STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING ______ B. WING ______	C 05/23/2019

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ELIZABETH CITY HEALTH AND REHABILITATION	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

(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) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted from 05/22/19 through 05/23/19. Past-noncompliance was identified at: CFR 483.60 at tag F805 at a scope and severity (J) Non-noncompliance began on 12/12/18. The facility came back in compliance effective 12/14/18. An extended survey was conducted.	F 000		
F 805 SS=J	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews, the facility failed to provide food in a form according to dietary orders for 1 of 3 residents reviewed for dietary orders. Resident #1, who was ordered a pureed diet, was given a regular peanut butter and jelly sandwich by facility staff which caused Resident #1 to choke and subsequently resulted in Resident #1 ' s death. Findings included: Resident #1 was admitted to the facility on 3/15/18. Her diagnoses included Alzheimer ' s disease and dementia. The physician ' s orders dated 6/20/18 revealed the resident was ordered to have a speech	F 805	Past noncompliance: no plan of correction required.	5/31/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/31/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 805	Continued From page 1 therapy evaluation and to change the resident ' s diet to a pureed diet. A speech therapy plan of care form dated 6/20/18 revealed Resident #1 was seen during dinner. She displayed a quick pace with her meal and required multiple cues to slow down. Due to the decreased chewing and increased signs and symptoms of aspiration with the mechanical soft diet, a pureed diet was recommended with nectar thick liquids. The speech therapy recommendation dated 6/27/18 revealed Resident #1 was recommended to have a pureed diet with nectar thick liquids. The speech therapy progress note dated 7/3/18 revealed Resident #1 demonstrated tolerance and safety with pureed diet and nectar thick liquids when maintaining a slower pace throughout the meal. And alternating between solids and liquids. She required skilled treatment for safety and education of staff on swallow precautions and strategies. The speech therapist progress and discharge summary dated 7/4/18 revealed Resident #1 was discharged from speech therapy. Resident #1 displayed difficulty and overt signs of aspiration with mechanical soft and ground meats diet. Resident #1 was downgraded to pureed, and no overt signs or symptoms of aspiration had been assessed. Resident #1 was tolerating pureed diet and demonstrating safety with diet. The post discharge recommendations for staff and caregivers were to position with meals at 90 degrees, small bites and sips, alternating solids and liquids and pacing Resident #1 throughout the meal. Resident #1 was to continue a pureed	F 805		

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F 805	Continued From page 2	F 805		

and nectar thick liquids diet.

Resident #1 ' s Minimum Data Set assessment dated 10/2/18 revealed she was assessed as severely cognitively impaired. She required limited assistance by one staff member with meals. She was assessed to be receiving a mechanically altered diet. She had not received speech therapy at that time.

Resident #1 ' s care plan dated 6/20/18 revealed the resident was ordered to have a pureed diet with nectar thick liquids. The interventions included to provide the resident her diet as ordered by the physician.

A nursing note written by Nurse #1 and dated 12/12/18 revealed at approximately 1:00 AM Nurse Aide #1 called Nurse #1 to the room and Nurse #1 observed Resident #1 with food in her mouth and could not expel all of the food. The resident was in a sitting position and continued to have difficulty getting food out of her mouth. The resident ' s eyes were opened and responded when spoken to. Back thrusts initiated with no success. Resident #1 became unable to breath and ceased respirations. Heimlich maneuver was performed with no success. A code was called, chest compressions were initiated, and 911 was called. Emergency medical services stopped cardiopulmonary resuscitation at 1:15 AM.

The Emergency Medical Services report dated 12/12/18 revealed at 12:54 AM on 12/12/18 a call was received from the facility and emergency medical services arrived at the resident ' s bedside at 1:03 AM. Nursing staff informed emergency medical services the resident had been eating a sandwich when she began

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F 805	Continued From page 3 choking. Nursing staff reported they had attempted the Heimlich maneuver without success and the resident became unresponsive, so staff initiated cardiopulmonary resuscitation at approximately 12:45 AM. Suction was applied by emergency medical services and the resident ' s airway was cleared and they took over cardiopulmonary resuscitation. At 1:10 AM Resident #1 was pronounced dead by emergency medical services. Resident #1 ' s death certificate dated 12/18/18 revealed the immediate cause of her death was asphyxia (choking) secondary to the occlusion (blockage) of her airway by a bolus (mass) of food. The injury was documented to have occurred due to eating a sandwich. During a phone interview on 5/22/19 at 2:49 PM Nurse Aide #1 stated she remembered Resident #1 very well and she was a familiar resident on her shift. She stated on 12/12/18 she was passing snacks in the facility and she went to Resident #1 ' s room and Resident #1 ' s roommate wanted a snack and so she gave her a peanut butter and jelly sandwich. Nurse Aide #1 checked the resident ' s care guide in the closet which indicated Resident #1 was on a regular diet. Then she gave Resident #1 a peanut butter and jelly sandwich as well and stayed in the room. She stated she broke the sandwich into four pieces and gave a little piece at a time. She stated the peanut butter and jelly sandwich was whole and she was giving it to Resident #1 in small pieces approximately the size of her thumb. She stated Resident #1 began eating too fast without chewing after a few bites which caused her to start choking on a piece of the sandwich. She stated she went and got the nurse. She	F 805		

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F 805	Continued From page 4	F 805		

stated the nurse came in immediately and started trying to get pieces of the sandwich out of her mouth herself and asked the nurse aide what she had eaten, and she told her it was a peanut butter and jelly sandwich. She stated the nurse was unable to clear the resident ' s airway, so she got behind Resident #1 and attempted the Heimlich maneuver with no success. She stated she shouted down the hall for extra help and the other two nurses on staff came running in and Resident #1 became unresponsive. She further stated every resident had a care guide that was placed in their closet which was to be used to know what diet the resident had. She stated at that time she was not aware that Resident #1 was on a pureed diet because the care guide in the resident ' s room was not updated correctly and still said regular diet in her closet. She stated the Assistant Director of Nursing then called the facility that night and asked what happened so the nurse aide told her. She stated the Assistant Director of Nursing informed Nurse Aide #1 that the care guide was wrong in the closet and Resident #1 was on a pureed diet and the nurse aide should have asked a nurse or someone else what kind of diet Resident #1 was on prior to giving the resident something to eat. Nurse Aide #1 concluded she had not given Resident #1 food except one other time since she was on night shift. She could not remember what she gave the resident previously.

During a phone interview on 5/22/19 at 2:25 PM Nurse #1 stated she took care of Resident #1 often and remembered her. She stated on 12/12/18 around 1:00 AM Nurse Aide #1 came to the nurse and told her Resident #1 was choking. She stated she then went into Resident #1 ' s room, saw the resident had something in her

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F 805	Continued From page 5 mouth, was coughing, and displayed signs of not being able to breath. The nurse stated Resident #1 was sitting up when she entered the room and she got behind Resident #1, pulled her straight up so she could get to her abdominal area, and then she performed the Heimlich maneuver on Resident #1. She stated she asked Nurse Aide #1 what Resident #1 was eating and the nurse aide told her it was a peanut butter and jelly sandwich. She stated the Heimlich maneuver did not work and Resident #1 then became unresponsive soon after she had entered the room. Once Resident #1 became unresponsive cardiopulmonary resuscitation was initiated and 911 was called. She stated Resident #1 had eaten some of a peanut butter and jelly sandwich and she was unable to tell if the sandwich was pureed, whole, or mechanically soft, however at night, to her knowledge, the only thing available was a peanut butter and jelly sandwich was whole. She stated they did also have apple sauce available for residents on a pureed diet who wanted a snack at night. She stated she normally did not provide meals for residents since she was on night shift but if a resident asked for a snack she would check what diet they were ordered on the electronic health record. During a phone interview on 5/22/19 at 5:10 PM Speech Therapist #1 stated she did work with Resident #1. She stated the resident was a very fast eater and drinker and would aspirate on her meals. She stated the resident required multiple cues to slow down and pace herself and ultimately required a downgrade to a pureed diet due to the issue of eating too fast and not chewing. She stated during her time working with the resident she continued to eat fast and was only able to demonstrate safety with a pureed	F 805		

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F 805	Continued From page 6	F 805		

diet. She stated she left the facility in October of 2018 and that was the last time she worked with the resident and Resident #1 had shown no sign of improvement. The dietary issues were a result of Resident #1 ' s disease process and it was very unlikely she would improve. She concluded even on one on one Resident #1 was not safe with any diet besides a pureed diet.

During a phone interview on 5/23/19 at 8:52 AM Dietitian #1 stated she was the dietitian for the facility. She continued to state a whole peanut butter and jelly sandwich broken into smaller pieces would never be okay in a pureed diet. She stated Nurse Aide #1 should not have given Resident #1 a peanut butter and jelly sandwich broken up since the resident was ordered a pureed diet.

During a phone interview on 5/23/19 at 7:55 AM Physician #1 stated he remembered Resident #1 and was her physician during her stay in the facility. Physician #1 continued to state he suspected that had the resident gotten a pureed snack instead of a regular peanut butter and jelly sandwich the resident ' s death at that time would have been avoided given the information in Resident #1 ' s medical record and death certificate. He stated Resident #1 was rather debilitated and when speech therapy recommended a pureed diet he felt the diet was appropriate and expected staff to follow the ordered diet and not give the resident regular food.

During an interview on 5/22/19 at 3:08 PM the Assistant Director of Nursing stated on 12/12/18 around 1:00 AM she got a call from Nurse #1 who informed her Resident #1 was choking and

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F 805	Continued From page 7 emergency medical services were in the facility working on her. She stated a few minutes later Nurse #1 called her back and informed her that emergency medical services had pronounced Resident #1 dead. She stated she then called the Administrator and then called back to speak with Nurse #1 and asked her what diet Resident #1 was on. She stated Nurse #1 told her she was on a pureed diet, so she asked to speak with Nurse Aide #1. She stated Nurse Aide #1 told her that Resident #1 had asked specifically for a peanut butter and jelly sandwich and that she had gotten the sandwich and Resident #1 started eating. She stated the nurse aide then told her she was still in the room and Resident #1 started to make some sounds and she went to get the nurse. She stated she then told Nurse Aide #1 that the resident was on a pureed diet. Nurse Aide #1 informed her the care guide in the closet indicated Resident #1 was on a regular diet. She stated she told Nurse Aide #1 to check with the nurse before giving any resident anything else. She then told Nurse #1 to remove all care guides from resident rooms. She stated she arrived at the facility around 7:00 AM and the Management met to come up with a quality assurance and performance improvement plan about the care guides. She concluded because Resident #1 was cognitively impaired, when she asked for a peanut butter and jelly sandwich, Nurse Aide #1 should have checked with her nurse about the resident ' s diet and because Resident #1 was on a pureed diet she should not have given her a regular peanut butter and jelly sandwich. She stated now all care guides are kept at the nurse ' s station as a result of their quality assurance and performance improvement plan. The Assistant Director of Nursing also said the dietary orders were no longer on the care guides and only on the	F 805		

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F 805	Continued From page 8 electronic record available to both nurse aides and nurses. She further stated there had not been any incidents or issues since implementing this plan. During an interview on 5/22/19 at 3:56 PM the Director of Nursing stated she remembered Resident #1. She stated she remembered at some point early on the morning of 12/12/18 she got a phone call from the Assistant Director of Nursing and notified her that Resident #1 choked. She stated the Assistant Director of Nursing informed her that Nurse Aide #1 had given Resident #1 a regular peanut butter and jelly sandwich and she choked on it. The Assistant Director of Nursing informed her it was an issue with the care guide in closet saying Resident #1 could have a regular diet but Resident #1 was actually on a pureed diet. The Assistant Director of Nursing informed her she had instructed staff to remove the care guide in everyone ' s closet and only go by what was on the electronic records until management could investigate the concern. She stated she came to work that morning and the facility nurse consultant was on the way to the facility as well for a meeting. She stated they audited the physician orders and compared them to the orders in the electronic records to ensure they were in correctly. She stated then they audited to insure the orders were correctly transcribed on the tray cards as well. All of this was completed within a few days. She stated the facility then did education with nursing assistants and staff about where to find what resident dietary orders were and they began using a part of the electronic chart that placed the dietary orders on the electronic chart and available to both nurses and nurse aides. She stated that was the immediate action. The nurse	F 805		

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F 805	Continued From page 9 consultant also educated the management staff about the use of the electronic records for dietary orders. She stated the crux of the issue was that the dietary order was placed in multiple locations and not all the locations were being updated in a timely manner. To fix this they removed dietary orders from the resident care guides and only place them in the electronic record where both nurses and nurse aides could access the orders. She stated every day for the first four weeks diet orders were compared with the diet slip, tray card, and order placed in the electronic record every morning and the results were brought to their clinical meetings. She stated nurse aides were also instructed to clarify with their nurse prior to giving requested snacks to residents. During an interview on 5/22/19 at 4:45 PM the Administrator stated she was not the Administrator at the facility during the time of the incident but was aware of the quality assurance and improvement plan that had been implemented prior to her arrival and there had been no concerns with dietary orders during her time in the facility. During an interview on 5/23/19 at 8:30 AM the Regional Operations Manager stated on 12/12/18 she was notified by the former Administrator that Resident #1 had died after choking on a sandwich. She stated the Administrator had already started education with staff about appropriate diets, care guides were removed from all closets prior to her arrival at the facility that day. Upon arriving at the facility, the Quality Assurance committee at the facility had already had started a 100% audit to include diet orders, tray card slips, and care guides for all residents. She stated she identified that the nurse aide did	F 805		

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F 805	Continued From page 10 check the care guide in the closet however the care guide was incorrect and not updated which lead to Resident #1 getting food from Nurse Aide #1 that was not compatible with her ordered pureed diet. She stated they developed a change in how the care guides were organized and removed diets from the care guides. They began entering the dietary orders into the electronic record where both nurses and nurse aides could access the orders in one place which removed having to update the orders in multiple locations. All staff were then educated about this new location for the dietary orders and non-clinical staff members without access to the orders were educated to ask the nurse prior to giving a resident any form of food or beverage. All care guides were placed in a book at the nurses ' station to be brought in to clinical meetings and updated as needed even though dietary orders were no long on the care guides. During these clinical meetings the dietary manager now reads new admission dietary orders or dietary order changes on his communication sheets and these orders are checked against the physician ' s orders in the electronic records. Any changes in physician ' s orders are then read to ensure they were captured by the dietary communication sheet to ensure no changes in dietary orders are missed by dietary. On 5/23/19 at 10:00 AM the facility provided the plan of correction for tag F805 as follows: "1. 100% care guides removed from resident closets on 12-12-18 by the floor staff and verified removal by the Medical Records Manager and Central Supply Coordinator. 2. Diet orders and fluid consistency were	F 805		

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F 805	Continued From page 11 removed from all Resident Care Guides and new care guides were created by the Administrator, Director of Nursing and Assistant Director of Nursing. This information has been entered into Matrix in Administration notes by 12/14/18. 3. 100% chart audit for diet order, to Matrix order, to tray card completed by DON, ADON, Unit Managers, Dietary Manager and MDS nurses on 12/12/18 to validate consistency of diet orders. Any discrepancies were corrected on 12/14/18. 4. In-service provided to the Administrator, DON, ADON, MDS, Activity Director, Business Office Manager, Payroll, Admission Coordinator, Marketing Director, Medical Records, Social Service Director, Maintenance, Dietary Manager, Unit Managers by the Regional Clinical Manager on where to find correct resident diets and consistency in the Matrix Computer system on 12-14-18. 5. A 100% in-service to all licensed Nurses, all certified Nursing Assistants, Activity Director, Activity Assistants, Social Services, Housekeeping, Laundry, Maintenance, Dietary, Admissions, Billing Office, Medical Records, Supply, Payroll, receptionist, therapy on where to find correct diet order and consistency for residents in Matrix on 12-12-18. No staff was allowed to work without being in serviced. 6. A 100% in service to all licensed Nurses by the Assistant Director of Nursing related to how to enter a diet order into Matrix and how to enter the diet into Administration Notes so that the diet is visible in Matrix Care Assist by 12/14/18 7. 100% diet orders were entered into	F 805		

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F 805	Continued From page 12	F 805		

Administrative Notes by the Regional Clinical Consultant, Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing and Unit Manager for CNA ' s to visualize in the resident care chart by 12/14/18. All diets were categorized in the orders to allow for a diet list to be pulled.

8. DON, ADON, Unit Managers will verify new diet orders are entered correctly in the Matrix system and diet slip is completely correctly 5 times a week x 4 weeks. Then weekly x 4 weeks, then monthly x one month.

9. The Dietary Manager and DON, ADON or Unit Managers will compare the tray card orders to the Matrix MD orders weekly x 8 then monthly x one month.
10. The Dietary Manager and the DON or ADON will bring the results to the QA Committee monthly x 3 months."

The final completion date was 12/14/18.

The plan of correction was verified through review of the 100% audits of diet orders, education provided to staff related to the location of dietary orders in the electronic health record, a review of the weekly and monthly audits and monitoring documentation, and quality assurance meeting minutes. Staff interviews verified the education provided to staff. A review of pureed diets and observations of pureed diets provided to residents was also completed. The facility ' s date of compliance of 12/14/18 was verified.