

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL070008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2024
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NAME OF PROVIDER OR SUPPLIER WATERBROOKE OF ELIZABETH CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 143 ROSEDALE DRIVE ELIZABETH CITY, NC 27909
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D 000	Initial Comments The Adult Care Licensure Section and the Pasquotank Department of Social Services conducted an annual survey and complaint investigation on 09/24/24 to 09/26/24. The complaint investigations were initiated by the Pasquotank County Department of Social Services on 07/18/24 and 09/16/24.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure hot water temperatures were maintained at 100° to 116° degrees Fahrenheit (F) for 5 of 6 fixtures in the common residents' bathroom and shared residents' bathrooms on the special care unit (SCU) with temperatures of 120° degrees F to 129.2° degrees F. The findings are: Observation of common shower/bathroom on 09/24/24 at 9:42am revealed: -The hot water temperature at the sink was 129.2°F.	D 113		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 113	<p>Continued From page 1</p> <p>-The hot water temperature of the shower was 126.7°F.</p> <p>Observation of room 63 and 65 shared bathroom on 09/24/24 at 9:51am revealed:</p> <p>-The hot water temperature at the sink was 128.1°F.</p> <p>-The hot water temperature of the shower was 120.0°F.</p> <p>Interview with a resident in room 63 on 09/24/24 at 8:44am revealed:</p> <p>-The water was too hot, but he added cold water to bring the temperature down.</p> <p>-He liked the water hot, but it had not burned him.</p> <p>-He had noticed the maintenance staff checking the water temperature, but he had not reported the issue with the hot water.</p> <p>-He had not reported the issue to staff.</p> <p>Observation of the TV room on 09/24/24 at 9:55am revealed the hot water temperature at the sink in the residents' TV/sitting room was 122.7°F.</p> <p>Review of the contracted plumber's letter dated 09/25/24 revealed:</p> <p>-The date of the service was noted documented.</p> <p>-There were leaks found in the ¾ inch and 1 ¼ inch copper pipes in the laundry room.</p> <p>-The contracted plumber informed the Maintenance Director of any leaks will cause the temperature to vary and to reset the system.</p> <p>Interview with a personal care aide (PCA) on 09/24/24 at 9:58am revealed:</p> <p>-She used the common bathroom to shower the residents.</p> <p>-She adjusted the water handle between hot and cold and had noticed the hot water being too hot.</p>	D 113		

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D 113	<p>Continued From page 2</p> <p>-Residents had not complained about the hot water being too hot.</p> <p>Interview with a second PCA on 09/24/24 at 10:05am revealed:</p> <p>-She tested the hot water temperature by using her hands then used the adjustments on the handle to set the water temperature with hot and cold water.</p> <p>-The hot water was not too hot.</p> <p>-The residents had not complained about the hot water being too hot.</p> <p>Interview with a medication aide (MA) on 09/24/24 at 10:11am revealed:</p> <p>-Sometime the residents had complained about the hot water being too hot.</p> <p>-She would adjust the water temperature to the residents liking.</p> <p>-The residents or the PCAs had not complained about the hot water being too hot.</p> <p>-She had reported the hot water being too hot to the maintenance staff when they completed water temperature checks (date was not provided).</p> <p>-The hot water should not be too hot because of the fragility of residents' skin and their diagnoses should be considered.</p> <p>Interview with the Maintenance Director on 09/24/24 at 10:17am revealed:</p> <p>-He completed hot water temperature checks on random fixtures weekly.</p> <p>-The hot water temperature were to be from 105°F to 116°F.</p> <p>-There was a leak in the hot water heater that serviced the SCU on 09/23/24 and it caused the hot water temperature to increase.</p> <p>-He could adjust the hot water temperature and make repairs to the hot water heater when needed.</p>	D 113		

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D 113	<p>Continued From page 3</p> <p>Observation of the water thermometers being calibrated on 09/25/24 at 2:44pm revealed: -The second maintenance staff and surveyor's water thermometers were placed in a cup of ice water. -The second maintenance staff's water thermometer temperature was calibrated at 32.7°F. -The surveyor's water thermometer temperature was calibrated at 32.4°F.</p> <p>Observation of the re-check of water temperatures with the second maintenance staff and surveyor on 09/25/24 at 2:48pm revealed: -At 2:48pm, a "Caution/Hot Water" sign had been placed over the sink and on the wall near the shower in the common bathroom. -At 2:48pm, the hot water temperature at the bathroom sink was at 115.0°F completed by the second maintenance staff and at 115.2°F completed by the surveyor.</p> <p>Observation of the re-check of water temperature in rooms 63 and 65 with the second maintenance staff on 09/25/24 at 2:51pm revealed: -At 2:51pm, a "Caution/Hot Water" sign had been placed on the bathroom wall of the residents' rooms 63 and 65. -At 2:51pm, the hot water temperature at the bathroom sink was at 113.7°F completed by the second maintenance staff and at 113.2°F completed by the surveyor. -At 2:52pm, the hot water temperature at the bathroom shower was at 106.3°F completed by the maintenance staff and at 105.6°F completed by the surveyor.</p> <p>Observation of the re-check of water temperature in residents' common shower/bathroom with the</p>	D 113		

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D 113	<p>Continued From page 4</p> <p>second maintenance staff on 09/25/24 at 3:18pm revealed: -At 3:18pm, "Caution Hot Water" sign had been placed on the door of the shower/bathroom door. -At 3:18pm, the hot water temperature at the 2nd sink was at 116.7°F completed by the second maintenance staff and at 116.4°F completed by the surveyor. -At 3:19pm, the hot water temperature at the 1st shower was at 112.2°F completed by the second maintenance staff and was at 112.5°F completed at by the surveyor.</p> <p>Observation of the re-check of water temperature in the residents' TV/sitting room with the second maintenance staff on 09/25/24 at 2:59pm revealed: -At 2:59pm, a "Caution/Hot Water" sign had been placed at the sink in the residents' TV/sitting room. -At 3:23pm, the hot water temperature at the sink was at 108.7°F completed by the second maintenance staff and at 108.7°F completed by the surveyor.</p> <p>Interview with the Administrator on 09/25/24 at 9:41pm revealed: -There had been issues with leaking from the hot water heaters which would cause the hot water temperature to increase. -The hot water heater had a leak on 09/18/24 and was repaired by a contracted plumber. -The hot water heater had another leak on 09/23/24 and was repaired by the Maintenance Director. -The hot water temperature checks were completed and documented by the Maintenance Director. -The maintenance director could adjust the hot water heater temperature.</p>	D 113		

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D 113	<p>Continued From page 5</p> <p>Review of the North Carolina Division of Health Service Regulation Construction Section Hot Water Safety Guide revealed a water temperature of 127.4 degrees Fahrenheit (°F) could result in a first-degree burn in 30 seconds and a second-degree burn in 60 seconds.</p> <p>_____</p> <p>The facility failed to ensure hot water temperatures were maintained between 100° to 116° degrees Fahrenheit (F) on the special care unit (SCU) which resulted in hot water temperatures of 120.0°degrees F to 129.2° degrees F at 5 of 12 fixtures accessible to the residents. A hot water temperature of 127.4 could cause a first degree burn in 30 seconds. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/24/24 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2024.</p>	D 113		
D 119	<p>0A NCAC 13F .0311(j) Other Requirements</p> <p>10A NCAC 13F .0311 Other Requirements (j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This rule applies to new and existing facilities.</p>	D 119		

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D 119	<p>Continued From page 6</p> <p>This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure that a call bell system was in place for residents residing on the special care unit (SCU).</p> <p>The findings are:</p> <p>Review of the facility's license revealed the capacity was for 130 residents with 26 residents for the SCU.</p> <p>Review of the residents' census dated 09/24/24 revealed there were 23 residents on the SCU.</p> <p>Observation of the SCU on 09/24/24 from 9:15am to 10:00am revealed:</p> <ul style="list-style-type: none"> -The call bell system in 11 residents' rooms and their bathrooms was not operational. -The community bathroom located near the entrance/exit of the SCU call bell system was not operable. -The 11 residents' rooms did not have another signaling device option in the rooms. -There were four residents seated in the opened TV sitting area with chair alarms attached to their Geri-chairs and wheelchairs. -Residents in rooms 54 and 59 had a bed alarms attached to their beds. <p>Interview with a resident on 09/26/24 at 8:44am revealed:</p> <ul style="list-style-type: none"> -If she needed staff assistance she would scream out for help or go to the nurse's station. -She did not know she has a call bell in her room. -She pulled the string to the call bell, and it did not work. -She had not been instructed on how to call for assistance. 	D 119		

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D 119	<p>Continued From page 7</p> <p>Interview with a second resident 09/26/24 at 9:12am revealed: -He knew the call system in the room did not work. -He called out to staff for help or would walk up to the nurses' station if he needed help. -If the staff were busy, they would yell back to tell him they were busy and would be to his room shortly. -Residents who used Geri-chairs and wheelchairs had call system attached to the chairs. -He had not been given a handheld bell or any other alarm device to use to call for help.</p> <p>Interview with a third resident on 09/26/24 at 9:22am revealed: -She had an alarm that was attached to her bed or clothing. -The alarm would sound when it was detached from her bed or clothes. -When she needed assistance, she would call out to staff or detach the alarm so it would sound.</p> <p>Interview with a personal care aide (PCA) on 09/24/24 at 10:18am revealed: -The call bell system did not work in the residents' room. -There were no other means for residents to call for help unless they yelled out or came to the PCAs sitting area. -She would respond immediately when she heard a chair alarm sound or if a resident called out for help.</p> <p>Interview with a second PCA on 09/25/24 at 10:26am revealed: -The residents with Geri-chairs and wheelchairs had alarms attached and would sound if the alarm was snatched off by the resident.</p>	D 119		

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D 119	<p>Continued From page 8</p> <p>-Staff were to sit in the TV area with the residents and watch the hall if a resident called out for help.</p> <p>Interview with a medication aide (MA) on 09/25/24 at 2:59pm revealed: -There were bells placed on the residents' nightstand to use. -The call system had not worked in years. -Staff completed rounds every 30 minutes and were to be stationed at the opened TV area when not providing care to the residents.</p> <p>Interview with the Special Care Director (SCD) on 09/26/24 at 10:08am revealed: -The call system in the residents' rooms did not work. -Staff were to remain in the open TV area to help monitor the hall when they were not providing resident care.</p> <p>Interview with the Administrator on 09/26/24 at 5:25pm revealed the residents were cognitively impaired and could not use a call system.</p>	D 119		
D 271	<p>10A NCAC 13F .0901(c) Personal Care and Supervision</p> <p>10A NCAC 13F .0901 Personal Care and Supervision</p> <p>(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.</p>	D 271		

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D 271	<p>Continued From page 9</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure immediate response and intervention by staff for 1 of 6 resident (#6) who was found unresponsive in the special care unit (SCU).</p> <p>The findings are:</p> <p>Review of the facility's Medical Emergency policy with revision date of 01/01/23 revealed: -Staff designate someone to immediately call 911. -For choking, staff should begin the Heimlich Maneuver and attempt to dislodge the source. -For loss of consciousness due to any reason other than blood loss, staff should assess breathing, check vital signs and blood sugar levels, check for do not resuscitate (DNR) order. -If the resident is not a DNR and is not breathing, staff should begin chest compressions only and continue until EMS arrives.</p> <p>Review of the facility's cardiopulmonary resuscitation (CPR) Policy revealed: -In the event of the need for CPR within the facility, staff will not be obligated to perform mouth to mouth resuscitations. -The facility adopted a "compression only" CPR policy to reduce the risks of communicable infections of both residents and staff. -Chest compressions were to be completed at the rate of 100-120 compressions per minute to be performed. -Compressions were to be performed on residents who are not a do not resuscitate (DNR). -Compressions were to be performed if the resident was unresponsive or experiencing</p>	D 271		

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D 271	<p>Continued From page 10</p> <p>agonal or labored breathing and cannot other respond otherwise.</p> <p>-Staff may stop the compressions upon the arrival of 911 or arrival of another staff member to take over the compressions of an entire around or exhaustion.</p> <p>-Staff were to document the performance of the CPR and who assisted, the time the compressions stopped and the reason.</p> <p>Review of Resident #6's current FL-2 dated 03/18/24 revealed:</p> <p>-Diagnoses included vascular dementia w/ behaviors, hypertension, nontraumatic subdural hemorrhage, unspecified, and constipation.</p> <p>-The resident was constantly disoriented, had wandering behavior and was verbally abusive.</p> <p>-There was a regular diet order.</p> <p>-The recommended level of care was Special Care Unit (SCU).</p> <p>Review of Resident #6's physician's order dated 03/28/24 revealed:</p> <p>-The reason for the restraint was for safety of resident, staff, and individual.</p> <p>-The type of restraint to be used was Geri chair.</p> <p>-The restraint should be removed during meal times, snack times, and bed time.</p> <p>Review of Resident #6's current care plan dated 03/28/24 revealed:</p> <p>-Diagnoses included vascular dementia w/ behaviors, hypertension, nontraumatic subdural hemorrhage, and constipation.</p> <p>-The resident's orientation was always disoriented.</p> <p>-The resident had significant memory loss.</p> <p>-The resident's cognitive ability affected his ability to perform activities of daily living.</p> <p>-The resident's nutrition was oral, normal.</p>	D 271		

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D 271	<p>Continued From page 11</p> <ul style="list-style-type: none"> -The resident's mental health and social history documented that he was not oriented to time or place, he was not able to communicate wants/needs, likes/dislikes, and verbally aggressive. -The resident was independent with eating (ability to chew or swallow). <p>Review of Resident #6's diet order dated 05/23/24 revealed a diet order for pureed meat only.</p> <p>Review of Resident #6's progress notes dated 06/25/24 5:00am - 7:00pm revealed:</p> <ul style="list-style-type: none"> -The resident was eating and drinking too fast during meals. -Resident had no concept of slowing down to chew and swallow. -Resident got strangled during dinner. <p>Review of Resident #6's progress notes dated 06/26/24 3:00pm-11:00pm revealed Resident #6 was still eating fast during dinner, staff monitored for strangulation.</p> <p>Review of facility incident report dated 07/02/24 at 7:30pm revealed:</p> <ul style="list-style-type: none"> -Resident #6's was sitting by the nursing desk area with personal care aide (PCA). -The Resident was sitting and fidgeting in a chair. -The PCA noticed he was quiet, pale in color, and unresponsive. -There was documentation that no vital signs were taken. -Cardiopulmonary resuscitation (CPR) was started by staff and emergency medical services (EMS) was contacted. -EMS could not keep a heart rhythm despite rescue efforts. -EMS called the time of death at 8:02pm. 	D 271		

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D 271	<p>Continued From page 12</p> <p>Review of Emergency Medical Services (EMS) report dated 07/02/24 revealed:</p> <ul style="list-style-type: none"> -Upon arrival at 7:34 pm Resident #6 was found in the dementia section, on the floor, staff performing Cardiopulmonary Resuscitation (CPR). -Staff stated that resident was eating a sandwich when he got quiet and pale. -EMS took over chest compressions while fire department personnel placed the Lund University Cardiopulmonary Assist System (LUCAS) device on resident. -Resident #6 was placed on the monitor with multi-use pads in place that showed resident was in asystole (when your hearts electrical system fails entirely). -An IV was established with a 1 mg Epinephrine being administered with a pulse check and rhythm check in between each administration. (Epinephrine is a hormone used to increase cardiac output.) -While fire department was using the Bag-valve-mask (BVM) to ventilate the resident they noted resistance. -Upon visualizing the resident's airway, it was noted that copious amounts of food was in the resident's mouth and esophagus. -The resident was suctioned as well as the I-GEL was removed and the yankauer was used to remove food from the resident's mouth. -After the food was removed from the resident's airway the paramedic intubated the resident. -Resident #6 was placed back on capnography, there was a brief change of cardiac rhythm to pulseless electrical activity (PEA), but this was not sustained. (Capnography measures carbon dioxide to monitor ventilation.) -The local hospital was called to discuss the situation, the doctor agreed to discontinue 	D 271		

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D 271	<p>Continued From page 13</p> <p>resuscitation efforts with the time of death being noted at 8:03pm.</p> <p>Review of the death certificate dated 07/15/24 revealed Resident #6's immediate cause of death was documented as cardiac arrest with the underlying cause being an unknown event.</p> <p>Interview with a personal care aide (PCA) on 07/19/24 at 3:00pm revealed:</p> <ul style="list-style-type: none"> -Around 8:00pm she was at the computer charting in the SCU. -Resident #6 was in his Geri-chair eating a sandwich, but she did not give it to him. -She did not know what kind of sandwich it was, but it had been wrapped in foil. -Her back was to the resident and, when she turned to him to look, he was leaned to the side and she tried to straighten him up. -The sandwich was gone and there was only bread left. -The medication aide (MA) on duty in the SCU had gone to lunch. -She told an alert resident to go to the assisted living side of the facility to get the MA. -She knew she could not leave the residents alone and the resident did exactly what she said. -She put the resident down on the floor, laid him down, and started chest compressions. -The MA called 911. -The resident had the tabletop on his Geri-chair at the time because she knew he would try to get up. -She provided chest compressions for 10 to 15 minutes until EMS arrived. -The resident's hands and face were cold. <p>Second interview with the PCA on 09/26/24 at 5:17pm revealed:</p> <ul style="list-style-type: none"> -She was a certified nursing assistant (CNA). 	D 271		

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D 271	<p>Continued From page 14</p> <p>-She did not remember and did not think she checked Resident #6's airway before she began chest compressions.</p> <p>-Chest compressions were not started on Resident #6 until the MA came back to the SCU, gave instructions to move the resident off of the SCU and they placed him on the floor.</p> <p>Review of the PCA's personnel record on 09/25/24 revealed:</p> <p>-She was hired by the facility on 05/14/24 as a PCA.</p> <p>-She completed CPR training on 07/17/24.</p> <p>-There was no documentation to show a current CPR certification prior to the CPR training on 07/17/24.</p> <p>Interview with a medication aide (MA) on 07/23/24 at 11:08am revealed:</p> <p>-She was told to come to the back because there was an issue with a resident.</p> <p>-Resident #6 was really pale and not breathing.</p> <p>-She was not assigned to the special care unit that night.</p> <p>Second interview with the MA on 09/26/24 at 3:53pm revealed:</p> <p>-She checked his carotid artery for a pulse, checked for airway obstruction and checked for breathing by holding her hand under his nose before moving him off of the SCU.</p> <p>-Resident #3 had a slight pulse.</p> <p>-She did not see any food when she tilted Resident #6's head back and looked in his mouth.</p> <p>-She and a PCA pushed Resident #6 off of the SCU while he was still in his gerichair and placed him on the floor.</p> <p>-The PCA started CPR while she called EMS and gathering paperwork for EMS.</p>	D 271		

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D 271	<p>Continued From page 15</p> <p>Interview with the Special Care Director (SCD) on 09/26/24 at 5:04pm revealed:</p> <ul style="list-style-type: none"> -The MA was responsible for gathering resident information and calling 911 in the event of an emergency. -Staff should call for assistance and start CPR. -CPR should be started by staff within 1-2 minutes to increase the chance of saving a life. -When the MA called her on 07/02/24, she instructed her to move Resident #6 off of the SCU where there were other residents to the area just off of the SCU. -She thought chest compressions had already been started when the MA called her. -The MA did not report any vital signs or that Resident #6 did not have a pulse. <p>Interview with the Administrator on 09/26/24 at 4:44pm revealed:</p> <ul style="list-style-type: none"> -Resident #6 was not a DNR. -She did not know if all staff were CPR certified. -There was at least one CPR trained staff in the building at all times. -The facility offered CPR classes every four months for recertification and to newly hired employees. -She was not informed the chest compressions had not started immediately. -She was informed the PCA began the chest compressions after learning Resident #6 was not a DNR. -The PCA that began chest compressions was not CPR certified at the time of the incident but the Administration thought the PCA could render CPR on residents under the Good Samaritan Law. -Any staff could call 911 in the case of an emergency. -The PCA could have made the 911 call while the MA started the chest compressions. 	D 271		

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D 271	<p>Continued From page 16</p> <p>-Because the staff were in a crisis, they did the best they could do.</p> <p>Telephone interview with Resident #6's primary care physician (PCP) on 08/07/24 at 1:02pm revealed:</p> <p>-When Resident #6 was admitted to the facility from the hospital his dementia was so advanced pureed was the safest diet.</p> <p>-Since being on the pureed diet Resident #6 had no choking episodes.</p> <p>-Because of his mental status, physical health, and not having many teeth the facility felt like they needed to change his diet to pureed.</p> <p>-If it were up to her everybody with dementia would be on a mechanical soft diet.</p> <p>-Resident #6 ate quickly, he ate with his hands full of food, and he would not be able to say that he was choking or put his hands to his throat as a sign.</p> <p>-She listed cardiac arrest on his death certificate, but she was not aware that his food had not been pureed.</p> <p>-If Residents #6's food was not pureed or cut up he probably choked to death.</p> <p>-She had observed Resident #6 eating fast and eating off of others plate.</p> <p>-Aside from the dementia Resident #6 was otherwise healthy and had no heart issues.</p> <p>Second telephone interview with Resident #6's PCP on 09/26/24 at 4:12pm revealed:</p> <p>-Resident #6 was on a puree diet for meat only.</p> <p>-Resident #6's diet was changed to a pureed meat only because he ate his food very fast.</p> <p>-Resident #6 did not have a do not resuscitate order.</p> <p>-Resident #6 was nonverbal and spoke with very few words and used a lot of motions to communicate.</p>	D 271		

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D 271	<p>Continued From page 17</p> <p>-She was informed Resident #6 cause of death was due to cardiac arrest.</p> <p>-CPR was to begin within 2 minutes of Resident #6 distress in order to prevent death or severe medical conditions.</p> <p>[Refer to Tag D0310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service]</p> <p>[Refer to Tag D0465, 10A NCAC 13F .1308(a) Special Care Unit Staff]</p> <p>_____</p> <p>The facility failed to respond immediately to Resident #6 who was found unresponsive while restrained after eating a sandwich. The resident was found by a personal care aide (PCA) who was working alone on the Special Care Unit (SCU). The PCA had to send another SCU resident to find staff from the assisted living side of the facility to assist her. When the medication aide arrived to the SCU the resident was removed from his gerichair and 911 was contacted. The PCA who was not certified in Cardiopulmonary Resuscitation performed chest compressions. Upon the arrival of EMS it was noted the resident had copious amounts of food in his mouth and esophagus which required suction to remove prior to intubation. A cardiac rhythm was not sustained, and the resident died. This failure resulted in serious neglect and constitutes a Type A1 Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/26/24 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 26, 2024.</p>	D 271		

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D 310	Continued From page 18	D 310		
D 310	<p>10A NCAC 13F .0904(e)(4) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on record reviews and interviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 6 sampled residents (#6) with a physician's order for pureed meat only was served as ordered.</p> <p>The findings are:</p> <p>Review of Resident #6's current FL-2 dated 03/18/24 revealed: -Diagnoses included vascular dementia w/ behaviors, hypertension, nontraumatic subdural hemorrhage, unspecified, and constipation. -The resident was constantly disoriented, had wandering behavior and was verbally abusive. -There was a regular diet order. -The recommended level of care was Special Care Unit (SCU).</p> <p>Review of Resident #6's diet order dated 05/23/24 revealed a diet order for pureed meat only.</p> <p>Review of Resident #6's current care plan dated 03/28/24 revealed: -Diagnoses included vascular dementia w/ behaviors, hypertension, nontraumatic subdural</p>	D 310		

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D 310	<p>Continued From page 19</p> <p>hemorrhage, and constipation.</p> <ul style="list-style-type: none"> -The resident's orientation was always disoriented. -The resident had significant memory loss. -The resident's cognitive ability affected his ability to perform activities of daily living (ADLs). -The resident's nutrition was oral, normal. -The resident's mental health and social history documented that he was not oriented to time or place, he was not able to communicate wants/needs, likes/dislikes, and verbally aggressive. -The resident was independent with eating (ability to chew or swallow). <p>Review of Resident #6's physician's order dated 03/28/24 revealed:</p> <ul style="list-style-type: none"> -The reason for the restraint was for safety of resident, staff, and individual. -The type of restraint to be used was Geri chair. -The restraint should be removed during meal times, snack times, and bed time. <p>Review of facility's diet list dated 06/20/24 revealed Resident #6 was listed on a special diet to not take his plate away early and puree meat only.</p> <p>Review of the menu for the dinner meal for 07/02/24 on 07/25/24 revealed pork rib on hoagie roll, green beans, and cinnamon apples.</p> <p>Review of the pureed dinner menu for 07/02/24 on 07/25/24 revealed the meal was chefs' choice.</p> <p>Review of Resident #6's progress notes dated 06/25/24 5:00am -7:00pm revealed:</p> <ul style="list-style-type: none"> -The resident was eating and drinking too fast during meals. -Resident #6 had no concept of slowing down to 	D 310		

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D 310	<p>Continued From page 20</p> <p>chew and swallow. -Resident #6 got strangled during dinner.</p> <p>Review of Resident #6's progress notes dated 06/26/24 3:00pm-11:00pm revealed that resident was still eating fast during dinner, staff monitored for strangulation.</p> <p>Review of facility incident report dated 07/02/24 at 7:30pm revealed: -Resident #6's was sitting by the nursing desk area with personal care aide (PCA). -The resident was sitting and fidgeting in a chair. -The PCA noticed he was quiet, pale in color, and unresponsive. -There was documentation that no vital signs taken. -Cardiopulmonary resuscitation (CPR) was started by staff and emergency medical services (EMS) was contacted. -EMS could not keep a heart rhythm despite rescue efforts. -EMS called the time of death at 8:02pm.</p> <p>Interview with personal care aide (PCA) on 07/19/24 at 3:00pm revealed: -Around 8:00pm she was at the computer charting. -Resident #6 was in his Geri-chair eating a sandwich, but she did not give it to him. -She did not know what kind of sandwich it was, but it had been wrapped in foil. -Her back was to the resident, when she turned to him to look, he was leaned to the side, she tried to straighten him up. -The sandwich was gone and there was only bread left. -The medication aide (MA) on duty had gone to lunch. -She told an alert resident to go up front to get the</p>	D 310		

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D 310	<p>Continued From page 21</p> <p>MA.</p> <ul style="list-style-type: none"> -She knew she could not leave the residents alone and the resident did exactly what she said. -She put the resident down on the floor, laid him down, and started chest compressions. -The MA called 911. -The resident had the tabletop on his Geri-chair at the time because she knew he would try to get up. -She provided chest compressions for 10 to 15 minutes, EMS arrived in no time. -As a PCA she did not know dietary orders, but she did give out snacks. -The sandwich was resident's dinner, and it was given by the MA. -For some reason the resident did not have dinner, but she did not know why. -The resident's hands and face were cold. <p>Interview with a medication aide (MA) on 07/23/24 at 11:08am revealed:</p> <ul style="list-style-type: none"> -She was told to come to the back because there was an issue with a resident. -Resident #6 was really pale and not breathing. -She was not assigned to the special care unit that night. -The MA in the unit had gone on break. -She was told that by other staff the resident had a sandwich, it looked like riblet cut up fine to her. -The resident did not go to dinner, so the MA grabbed a sandwich to give to him. -She could not recall the resident's diet, but it was pureed meat at one time, she was not sure if his diet had changed. -The sandwich was given by the other MA. -It was a sandwich left from dinner. <p>Second interview with the MA on 09/26/24 at 3:53pm revealed:</p> <ul style="list-style-type: none"> -She checked his carotid artery for a 	D 310		

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D 310	<p>Continued From page 22</p> <p>pulse,checked for airway obstruction and checked for breathing by holding her hand under his nose before moving him off of the SCU. -She did not see any food when she tilted Resident #6's head back and looked in his mouth. -She and a PCA pushed Resident #6 off of the SCU while he was still in his gerichair and placed him on the floor. -The PCA started CPR while she called EMS and gathering paperwork for EMS.</p> <p>Interview with second MA on 07/24/24 at 4:44pm revealed: -She was on break when the incident occurred on 07/02/24. -Resident #6 was fine before she left, he was in his Geri-chair eating a sandwich. -EMS was present when the MA returned, and they were completing chest compressions. -She thought his diet was pureed meat. -She had given the resident the sandwich, she did not know what type of meat it was, but it was a pureed sandwich.</p> <p>Interview with a kitchen aide on 07/29/24 at 10:39am revealed: -She prepared snacks. -Snacks consisted of applesauce, pudding, chips, cookies, pies, fudge rounds, goldfish, etc. -Applesauce and pudding were for residents on a puree diet. -They did not prepare pureed sandwiches. -They did not put pureed meat on bread. -Residents on a pureed diet would not get regular snacks, pudding or applesauce only.</p> <p>Interview with the Kitchen Manager on 08/14/24 at 12:04pm revealed to prepare pureed meals she cooked the food, seasoned it, put it in a machine, and added broth.</p>	D 310		

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D 310	<p>Continued From page 23</p> <p>Review of Emergency Medical Services (EMS) report dated 07/02/24 revealed:</p> <ul style="list-style-type: none"> -Upon arrival at 7:34 pm Resident #6 was found in the dementia section, on the floor, staff performing Cardiopulmonary Resuscitation (CPR). -Staff stated that resident was eating a sandwich when he got quiet and pale. -EMS took over chest compressions while fire department personnel placed the Lund University Cardiopulmonary Assist System (LUCAS) device on resident. -Resident #6 was placed on the monitor with multi-use pads in place that showed resident was in asystole (when your hearts electrical system fails entirely). -An IV was established with a 1 mg Epinephrine being administered with a pulse check and rhythm check in between each administration. (Epinephrine is a hormone used to increase cardiac output.) -While fire department was using the Bag-valve-mask (BVM) to ventilate the resident they noted resistance. -Upon visualizing the resident's airway, it was noted that copious amounts of food was in the resident's mouth and esophagus. -The resident was suctioned as well as the I-GEL was removed and the yankauer was used to remove food from the resident's mouth. -After the food was removed from the resident's airway the paramedic intubated the resident. -Resident #6 was placed back on capnography, there was a brief change of cardiac rhythm to pulseless electrical activity (PEA), but this was not sustained. (Capnography measures carbon dioxide to monitor ventilation.) -The local hospital was called to discuss the situation , the doctor agreed to discontinue 	D 310		

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D 310	<p>Continued From page 24</p> <p>resuscitation efforts with the time of death being noted at 8:03pm.</p> <p>Review of the death certificate dated 07/15/24 revealed Resident #6's immediate cause of death was documented as cardiac arrest with the underlying cause being an unknown event.</p> <p>Telephone interview with EMS staff on 07/24/24 at 4:33pm revealed:</p> <ul style="list-style-type: none"> -Upon arrival staff reported that the resident was eating a sandwich, staff walked away, he was quiet and was unresponsive. -She believed staff performed chest compressions. -They noticed a lot of food in the resident's mouth. -They suctioned food from the resident's mouth trying to get oxygen to his lungs, but it still was not working. -They continuously removed food to get a better airway to get a pulse. -After pulling food out of the resident's mouth they inserted an ET tube in the resident's trachea, it was consistent on the monitor, and they were still unable to get a pulse. -The doctor instructed them to do 1 more round of compressions and then discontinue. -The resident had eaten pulled pork or barbeque type of sandwich. -She believed the resident choked on the food, aspirated, could not breathe, and the food traveled to his trachea and into his lungs. <p>Telephone interview with a second EMS staff on 07/26/24 at 2:20pm revealed:</p> <ul style="list-style-type: none"> -Upon arrival the resident was lying on the floor in front of the nursing station, staff was performing CPR. -They received the call as a dead on arrival 	D 310		

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NAME OF PROVIDER OR SUPPLIER WATERBROOKE OF ELIZABETH CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 143 ROSEDALE DRIVE ELIZABETH CITY, NC 27909
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D 310	<p>Continued From page 25</p> <p>(DOA), there was no DNR in place.</p> <ul style="list-style-type: none"> -Her captain took over chest compressions. -There were large chunks of barbeque or chicken meat in resident's airway. -She reviewed the chart for history to find out the reason for the cardiac arrest. -She mentioned to the staff that the resident was on a pureed meat diet and told them there were whole chunks of meat. -Staff had given the resident a sandwich. -They pulled large amounts of food from his airway and were unable to resuscitate. -Pureed meat should have been baby food consistency instead there were whole chunks of chicken or pork. -There was half to a whole sandwich in the resident's throat which contributed to resident's death. <p>Telephone interview with a third EMS staff on 07/26/24 at 4:11pm revealed:</p> <ul style="list-style-type: none"> -Upon arrival the resident was on the floor and staff was providing chest compressions. -Staff stated that resident was in the chair, unresponsive, making a gasping noise, but when she checked on him, he was not breathing. -The resident was eating pulled pork, they just tried to pull the pork from his throat. -They pulled quite a bit from his throat, enough to make another sandwich. <p>Telephone interview with Resident #6's primary care physician (PCP) on 08/07/24 at 1:02pm revealed:</p> <ul style="list-style-type: none"> -When Resident #6 was admitted to the facility from the hospital his dementia was so advanced pureed was the safest diet. -Since being on the pureed diet Resident #6 had no choking episodes. -Because of his mental status, physical health, 	D 310		

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D 310	<p>Continued From page 26</p> <p>and not having many teeth the facility felt like they needed to change his diet to pureed.</p> <p>-If it were up to her everybody with dementia would be on a mechanical soft diet.</p> <p>-Resident #6 ate quickly, he ate with his hands full of food, and he would not be able to say that he was choking or put his hands to his throat as a sign.</p> <p>-She listed cardiac arrest on his death certificate, but she was not aware that his food had not been pureed.</p> <p>-If Residents #6's food was not pureed or cut up he probably choked to death.</p> <p>-She had observed Resident #6 eating fast and eating off of others plate.</p> <p>-Aside from the dementia Resident #6 was otherwise healthy and had no heart issues.</p> <p>Second telephone interview with Resident #6's PCP on 09/26/24 at 4:11pm revealed:</p> <p>-Staff never reported Resident #6 had difficulty swallowing and there had been no swallow study conducted.</p> <p>-Resident #6 would not have been able to follow the instructions if a swallow study had been ordered.</p> <p>-Resident #6's diet was changed to pureed meats only because he ate too fast.</p> <p>-A sandwich would not be part of a pureed diet.</p> <p>-She did not know what Resident #6 was given to eat but she did not think he choked because he would have flailed about.</p> <p>-The benefit of modified texture diet was to prevent food from getting lodged in the throat and prevent choking.</p> <p>-Airway obstruction could cause cardiac arrest.</p> <p>Interview with the Special Care Director (SCD) on 07/19/24 at 2:43pm revealed:</p> <p>-She was contacted by the MA, and she</p>	D 310		

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D 310	<p>Continued From page 27</p> <p>responded immediately.</p> <ul style="list-style-type: none"> -Upon her arrival EMS was still working on Resident #6. -Staff really did not say what happened. -EMS asked what type of diet Resident #6 was on. -Resident #6 was on a pureed meat only diet. -The resident was normally fidgety, not really verbal, and you could hear resident moving around. -She thought that the resident had eaten a peanut butter and jelly sandwich because the resident was on a pureed meat only diet, it was dark colored, she remembered seeing it on the floor when she came in, and it was in the resident's esophagus area. -The resident did not have dinner. -There were different things on the cart for snack like yogurt, Jello, or pudding. -The resident stayed hungry so at night they gave him something more filling, the resident was very receptive to food, and very food motivated. -Residents did not choose their own snacks. -There was no way to know exactly what snacks were on the cart, they were randomly assorted, normally peanut butter and jelly sandwiches at night because ham or turkey did not keep. <p>Interview with the Administrator's Assistant on 07/29/24 at 10:34am revealed:</p> <ul style="list-style-type: none"> -She was responsible for making changes to the therapeutic diet sheet, reprinting them, and placing it in a book located in the kitchen. -She hung the list of changes for the cooks and aides monthly. -The list would only tell who is on a pureed diet. <p>_____</p> <p>The facility failed to ensure a therapeutic pureed meat only diet was served as ordered for Resident #6 who had advanced dementia, poor</p>	D 310		

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D 310	Continued From page 28 dentition and constantly disoriented and known to consume his food at a fast pace. Resident #6 was served and ate a pork rib hoagie sandwich, where he choked and became unresponsive. This failure resulted in serious physical harm and death to the resident constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/29/24 with amendment on 09/25/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 26, 2024.	D 310		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure staff were present in the special care unit (SCU) at all times in sufficient number to meet the needs of the residents as evidence by a resident requiring immediate medical attention and no other staff were present to assist the personal care aide (PCA) on duty at the time of the incident.	D 465		

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D 465	<p>Continued From page 29</p> <p>The findings are:</p> <p>Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 26 special care unit (SCU) residents.</p> <p>Review of the facility's resident census report dated 07/02/24 revealed there was a census of 20 residents in the SCU.</p> <p>Interview with a personal care aide (PCA) on 09/25/24 at 4:26pm revealed:</p> <ul style="list-style-type: none"> -She worked on 07/02/24 in the special care unit with a medication aide (MA). -She and the MA were scheduled to work as floor staff. -The MA took her break, and she was left alone in the unit. -She did not recall if another PCA was working with her and the MA in the unit. -When she needed help, she had a resident go to the assisted living (AL) unit and let the MA know she needed her. <p>Interview with a MA on 09/26/24 at 9:14am revealed:</p> <ul style="list-style-type: none"> -She worked in the assisted living (AL) unit on 07/02/24 as the medication aide. -There were usually 2 PCAs and 1 MA scheduled to work in the SCU. -There should have always been 2 staff at the same time in the SCU. -She knew the MA had gone to lunch because she saw her when she exited the facility. -She was not aware the PCA was in the unit by herself. -She realized the PCA was alone when an SCU resident approached her for help. -She did not ask the PCA if anyone else was in 	D 465		

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D 465	<p>Continued From page 30</p> <p>the unit with her.</p> <p>-She observed there was only one PCA in the SCU on duty at the time.</p> <p>-Once she saw the resident who needed medical attention, she told the PCA they needed to take him to the other side of the door, remove him from the chair, and lay him on the floor.</p> <p>-The PCA started cardiopulmonary resuscitation (CPR) once the resident was lying on the floor without her telling her to do so.</p> <p>Interview with the Special Care Director (SCD) for the special care unit on 09/26/24 at 10:30am revealed:</p> <p>-There were times when a PCA worked 12 hour shifts from 7:00am to 7:00pm.</p> <p>-When the 12 hour shift person left duty, that left 1 MA and 1 PCA to care for the residents on the SCU.</p> <p>Attempted telephone interview with an agency staff PCA on 09/26/24 at 10:30am was unsuccessful.</p> <p>Interview with the Administrator on 09/25/24 at 2:20pm revealed:</p> <p>-She was responsible to complete the schedule on a weekly basis.</p> <p>-On 07/02/24, she had two PCAs and 1 MA scheduled in the special care unit.</p> <p>Second interview with the Administrator on 09/26/24 at 9:28am revealed:</p> <p>-On 07/02/24, there were 2 PCAs and 1 MA scheduled to work in the SCU.</p> <p>-Staff should not take breaks at the same time.</p> <p>-She was made aware after the incident with the resident the PCA was alone in the unit.</p> <p>-She was not aware the PCA was in the unit alone before the incident.</p>	D 465		

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D 465	Continued From page 31 -If staff were alone in the SCU they should have notified the MA in the AL unit.	D 465		