orange slice from Resident #5's throat.
-Resident #5 began breathing again and was transported to the hospital.
-Resident #5 had a previous choking incident with bacon approximately 1-2 months prior.
-Resident #5 routinely ate orange slices with no issue.
-Resident #5 was receiving ST services and had been placed on a ground meat diet with no bacon.
-The only modification made to Resident #5's diet was grinding of the meat and no bacon served.

Telephone interview with a PCA on 04/24/20 at 3:23pm revealed:
-Resident #5 had a choking episode between 8:00am and 9:00am on 02/22/20.
-Resident #5's tray arrived from the kitchen with raw orange slices on it.
-Resident #5 had issues in the past with trying to place whole orange slices in her mouth so she removed the bowl of orange slices and placed them in the center of Resident #5's table.
-Resident #5 would "do okay if you sat with her and encouraged her to take small bites of the orange slice."
-She did not know Resident #5 had eaten an

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orange slice until EMS staff reported that was what she choked on.
-She did not know if Resident #5 had been able to reach her removed bowl of orange slices, or if she had taken orange slices off her neighbor's plate.
-She had been told by other staff, Resident #5 had a "couple" choking incidents prior to her coming to work at the facility in December 2019.
-Resident #5 was on a ground meat diet with no bacon.
-The only modification made to Resident #5's diet was grinding of the meat and no bacon served.

Telephone interview with a second MA on 04/28/20 at 11:45am revealed:
-On 02/22/20, the SCU PCA came over to the AL side of the facility to get her because Resident #5 was choking.
-911 was called and the dispatcher instructed them to start CPR, so she did.
-EMS staff used "tongs" to remove an orange slice "wedged deep down" in Resident #5's throat.
-Resident #5 had a diet order for either chopped or ground meats (she could not remember which) with no bacon.
-She did not know Resident #5 had any difficulty in the past with eating orange slices.
-She was not sure if Resident #5 had been served orange slices or if she had taken them off another resident's plate.
-Resident #5 was receiving HH ST services.
-She documented in a progress note on 02/18/20, Resident #5 had been seen by her HH SLP and "she (the HH SLP) reported Resident #5 should have a mechanical diet, regular liquids and absolutely no straws."
-She also verbally reported this information to the Memory Care Coordinator (MCC) on 02/18/20 and was told this was the diet Resident #5 was

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D 273	Continued From page 23 already on. Telephone interview with the facility cook on 04/27/20 at 11:38am revealed: -She was not working on 02/22/20 when Resident #5 had a choking incident with an orange slice. -Resident #5's diet order was chopped meats with no bacon. -Residents on a chopped meat diet had their meats finely chopped in the food processor, but there were no modifications made to other foods on the menu. -She had never been told Resident #5 had any issues with eating orange slices. -Fresh fruit, either orange slices or bananas, were served to residents daily for breakfast. -Orange slices were routinely served to Resident #5. -The oranges were raw and cut into four slices with the peel left on. -Meals were plated in the kitchen by kitchen staff and taken to the SCU in a cart. Telephone interview with the dietary manager (DM) on 04/28/20 at 1:07pm revealed: -She was working as the cook on 02/22/20 when Resident #5 had a choking incident with an orange slice. -She did not witness the choking incident. -She plated Resident #5's plate in the kitchen with scrambled eggs, ground sausage, orange slices, and either toast or pancakes. -The oranges were raw with the peel left on and cut into 4-5 sections. -She delivered Resident #5's plate to the SCU dining room for the MA and PCA to serve. -She was told after the choking incident; the care staff had removed the orange slices from Resident #5's plate because "she couldn't have them."	D 273		

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-She routinely plated Resident #5's plate with orange slices because no one had ever told her Resident #5 could not have orange slices.
-Resident #5's diet order was ground meat with no bacon.
-The only modifications made to Resident #5's meals were grinding of her meat in the food processor and no bacon served.

Telephone interview with an Emergency Medical Technician (EMT) on 04/27/20 at 2:19pm revealed:
-He responded to the facility on 02/22/20 during Resident #5's choking incident.
-He "assessed the environment" and all the residents' meal trays he saw had raw orange slices on them.
-A facility staff member told him "I think she (Resident #5) has choked on an orange slice."
-Resident #5 did not have a pulse when he arrived.
-He used forceps to remove an orange slice from deep within Resident #5's throat.
-The peel had been removed from the orange slice found in Resident #5's throat.
-CPR was performed for about 10 minutes.
-Once EMS staff were able to obtain a pulse for Resident #5, they transported her to the hospital.

Telephone interview with a SLP on 04/29/20 at 1:44pm revealed:
-She saw Resident #5 for a MBSS on 11/05/19 after receiving a referral from the resident's gastrointestinal physician.
-The result of Resident #5's MBSS on 11/05/19 was "mild oral pharyngeal dysphagia likely exacerbated at times by Resident #5's advanced cognitive deficits with distractibility."
-Her recommendations included a diet for mechanically altered foods with a finely chopped

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consistency.
-She provided a report with all her recommendations to Resident #5's family member and sent a report to the referring physician.
-On 01/27/20, Resident #5's family member contacted her via phone requesting she fax her recommendations from the 11/05/19 MBSS to the facility because Resident #5 had a recent choking episode with bacon.
-She faxed her recommendations to the facility on 01/27/20 at 10:08am.
-She saw Resident #5 again on 02/14/20 for another MBSS after receiving a referral from the resident's primary care provider (PCP).
-The result of Resident #5's MBSS on 02/14/20 was "mild oral and mild to moderate pharyngeal deficits."
-Her recommendations included a diet for mechanically altered foods with a ground consistency.
-She faxed a report with all her recommendations to the facility on 02/14/20 at 3:54pm and provided a copy to Resident #5's family member.

Telephone interview with Resident #5's HH SLP on 04/27/20 at 10:24am revealed:
-Resident #5's start of care date for HH ST services was 02/05/20 after receiving a referral due to a recent choking incident with bacon.
-She recommended a mechanical soft diet and was told by facility staff that was already Resident #5's diet order.
-A mechanical soft diet and a mechanically altered diet were "universally" understood as a diet that required foods be a ground consistency, similar to ground hamburger meat, and did not allow any raw fruits or vegetables.
-Bacon and raw orange slices were not allowed on a mechanical soft diet.

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D 273	Continued From page 26 -The terms "chopped meats diet" and "ground meats diet" only referred to modifications made to meats and was not the same as a mechanical soft diet. -During her breakfast meal observation on 02/10/20, Resident #5 was not served bacon or orange slices. -On 02/05/20, after her initial evaluation of Resident #5, she provided a 4-page written document with her recommendations to the MCC with documentation Resident #5 was to be on a mechanical soft diet. -The MCC told her she would share her recommendations with the care staff. Telephone interview with Resident #5's family member on 05/01/20 at 9:46am revealed: -She accompanied Resident #5 to her swallow study on 11/05/19. -When she brought Resident #5 back to the facility after her swallow study, she provided a written copy of the SLP's recommendations to the MCC. -After Resident #5's choking episode on 01/26/20, she requested the SLP fax another copy of the recommendations to the facility on 01/27/20. -She accompanied Resident #5 to her swallow study on 02/14/20. -When she brought Resident #5 back to the facility after her swallow study, she provided a written copy of the SLP's recommendations to an evening shift MA. -The family never refused for the facility to implement any of the SLP's recommendations. Telephone interview with the MCC on 04/28/20 at 9:06am revealed: -She provided oversight to the care staff in the SCU.	D 273		

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-She worked night shift, and had already left for the day, so she was not working at the time of Resident #5's choking incident on 02/22/20.
-She received a phone call from the MA reporting Resident #5 had choked on scrambled eggs and EMS staff had removed an orange slice wedged in her throat.
-She thought Resident #5 was on a mechanical soft ground meat diet and orange slices were not allowed to be served to her.
-Staff reported Resident #5 was not served orange slices, and that she must have gotten them from another resident's plate.
-She never saw the written recommendations from Resident #5's SLP who performed her two MBSS.
-She was responsible for processing recommendations and orders for the SCU residents.
-If there was a recommendation for a diet order change, it was her responsibility to contact the residents' PCPs and request a new diet order.
-She knew Resident #5's HH SLP recommended a mechanical soft diet, but she thought Resident #5's diet order was already mechanical soft.
-She thought maybe she had requested a diet order change from Resident #5's PCP after her HH SLP made the recommendation for a mechanical soft diet, but she was not at the facility to locate it.
-Resident #5's family never refused for her to be served a mechanical soft diet.

Telephone interview with Resident #5's PCP's family nurse practitioner (FNP) on 04/29/20 at 11:21am revealed:
-Her last visit with Resident #5 was a well care visit on 11/14/19.
-She was on leave from 12/31/19-03/20/20.
-Resident #5 had been referred for a MBSS in

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D 273	Continued From page 28 November 2019 due to dysphagia. -The facility did not reach out to her to request a diet order change. Telephone interview with the Clinic Coordinator for Resident #5's PCP on 04/30/20 at 10:46am revealed: -The facility never reached out to Resident #5's PCP to request a diet order change from chopped meats only to mechanical soft. -If the facility had requested a diet order change, Resident #5's PCP would have changed her diet to mechanical soft based on the SLP's recommendations. Telephone interview with the Administrator in Charge (AIC) on 04/29/20 at 4:05pm revealed: -She was not working on the day of Resident #5's choking incident on 02/22/20. -Staff initially thought Resident #5 had choked on scrambled eggs until EMS staff removed an orange slice from her throat. -No one had communicated to her Resident #5 had ever had issues with eating orange slices. -Orange slices were allowed on Resident #5's diet, but she was not sure if she had been served orange slices on the day of her choking incident. -She did not know if the facility had received the SLP's recommendations for Resident #5 to be served a mechanical soft diet. -It would be the MCC's responsibility to process recommendations and orders for residents residing in the SCU. -She thought Resident #5's family had refused dietary recommendations in the past, but she was not sure which recommendations they refused. -If the family refused recommendations, it should be documented in Resident #5's progress notes and she would attempt to locate this documentation.	D 273		

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D 273	Continued From page 29 Review of an email from the AIC on 04/30/20 at 1:12pm revealed she was not able to find any further documentation in Resident #5's record to share with the survey team. Telephone interview with the Administrator on 04/30/20 at 2:51pm revealed: -The MCC was responsible for processing recommendations received from providers such as SLPs. -The MCC was responsible for following up with the residents' PCPs and family. -The MCC should request results of tests and documentation of any subsequent recommendations if no information was provided. -If Resident #5's family refused to allow the facility to request a change in her diet order from her PCP, there should be documentation in Resident #5's progress notes in regard to the family's refusal, education provided to the family regarding the risk of not following the recommendations, and the family's understanding of the information provided. _____ The facility failed to follow-up with Resident #5's PCP to request a diet order change based on recommendations from a SLP after multiple MBSS. This failure put Resident #5, who had a history of dysphagia, at risk for choking. Failure to ensure healthcare follow-up was detrimental to the health and safety of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/29/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 15, 2020.	D 273		

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D 443	10A NCAC 13F .1208 (c) Death Reporting Requirements 10A NCAC 13F .1208 Death Reporting Requirements (c) A written notice containing the information under Paragraph (d) of this Rule shall be made within three days of any death resulting from violence, accident, suicide or homicide. (d) Written notice may be submitted in person or by telefacsimile or electronic mail. If the reporting facility does not have the capacity or capability to submit a written notice immediately, the information contained in the notice may be reported by telephone following the same time requirements under Subparagraphs (b) and (c) of this Rule until such time the written notice may be submitted. The notice shall include at least the following information: (1) Reporting facility: Name, address, county, license number (if applicable), Medicare/Medicaid provider number (if applicable), facility administrator and telephone number, name and title of person preparing report, first person to learn of death and first staff to receive report of death, and date and time report prepared; (2) Resident information: Name, Medicaid number (if applicable), date of birth, age, sex, race, primary admitting diagnoses, and date of most recent admission to an acute care hospital. (3) Circumstances of death: place and address where resident died, date and time death was discovered, physical location decedent was found, cause of death (if known), whether or not decedent was restrained at the time of death or within 7 days of death and if so, a description of the type of restraint and its usage, and a description of events surrounding the death; and (4) Other information: list of other authorities	D 443		

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such as law enforcement or the County Department of Social Services that have been notified, have investigated or are in the process of investigating the death or events related to the death.
(e) The facility shall submit a written report, using a form pursuant to G.S. 131D-34.1(e). The facility shall provide, fully and accurately, all information sought on the form. If the facility is unable to obtain any information sought on the form, or if any such information is not yet available, the facility shall so explain on the form.
(f) In addition, the facility shall:
(1) Notify the Division of Facility Services immediately whenever it has reason to believe that information provided may be erroneous, misleading, or otherwise unreliable;
(2) Submit to the Division of Facility Services, immediately after it becomes available, any information required by this rule that was previously unavailable; and
(3) Provide, upon request by the Division of Facility Services, other information the facility obtains regarding the death, including, but not limited to, death certificates, autopsy reports, and reports by other authorities.

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to provide a written death notification for 1 of 1 resident (#5).

Review of Resident #5's current FL2 dated 10/23/19 revealed diagnoses included hypertension, hyperlipidemia, vitamin D deficiency, Stress urinary incontinence, osteoporosis, history of transient ischemic attack, vascular dementia with behavioral disturbances,

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D 443	Continued From page 32 and forgetfulness. Review of Resident #5's Accident /Incident Report dated 02/22/20 revealed a choking incident occurred in the dining room requiring the Heimlich maneuver, finger sweep, cardiopulmonary resuscitation (CPR), and emergency medical services to transport Resident #5 to the hospital. Telephone interview with the Administrator on 04/30/20 at 2:45pm revealed: -After Resident #5's death occurred 02/27/20 she was notified within one to two days later by the family. -She did not complete the written death report because the death did not occur at the facility. -When she spoke to the county Adult Home Specialist, she gave her the impression a written death report was not required because Resident #5's death did not occur at the facility. -She did not know a written death report was required within 3 days after the facility was notified of Resident #5's death. -She was responsible for ensuring written death reports were completed. Telephone interview with the county Adult Home Specialist on 04/30/20 at 4:00pm revealed: -She was informed of Resident #5's death a week ago when the complaint investigation was initiated. -She did not receive written notification from the facility of Resident #5's death on 02/27/20.	D 443		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents	D 451		

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D 451	Continued From page 33 (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to report to the County Department of Social Services (DSS) two incidents of choking requiring emergency medical care for 1 of 1 resident (#5). The findings are: Review of Resident #5's current FL2 dated 10/23/19 revealed diagnoses included hypertension, hyperlipidemia, vitamin D deficiency, Stress urinary incontinence, osteoporosis, history of transient ischemic attack, vascular dementia with behavioral disturbances, and forgetfulness. a. Review of Resident #5's Accident/Incident Report dated 01/26/20 revealed a choking incident occurred in the dining room requiring the Heimlich maneuver and emergency medical services (EMS) to transport Resident #5 to the hospital. Review of Resident #5's electronic progress notes revealed: -On 01/26/20 Resident #5 choked at breakfast.	D 451		

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-The medication aide (MA) and personal care aide (PCA) attempted to perform the Heimlich maneuver with finger sweep to stop the choking incident.
-EMS was called, and EMS transported Resident #5 to the hospital.

b. Review of Resident #5's Accident /Incident Report dated 02/22/20 revealed a choking incident occurred in the dining room requiring the Heimlich maneuver, finger sweep, cardiopulmonary resuscitation (CPR), and emergency medical services transported Resident #5 to the hospital.

Review of Resident #5's electronic progress notes revealed:
-On 02/22/20 Resident #5 started choking on eggs and oranges.
-The MA attempted to perform the Heimlich maneuver with finger sweep to stop the choking without success.
-Another MA called 911 who instructed the MAs to begin CPR until EMS arrived and transported Resident #5 to the hospital.

Telephone interview with the Memory Care Coordinator (MCC) on 04/30/20 at 3:00pm revealed:
-She received Resident #5's completed incident reports for incidents that occurred on 01/26/20 and 02/22/20 that were completed by the medication aides (MA).
-She reviewed Resident #5's incident report and faxed them to DSS the same day she received them.
-She placed Resident #5's incident reports and the faxed confirmations in the notebook in the nurses' station.
-At times the fax machines did not provide a

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confirmation that a fax was transmitted successfully.
-She did not call DSS to confirm the receipt of the fax.

Telephone interview with the Administrator in Charge on 04/30/20 at 2:15pm revealed:
-The MAs and the MCC were responsible for completing incident reports for Resident #5.
-The MCC was responsible for reviewing Resident #5's incident reports and faxing them to DSS.
-After Resident #5's incident reports were reviewed and faxed to DSS they were placed in a notebook in the nurses' station.
-She reviewed the incident reports for Resident #5 dated 01/26/20 and 02/22/20.
-She did not check the notebook to see if Resident #5's incident reports had been faxed to DSS.

Telephone interview with the Administrator on 04/30/20 at 2:45pm revealed:
-She was told Resident #5 had two incidents of choking on 01/26/20 and 02/22/20.
-She expected the MAs and MCC to complete incident reports for Resident #5.
-The MCC or the Resident Care Manager reviewed facility incident reports and faxed them to DSS.
-She did not review Resident #5's incident reports and check to see if they were faxed to DSS.
-She was responsible for ensuring Resident #5's incident reports were sent to DSS.

Telephone interview with the DSS Adult Home Specialist on 04/30/20 at 4:00pm revealed she did not receive notification of Resident #5's two incidents of choking requiring emergency medical care.

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D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on 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 as related to health care. The findings are: Based on record reviews and interviews the facility failed to follow-up with Resident #5's Primary Care Provider to request a diet order change based on recommendations from a Speech Language Pathologist after multiple modified barium swallow studies. This failure put Resident #5, who had a history of dysphagia, at risk for choking. Failure to ensure healthcare follow-up was detrimental to the health and safety of the resident. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		
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:	D914		

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D914	Continued From page 37 Based on observation, interview and record review, the facility failed to ensure residents were free of neglect, abuse and exploitation related to health care. The findings are: Based on interviews and record reviews, the facility failed to ensure Resident #5, who resided in the Special Care Unit with a diagnosis of vascular dementia, a history of dysphagia, and a previous choking episode, was properly supervised at meals which led to her choking on a whole orange slice, going into cardiac arrest with no pulse for at least 10 minutes, suffering severe brain damage, and resulted in her death. Failure to ensure proper supervision resulted in serious physical harm and death of a resident. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D914		