STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	**230 EAST PRESNELL STREET ASHEBORO, NC 27203**

(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 and follow up survey was conducted from 7/2/18 through 7/3/18 and 7/5/18 through 7/6/18. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity J CFR 483.25 at tag F684 at a scope and severity J CFR 483.90 at tag F925 at a scope and severity J The tags F600 and F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 6/14/18 and was removed on 7/6/18. A partial extended survey was conducted. All tags cited during the previous survey of 6/7/18 were corrected effective 7/6/18 except F656 which was recited during this survey.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		7/21/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 600	Continued From page 1 by: Based on record review, Nurse Practitioner (NP) interview, and staff and resident interviews, the facility neglected to implement interventions in place to address the resident's refusal of daily showers which were ordered by the physician to treat 1 of 2 residents for having maggots on her body. Resident #2 experienced a second occurrence of maggots growing on her body which required continued treatment at the facility. Immediate jeopardy began on 6/22/18 when Resident #2 refused showers and the facility failed to implement any interventions to address the resident's refusal of showers. Maggots were found again in her abdominal folds. Immediate Jeopardy was removed on 7/06/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service. Findings included: Resident #2 was admitted on to the facility on 7/28/17. Diagnoses were diabetes, at risk for falls, bowel incontinence, and hemiplegia. Resident #2's care plan dated 4/27/18 revealed goals and interventions for dependent on staff for emotional and social needs, self-care deficit, desired to return to home, fluid volume deficit, poor oral hygiene, diabetes, at risk for falls, bowel incontinence, hemiplegia, potential for pressure ulcer, and actual impairment to skin integrity.	F 600	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by the provision of the Federal & State Law. F600 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)On July 5, 2018 Resident #2 had a shower and was made aware by the Nurse Practitioner the importance of the need for a shower versus a bed bath. On July 4, 2018 the Unit Coordinators, Unit Managers, Wound Care Nurse, Treatment Nurse, and Assistant Director of Nursing completed head to toe skin assessments on 100% of the residents. No negative findings of flies or maggots were identified as a result of this audit. On July 5, 2018 the Director of Nursing, Assistant Director of Nursing, Unit Managers, and Unit Coordinators conducted a %100 audit of all residents to identify refusals of bed baths and showers as ordered by the facility's physician. July 6, 2018, all residents identified had their care plans updated by the Resident Care Management Director and MDS Coordinators to include resident specific interventions to attempt when refusals of showers or bed baths occur. All licensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 600	Continued From page 2 The quarterly Minimum Data Set dated 5/24/18 revealed the resident had adequate hearing, clear speech, and was understood and understands. The resident had an intact cognition. The resident required extensive assistance of 2 persons for all transfers, bed mobility, and locomotion. Dressing and personal care required 2 staff members limited assistance. A Nurses' note dated 6/19/18 at 3:31 pm revealed the resident had maggots in the abdominal folds. The Nurse Practitioner was notified and an order was obtained for an anti-bacterial wash every day. Review of Resident #2's physician orders revealed an order an order dated 6/19/18, which was written by the Nurse Practitioner for an anti-bacterial wash every day. Further review of the physician orders revealed the NP wrote an order on 6/20/18 for Resident #2 to receive a shower each day. Review of a nurses' note dated 6/22/18 revealed the resident felt a shower every day was too much. A Physician order dated 6/25/18 revealed Nystatin powder to abdominal folds and groin every shift (for candida) was ordered for Resident #2. Review of a nurses' note dated 6/30/18 revealed the resident had refused some of her every day showers and had requested to go back to the twice a week schedule. On 7/3/18 at 9:45 am an interview was conducted with the Treatment Nurse (TN) who stated that	F 600	nurses and certified nursing assistants to include full-time, part-time, and as needed (PRN) staff were in-serviced by Staff Development Coordinator (SDC)July 6, 2018 on notification of refusal of bed baths or showers. No licensed nurses or certified nursing assistants to include all full-time, part-time, and PRN will be allowed to work until the in-service has been completed. On July 5, 2018 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Nursing Supervisor, Unit manager, and Unit Coordinators educated all staff including full-time, part-time, and PRN on the facility's Abuse and Neglect Policies and Procedures emphasizing that not adhering to physician orders was considered neglect. No staff will be allowed to work until they have been in-serviced. It is alleged that the facility failed to implement any interventions in place to address refusal of daily showers. (Resident #2) 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) On July 5, 2018 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Nursing Supervisor, Unit manager, Unit Coordinators educated all staff including full-time, part-time, and PRN on the facility's Abuse and Neglect Policies and Procedures emphasizing that not adhering to physician orders was considered neglect. No staff will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 600	Continued From page 3 Resident #2 had maggots on her body and in her bed. The TN stated she observed that Resident #2 had several maggots in her bed with food debris and two in the skin folds of her lower abdomen about 6/20/18. The Nurse Practitioner (NP) was notified and daily showers with anti-bacterial wash were ordered. By about day 3 the resident refused her showers and the nursing assistants provided a bed bath with anti-bacterial wash. Nursing staff was not notified of the refusal. On day 5 the resident had a few maggots again in the same area of her abdominal fold. The TN stated that the maggot issue information was passed verbally during shift change. The staff was verbally directed to look for maggots during routine care. On 7/3/18 at 11:45 am an interview was conducted with the Assistant Director of Nursing (ADON) who stated that Resident #2 had maggots found on her body shortly after another resident was found to have maggots. The resident was found to have maggots in the folds of her lower abdominal skin. The ADON stated the TN identified the maggots during treatment and was not sure if there was tissue injury. The resident was always dressed and it was unclear how maggots were able to get under her clothing. The NP was called and an order for anti-bacterial wash and shower each day was obtained. The maggots were found on Sunday and the Administrator was verbally informed on Monday of the second incidence of maggots. The ADON expected the treatment nurse assigned for that day to inform her if there were any maggots. The ADON stated that the maggots were mentioned in the Monday morning meeting but not discussed for prevention or new process. The staff were directed to kill any flies.	F 600	allowed to work until they have been in-serviced. All licensed nurses and certified nursing assistants to include full-time, part-time, and PRN were in-serviced on July 6, 2018 on notification of refusal of bed baths or showers. No licensed nurses or certified nursing assistants will be allowed to work until the in-service has been completed. Newly hired staff we be in-serviced on the facility's Abuse and Neglect Policies during their classroom orientation prior to providing care to residents. Licensed nurses will document residents refusals of showers and interventions attempted in a progress note. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)Daily Monday - Friday in the Clinical Morning Meeting for 12 weeks, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers will audit Treatment Administration Records of residents who refuse showers and bed baths to validate showers and bed baths are offered as needed based on resident preference, and offered specific interventions to encourage the resident to comply if there is a physician's order. If a Licensed Nurse is identified as not having offered various specific interventions when refusals are noted, the nurse will be provided a one to one re-education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 600	Continued From page 4 On 7/3/18 at 5:45 pm an interview was conducted with Resident #2 who stated there was a quick increase in the number of flies in her room about 1 to 2 weeks ago. The resident stated about a week ago there were maggots on her stomach and in her bed which caused her anxiety. The NP ordered anti-bacterial wash and showers every day which were still in place at this time. The resident stated that during the first five days of the showers there were additional maggots that had hatched. The resident preferred a bed bath and when she refused and had a bed bath instead of a shower the maggots returned. The resident informed the staff that she did not need a shower. The resident stated she was informed by the NP her lymph edema can attract flies and cause maggots and agreed to have a shower. On 7/5/18 at 8:05 am an interview was conducted with the NP who was very familiar with Resident #2. The resident was alert and oriented and able to make her own decisions. The resident was her own resident representative. The resident was known to resist personal care and preferred a bed bath. Resident #2 had maggots to her right lateral lower abdominal fold and maggots in the bed. The NP stated she ordered daily showers and cleanse with anti-bacterial wash. The resident agreed to daily showers and education was provided why showers were needed. After the first three days the resident started to complain to the nursing assistant that a daily shower was too much for her and began to inform personal care staff that the NP informed the resident she no longer needed a daily shower. The NP stated that the resident manipulated staff. The staff did not inform the NP of the resident's refusal on day three of the order for daily showers	F 600	b)The DON and/or the ADON will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for six months for tracking and trending purposes with all follow up action determined by the QAPI team. 4.Title of person responsible for implementing the acceptable POC. a)The DON and/or the ADON will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) July 21, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 600	Continued From page 5	F 600		

and by day five the resident had maggots again in her abdominal folds, same place. The showers were more effective at washing the lymph edema and any potential fly eggs. The resident did not like to transfer via the mechanical lift because of her size and fear of falling which contributed to the shower refusal. The resident had lymph edema which wept fluid continuously and put the resident at increased risk for maggots.

The NP stated that when a resident refused care or treatment her expectation was for staff to re-educate the resident to obtain compliance and if the refusal continued to inform her. The NP has attempted to get resident cooperation to make better choices by explaining why and the consequences. This method had been repeated and sometimes it worked and sometimes it had not.

On 7/5/18 at 10:45 am an interview was conducted with Resident #2 who stated that the resident had a shower this morning and was made aware by the NP the importance of the need for a shower versus her preferred bed bath. The staff used the shower gurney to transfer the resident to the shower and that worked better than the mechanical lift. The resident stated that it was over a five-day period that she had maggots and was very concerned about their returning. The resident had received her usual, daily ant-anxiety medication. The resident commented that the flies were better.

On 7/5/18 at 12:15 pm an interview was conducted with Nursing Assistant (NA) #1 who stated that she was assigned to Resident #2 who received a shower or complete bed bath every day. The resident preferred a bed bath and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 600	Continued From page 6	F 600		

to be coaxed to take her shower when it was ordered. NA #1 was aware of the maggots and had seen flies in the resident's room, but not more than usual. When the NP ordered for the resident to take a shower, the resident refused and said she did not need a shower anymore. NA #1 provided a bed bath and later learned that the shower order continued. NA #1 indicated that she would inform the nurse if the resident refused a shower.

On 7/5/18 at 11:00 am an interview was conducted with the Director of Nursing (DON) who stated that Resident #2 sometimes refused her ordered shower and the staff at times had called the resident's family member to influence the resident to take a shower, which was effective. The resident was in agreement that her family member was called. On day three of the ordered daily shower the resident refused to have a shower and the nursing assistant gave the resident a bed bath. The family member was not called as an intervention. The resident did not receive a shower for two days of the ordered daily shower and maggots appeared again. The DON's expectation was for nursing assistants to inform the nurses of resident refusals and confirmed that the nursing assistants did not inform the nurses of the refused showers, the NP was not aware, and maggots were again observed on the resident on 6/23/18.

The Administrator, Assistant Administrator, Corporate Nurse Consultant and Director of Nursing were notified of the Immediate Jeopardy on 7/5/18 at 12:32 pm.

On 7/6/18 the facility provided an acceptable credible allegation for immediate jeopardy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 600	Continued From page 7	F 600		

removal that included the following:

The plan of correcting the specific deficiency including the processes that lead to the deficiency cited:

Resident #2 was admitted to center on 7/28/17 with diagnosis including, but not limited to morbid obesity, Chronic Obstructive Pulmonary Disease, Anxiety, Hemiplegia and Hemiparesis. On 6/15/18 a Weekly Skin Assessment was performed with no findings noted. On 6/19/18 Resident #2 was noted to have maggots to her abdominal folds. Resident #2 Nurse Practitioner was notified with orders for anti-bacterial wash received. On 6/20/18 Resident #2 Nurse Practitioner ordered Daily Showers. Resident #2 refused showers on 6/22/18, 6/25/18, 6/26/18, 6/27/18 and 6/29/18. After review of the medical record for Resident #2 noting the number of refusals of care related to showers, the center failed to implement specific interventions to encourage the resident to comply with the physician's order to shower. Resident #2 had a skin evaluation assessment performed by the Charge Nurse assigned to Resident#2 on 7/6/18; there were no signs of maggots noted. On 7/6/18 the Unit Coordinator interviewed Resident #2 regarding her bed baths. Resident #2 stated she receives good bed baths and denied having any concerns with bed baths.

" A Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) including the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers and Social Services Director on 7/5/18 and it was determined that there was not a resident specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 600	Continued From page 8	F 600		

plan of care for alternate interventions to offer the resident to help promote the likelihood the resident will comply with showers per physician orders. The IDT determined the center did not educate the resident on the risks of refusals of showers including risk of maggots. The facility audit of the current residents was reviewed on 7-5-18 and did not reveal any other residents with physician orders for showers or documented refusals. An additional Root Cause identified by the IDT was the Certified Nursing Assistants lacked knowledge of how to identify maggots.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited:

" Residents who refuse bed baths and showers who are not offered specific interventions to encourage the resident to comply have been identified as having the potential to be affected. All residents in the center had a head to toe skin assessment completed on 7/4/18 by the Unit Coordinators, Unit Managers, Wound Care Nurse, Treatment Nurse and Assistant Director of Nursing. No other residents were identified as having maggots. On 7/5/18 the Director of Nursing completed an audit for refusals of physician's orders for bed baths and showers. On 7/5/18 identified residents had their care plans updated to include resident specific interventions to attempt when refusals of showers or bed baths occur.

" The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, 11-7 Supervisor, Unit Managers, and Unit Coordinators re-educated licensed nurses and Certified Nursing Assistants on Abuse and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 600	Continued From page 9	F 600		

Neglect Prevention beginning on 7/5/18. Beginning 7/6/18 No Licensed Nurses and no Certified Nursing Assistants will be allowed to work until the training is complete. This education also included ensuring staff awareness that failure to provide showers or bed baths as ordered by the physician can constitute resident neglect. The Licensed Nurses will document interventions offered and if the interventions were accepted or refused on the Treatment Administration Record and or the Resident Progress Notes. The NHA and DON will have a no tolerance approach to any deviation from the policy. Newly hired Licensed Nurses will be educated on Abuse and Neglect Prevention by the Staff Development Coordinator, Director of Nursing, Assistant Director of Nursing, Unit Managers and / or Unit Coordinators during their classroom orientation prior to providing care to residents.

Of the 48 Licensed Nurses, 30 of the Licensed Nurses have received the education for F600. Six of the Licensed Nurses who have not yet received the education work on an as needed basis. Three of the Licensed Nurses who has yet to receive the education are currently on vacation. One of the Licensed Nurses who has yet to receive the education is on Family Medical Leave Act (FMLA). Each of the Licensed Nurses who have not yet received the education will not be permitted to work until the education is received.

Of 57 the 83 Certified Nursing Assistants have received the education for F600. 21 of the Certified Nursing Assistants who have not yet received the education work on an as needed basis, 7 of the Certified Nursing Assistants who have yet to receive the education are currently on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 600	Continued From page 10	F 600		

vacation. Three of the Certified Nursing Assistants who has yet to receive the education is on Family Medical Leave Act (FMLA). Each of the Certified Nursing Assistants who have not yet received the education will not be permitted to work until the education is received.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and / or in compliance with the regulatory requirements.

"Daily Monday - Friday in the Clinical Morning Meeting for 12 weeks, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers will audit Treatment Administration Records of residents who refuse showers and bed baths to validate showers and bed baths are offered as needed based on resident preference, and offered specific interventions to encourage the resident to comply with the physician's order. If a Licensed Nurse is identified as not having offered various specific interventions when refusals are noted, the nurse will be provided a one to one re-education.

" The Director of Nursing will present the results of the audits to the Quality Assessment and Performance Improvement Committee monthly for six months for recommendations including new interventions to assure compliance is sustained ongoing.

" The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor and 11-7 Nurse Supervisor began education for the Nursing Assistants that if resident refuses a bed bath or shower that the charge nurse is to be informed of the refusal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 600	Continued From page 11 The Nursing Assistants were also provided education on what maggots look like. Beginning 7/6/18 no Nursing Assistant will be allowed to work until the training is complete. The Title of the person responsible for implementing the acceptable plan of correction: Nursing Home Administrator will be responsible for implementing this acceptable plan of correction. Immediate Jeopardy removal date: 7/6/18 Validation: Immediate Jeopardy (IJ) was removed on 7/6/18 at 4:15 pm validation was completed of the credible allegation for IJ removal as evidenced by interviews of one licensed and one nursing assistant for each of the 7 facility halls for evidence of in-service completion. Pest control and maintaining a clean facility in-service was completed for 123 staff members on 7/2/18 and 56 staff members on 7/3/18. On 7/6/18 an outside professional pest control was observed to treat the facility grounds with a liquid spray. On 7/6/18 the Administrator stated that the facility and grounds were treated for flies.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		7/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 656	Continued From page 12 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner (NP) interview, and staff and resident interviews, the facility failed to develop comprehensive person centered care plans to address leaves of absences (LOAs) from the facility and refusals of	F 656	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 656	Continued From page 13 care and treatment for 2 of 2 residents reviewed for refusals of care and treatments (Residents #1 and #2). Findings included: 1. Resident #1 was admitted on 8/10/17 and recently readmitted on 6/24/18. The resident was discharged to the hospital on 6/30/18, and remained in the hospital during this survey. A nurses' note dated 6/12/18 revealed Resident #1 was started on an antibiotic for treatment of a right leg wound infection. Resident went LOA (leave of absence) twice in his motorized wheel chair going to town. Both LOAs on 6/12/18 the resident returned to the facility with his right lower leg/foot dressing missing. Review of a nurses' note dated 6/13/18 revealed the resident continued to be non-compliant with treatments and refusal to have wound dressings changed. A review of the out of facility release of responsibility form revealed Resident #1's last out of building was on 6/13/18. The resident left the facility almost every day for the past 3 months. Resident #1's care plan dated review date 6/14/18 revealed goals and interventions for daily care decisions at times refused wound treatment, independent with smoking, activities of daily living self-care deficit, resistive to care related to schizophrenia, multiple pressure ulcers (PU), altered skin integrity, and cellulitis of the right lower extremity. The resident's care plan did not address the	F 656	of correction is prepared solely because it is required by the provision of the Federal & State Law. F656 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)The care plan for Resident #1 was updated by the Resident Care Management Director (RCMD) on July 9, 2018 after Resident #1 returned from hospital. Resident #1□s care plan addresses his independent leave of absences (LOA) from the facility and refusals of care and treatments as well as re-enforcing the dressings, as needed, when Resident #1 goes on independent LOA. Resident #2□s care plan was updated July 6, 2018 by the Resident Care Management Director to include refusals of care and treatments. Re-education was provided by the District Director of Care Management on July 6, 2018 to Resident Care Management Director and Assistant Director of Nursing on policies and procedures for developing comprehensive care plans for residents who take independent LOA from the facility and residents who have refusal of care and treatments. It is alleged that the facility failed to develop comprehensive person centered care plans to address independent LOA from the facility (Resident #1) and refusals of care and treatments (Resident #1 and #2).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 656	Continued From page 14 resident's need to have his wound dressing more secured when on LOA from the facility. There were limited care plan interventions that addressed the resident's personal and wound care treatment refusals. Interventions for wound care were to encourage compliance with treatments and to administer treatments as ordered and observe for effectiveness. There was no intervention for of wound care needs related to LOA. Resident #1's quarterly Minimum Data Set dated 6/14/18 revealed the resident had adequate hearing, clear speech, and understood and understands. He had intact cognition, no psychosis, and no behaviors. The resident required one-person extensive assistance for bed mobility and total dependence of two for transfer. Locomotion on and off the unit was supervision set-up only. Dressing, personal hygiene, and toileting was one-person physical assistance and set up was for meals. The resident's diagnoses were paraplegia, depression, manic depression, schizophrenia, dependence on a wheel chair, PU of the right hip stage 4, polyneuropathy, and Burkitt lymphoma (cancer of the lymphatics). \ SBAR (written communication) dated 6/14/18 revealed the NP was informed that the resident had been noncompliant with treatments. Nurses' note dated 6/24/18 revealed Resident #1 refused his weight in order to go smoke. Nurses' note dated 6/26/18 revealed hematuria and the resident refused to go to the hospital as ordered and the NP was made aware. Resident #1 stated "I just got back."	F 656	2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)It is the policy of Randolph Health and Rehabilitation to ensure applicable residents have comprehensive care plans for residents who take independent LOA from the facility and residents who have refusals of care and treatments. Staff education was provided by the District Director of Case Management on July 6, 2018 to Resident Care Management Director (RCMD)and Assistant Director of Nursing(ADON)on policy and procedure regarding comprehensive care plans for residents who take independent LOA from the facility and residents who have refusals of care and treatment. 100% audit completed on all residents who independently take LOA from facility by Director of Nursing (DON) and Assistant Director of Nursing (ADON) on July 5, 2018. 100% audit completed on all residents who have refusals of care and treatments by DON and ADON on July 5, 2018. Results of audit updated to ensure all residents who take independent LOA and refuse care and treatments comprehensive care plans developed by July 6, 2018. No additional residents noted without independent LOA and refusal and treatment comprehensive care plans. DON and/or ADON will maintain a communication log based on updates to the 24 hour report that will be discussed daily in clinical meeting with revisions to care plans updated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 656	Continued From page 15 On 7/3/18 at 9:45 am an interview was conducted with the Treatment Nurse (TN) who stated that Resident #1 was frequently known to leave the facility, by signing himself out and by motorized wheel chair in the extreme heat as far as 2 miles to the store. There were times when the resident dragged his right foot while outside and his dressing came off and there were times when the resident refused to have his dressing changed putting him at higher risk for infection. On 7/5/18 at 10:30 am an interview was conducted with the facility Nurse Practitioner (NP) who stated she was very familiar with Resident #1. The resident was frequently non-compliant with wound care dressing change. The resident preferred to have his dressings changes while still in bed before he got up to his motorized wheel chair. The NP stated the resident was alert and oriented. NP stated on 6/13/18 she evaluated the resident's wound and the dressing was soaked through and the drainage was like mud. The resident refused to go to the Emergency Department (ED) so the NP ordered a broad-spectrum antibiotic for concerned infection and labs and the wound care was completed after NP intervention. The resident had an intact cognition and stable schizophrenia. The NP stated that the resident made poor choices. The NP stated that at times personal care was refused as well as wound care. On 7/5/18 at 11:00 am an interview was conducted with the Director of Nursing (DON) who stated that Resident #1 had a long history of refusing wound and personal care. The resident preferred to be up in his motorized wheel chair (WC) and wanted the dressings to be changed before he got into his WC. The DON agreed that	F 656	3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)The ADON and/or the RCMD will audit residents who take independent LOA and residents who have refusals of care and treatment for four weeks, then five random care plans weekly for eight weeks to ensure that the facility care plans are developed according to facility policy and that they contain required components needed to care for each resident. b)The ADON and/or RCMD will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. 4.Title of person responsible for implementing the acceptable POC. a)The ADON and/or the RCMD will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 656	Continued From page 16	F 656	a)July 21, 2018	

the current care plan interventions were not always effective for this resident and that his very frequent LOAs from the facility should be care planned.

2. Resident #2 was admitted on to the facility on 7/28/17. Diagnoses were diabetes, at risk for falls, bowel incontinence, and hemiplegia.

Resident #2's care plan dated 4/27/18 revealed goals and interventions for dependent on staff for emotional and social needs, self-care deficit, desired to return to home, fluid volume deficit, poor oral hygiene, diabetes, at risk for falls, bowel incontinence, hemiplegia, potential for pressure ulcer, and actual impairment to skin integrity. There were no interventions on the care plan for an order to shower every day anti-bacterial wash and no interventions to address refusals of care that were consistently effective.

The quarterly Minimum Data Set dated 5/24/18 revealed the resident had adequate hearing, clear speech, and was understood and understands. The resident had an intact cognition. The resident required extensive assistance of 2 persons for all transfers, bed mobility, and locomotion. Dressing and personal care required 2 staff members limited assistance. Meals required set up. The active diagnoses were neurogenic bladder, diabetes, and hemiplegia.

A Nurse Practitioner's order dated 6/20/19 revealed for the resident to shower every day anti-bacterial wash.

A nurses' note dated 6/22/18 revealed the resident felt a shower every day was too much and had declined her shower.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 656	Continued From page 17	F 656		

A nurses' note 6/30/18 revealed the resident had refused some of her every day showers and had requested to go back to the twice a week schedule.

On 7/3/18 at 9:45 am an interview was conducted with the Treatment Nurse (TN) who stated the resident refused her ordered showers and the nursing assistants provided a bed bath. Nursing staff was not notified of the refusal which resulted in a bed bath provided that was not effective to prevent a second occurrence of maggots being observed on her body.

On 7/3/18 at 5:45 pm an interview was conducted with Resident #2 who stated about a week ago there were maggots on her stomach and in her bed. The NP ordered anti-bacterial wash and showers every day which were still in place at this time. The resident stated that she preferred a bed bath and when she refused a shower and was provided a bed bath instead, the maggots returned.

On 7/5/18 at 8:05 am an interview was conducted with the NP who was also very familiar with Resident #2. The resident was alert and oriented and able to make her own decisions. The resident was her own resident representative. The resident was known to resist personal care and preferred a bed bath. Resident #2 had maggots to her right lateral lower abdominal fold and maggots in the bed. The NP stated she ordered daily showers and cleanse with anti-bacterial wash. The resident agreed to daily showers and education was provided why showers were needed. After the first three days the resident started to complain to nursing that a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 656	Continued From page 18	F 656		

daily shower was too much for her and began to inform personal care staff that the NP informed the resident that she no longer needed a daily shower. The NP stated that the resident manipulated staff. The staff did not inform the NP of the resident's refusal on day three of the order for daily showers and by day five the resident had maggots again in her abdominal folds, same place. The showers were more effective at washing the lymph edema and any potential fly eggs. The resident did not like to transfer via the mechanical lift because of her size and fear of falling. The resident had lymph edema which wept fluid continuously and put the resident at increased risk for maggots.

The NP stated that when a resident refused care or treatment her expectation was for staff to re-educate the resident to obtain compliance and if the refusal continued to inform her.

On 7/5/18 at 12:15 pm an interview was conducted with Nursing Assistant #1 who stated that she was assigned to Resident #2 who received a shower or complete bed bath every day. The resident preferred a bed bath and had to be coaxed to take her shower. NA #1 was aware of the maggots and had seen flies in the resident's room, but not more than usual. When the NP ordered for the resident to take a shower, the resident refused and said she did not need a shower anymore and a bed bath was provided. NA #1 was aware of the daily shower order and would encourage the resident if she refused.

On 7/5/18 at 11:00 am an interview was conducted with the Director of Nursing (DON) who stated that Resident #2 sometimes refused her ordered shower and the staff at times had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 656	Continued From page 19 called the resident's family member to influence the resident to take a shower, which was effective. On day three of the ordered daily shower the resident refused to have a shower and the staff gave the resident a bed bath. The family member was not called as an intervention. The resident did not receive a shower for two days of the ordered daily shower and maggots re-appeared. The DON confirmed the resident's care plan did not contain an intervention to contact the resident's family member when the resident refused a shower. The DON would expect interventions that were being implemented for refusals be care planned.	F 656		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and Nurse Practitioner and staff interviews, the facility failed to provide basic care and cleanliness for 2 of 2 sampled residents reviewed for maggots (Residents #1 and #2). Maggots were found in Resident #1's right lower extremity wound and in Resident #2's abdominal folds. Resident #1 was sent to the hospital for treatment and Resident #2 received treatment for maggots at the facility.	F 684	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by the provision of the Federal & State Law. F684	7/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 20 Immediate jeopardy (IJ) began on 6/14/18 when for Resident #1 was not provided basic care and cleanliness by staff and live maggots were found in his right lower extremity wound. IJ began on 06/19/18 for Resident #2 when she was not provided with basic care and cleanliness by staff and live maggots were found in her abdominal folds. The Immediate Jeopardy was removed on 7/6/18 when the facility implemented a credible allegation of IJ removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service. Findings included: 1. Record review revealed Resident #1 was admitted to the facility on 8/10/17 and readmitted on 6/24/18. The resident was discharged back to the hospital on 6/30/18 and remained in the hospital during this survey. The resident's diagnoses included; paraplegia, depression, manic depression, schizophrenia, dependence on a wheelchair, pressure ulcer (PU) of multiple sites, polyneuropathy, Burkitt lymphoma (cancer of the lymphatics), peripheral arterial vascular disease, and above the knee amputation. A nurses' note dated 6/12/18 revealed Resident #1 was started on an antibiotic for treatment of a right leg wound infection. The first dose of Zosyn 600 milligrams every 12 hours for 14 days was administered. Resident went LOA (leave of absence) on 6/13/18 twice in his motorized wheelchair going to town. Both LOAs the resident returned with his right lower leg/foot dressing missing. When the resident returned to	F 684	1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. Resident #1 was hospitalized from 6/27/18-7/6/18. On 7/7/18 Resident #1 has new orders for all wound treatments and now has an additional PRN order to ensure treatments can be scheduled based on residents preference. On July 6, 2018 Licensed nurse completed a complete head to toe skin assessment on resident #1. No negative findings were observed as a result of the skin assessment. On July 4, July 5,and July 6, 2018 the licensed nurse completed a complete head to toe assessment of resident #2. No negative findings were observed as a result of the skin assessment. On July 5, 2018 resident #2 received shower with no negative findings noted. On July 4, 2018 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordiantor, Unit Coordinator, Unit Managers, Nursing Supervisor conducted an audit on 100% of residents to determine any residents who routinely leave the center on Leave of absence and do not receive treatments due to LOA. All residents who have treatment orders in place and leave the facility LOA had their treatment orders updated to include PRN dressing changes to accommodate personal preferences	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 21 the facility the second time, blood was dripping onto the floor (from the resident's right lower extremity wound) of the facility hall way. The resident was reminded that it was not safe for him to continue to injure his foot. A nurses' note dated 6/13/18 revealed the resident continued to be non-compliant with treatments and refused to have wound dressings changed. The reason for the resident's refusal was not documented. A review of the out of facility release of responsibility form revealed Resident #1's last out of building was on 6/13/18. The resident left the facility almost every day for the past 3 months. Resident #1's care plan dated review date 6/14/18 revealed goals and interventions for daily care decisions at times refuses wound treatment, independent with smoking, activities of daily living self-care deficit, resistive to care related to schizophrenia, at risk for falls, at risk for infection, antidepressant and antipsychotic medication, nutritional deficit, polyneuropathy, multiple PUs, altered skin integrity, and cellulitis of the right lower extremity. The only intervention for wound care non-compliance was to encourage the resident. Resident #1's quarterly Minimum Data Set dated 6/14/18 revealed the resident had adequate hearing, clear speech, and understood and understands. He had intact cognition, no psychosis, and no behaviors. The resident required one-person extensive assistance for bed mobility and total dependence of two for transfer. Locomotion on and off the unit was supervision set-up only. Dressing, personal hygiene, and	F 684	and needs. On July 4, 2018 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit managers and nursing supervisor completed head to toe assessments on 100% of the residents. As a result of the skin assessments, no other negative findings were observed. On July 4, 2018 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit managers and nursing supervisor completed an audit on 100% of residents to identify any residents who refuse showers and bed baths as ordered by the physician. It is alleged that the facility failed to provide basic care and cleanliness for Resident #1 and Resident #2. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)July 4, 2018, The Staff Development Coordinator (SDC),re-educated all Licensed nursing staff to include full-time, part-time, and PRN on interventions to encourage compliance when resident refuse care and treatments. No licensed nurse will be allowed to work until the education is completed. Newly hired Licensed Nurses will be educated by the SDC during their classroom orientation. Licensed nurses will document residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 22 toileting was one-person physical assistance and set up was for meals. A nurses' note dated 6/14/18, written by the treatment nurse, revealed Resident #1 complained of increased pain to his wounds. During dressing change of the right lower extremity wound revealed there was a large amount thick, brown drainage with foul odor and white objects were moving in the wound. The NP was notified and ordered for the wounds to be open to air and to send the resident to the hospital. 911 was called and the resident was immediately transferred. The hospital discharge summary dated 6/24/18 revealed Resident #1 was admitted on 6/14/18 and his diagnoses were acute cellulitis of the lower right extremity, acute pressure ulcer site not specified, pressure ulcer of right leg, right above the knee amputation (AKA), Burkitt lymphoma, and acute kidney injury. Burkett lymphoma rendered the resident paralyzed due to spinal invasion. The resident was treated for a urinary tract infection. Operative report for the right AKA dated 6/19/18 documented that the residents right lower extremity had active infection with diffuse edema. A nurses' note dated 6/24/18 revealed Resident #1 returned to the facility with no pain and a wound vacuum to his new AKA and several areas of open skin. Resident returned with orders for antibiotic administration to treat a urinary tract infection. On 7/3/18 at 9:45 am an interview was conducted with the Treatment Nurse (TN) who stated that two residents on Hall 700 had maggots. Resident	F 684	refusals of showers, treatments, refusals, and any interventions attempted in a progress note. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)Daily Monday - Friday in the Clinical Morning Meeting for 12 weeks, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers will audit Treatment Administration Records of residents identified as routinely going on LOA, and / or residents who routinely refuse treatments. If concerns, such as not offering treatments at times suitable to meet the preference of the resident are identified, the affected resident will be interviewed to determine any change in preferred time, physician's order obtained, Treatment Administration Record updated and care plan updated as needed. If concerns such as non-compliance are identified alternative interventions will be attempted to encourage compliance. If alternative interventions are not noted as attempted, the Licensed Nurse identified as not having offered treatments at different times or alternative interventions to encourage compliance will be provided a one to one re-education. Daily Monday - Friday in the Clinical Morning Meeting for 12 weeks, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 23 #1 had white moving bugs that were believed to be maggots coming out of his lower right extremity/foot wound with 100% necrotic tissue with recent diagnoses of vascular disease and he was sent immediately to the hospital. The resident also had a planned above the knee amputation pending which was performed on his last hospital admission. The resident was known to frequently leave the facility by motorized wheelchair in the extreme heat and go as far as 2 miles away to the store. There were times when the resident dragged his right foot while outside and his dressing came off and there were times when the resident refused to have his dressing changed putting him at higher risk for infection. The dressing to the right lower extremity was dressed as ordered and no other form of securing the dressing was done by the TN. The resident had to have his dressing redressed frequently due to falling off and drainage. The TN stated that the maggot issue information was passed verbally during shift change. On 7/5/18 at 8:05 am an interview was conducted with the facility Nurse Practitioner (NP) who stated she was very familiar with Resident #1. The resident was frequently non-compliant with wound care dressing change. The resident preferred his dressing changes while still in bed before he got up to his motorized wheelchair (WC). The NP stated from what she observed the resident would request to get up to his WC at various times and the dressing change time was not always altered to meet this schedule. The resident was alert and oriented. NP stated on 6/13/18 she evaluated the resident ' s wound and the dressing was soaked through and the drainage was like mud. The NP stated that the resident had a recent doppler test (an observation	F 684	Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers will audit Treatment Administration Records of residents with physician orders for showers or bed baths to validate treatments are offered as needed based on resident preference. If concerns such as non-compliance are identified alternative interventions will be attempted to encourage compliance. If alternative interventions are not noted as attempted, the Licensed Nurse identified as not having offered treatments at different times or alternative interventions to encourage compliance will be provided a one to one re-education. b)The DON and/or the ADON will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. 4.Title of person responsible for implementing the acceptable POC. a) The DON and/or ADON will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 24 of arteries and veins) of his lower extremities and peripheral vascular disease (PVD) was found. The NP commented that PVD can cause slow or non-healing of wounds. The resident refused to go to the Emergency Department (ED) so the NP ordered a broad-spectrum antibiotic for concerned infection and labs and the wound care was completed. The NP commented that she was surprised the resident was not septic. On 6/14/18 when the Treatment Nurse removed the resident's right lower extremity wound dressing there were white moving objects in the wound believed to be maggots. The resident was transferred to the ED with his wound open to air kill the maggots. The resident was informed and re-educated as to the seriousness of his right leg infection and then agreed to the plan of treatment. The resident had an above the knee amputation planned which was performed during this hospitalization. The resident had an intact cognition and stable schizophrenia. The NP stated that the resident made poor choices. The resident's only significant other was in the facility and was estranged from his family. The NP witnessed the resident's right lower extremity dressing was soaked through from drainage and smelled foul. All staff involved would talk to the resident and reeducate him when there were refusals. The NP stated she felt the resident understood the consequences of refusal. The resident was oriented enough he would most likely not be deemed incompetent but was not aware if there was a competency evaluation. The resident was his own representative. The NP stated the resident was safe to leave the building and had always returned. On 7/5/18 at 11:00 am an interview was conducted with the Director of Nursing (DON)	F 684	a)July 21, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 25	F 684		

who stated that Resident #1 had a long history of refusing wound and personal care. The resident preferred to be up in his motorized wheelchair (WC) and wanted the dressings to be changed before he got into his WC. The resident did not want to get back into the bed for wound care. Removal of the resident's WC for behavior caused the resident's non-compliance to increase. The resident contracted for safe WC use, the WC was returned and his wound care compliance was 100% for a while. Staff tried changing the resident's dressing on night shift while in bed and that worked for a while with return of refusal. The resident would change the time he wanted his wound dressing changed depending on his needs and how he felt which caused communication breakdown between the shifts and whether the resident should be offered wound care before getting up to his WC. At times the resident would ask the night staff to place him in the WC before his dressing were changed by day shift. Once up in the WC the resident would not allow dressing changes unless he had a problem. The resident was alert and oriented and his own resident representative. The resident was asked each day if he would allow wound care. The DON stated that the current interventions were not always effective for this resident and some of them were not care planned. The DON stated a psychiatrist was not obtained to evaluate the resident's non-compliance and competency. The resident had refused psychiatry services in the past.

2. Resident #2 was admitted to the facility on 7/28/17. Diagnoses included; diabetes, pulmonary disease, at risk for falls, bowel incontinence, and hemiplegia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 26	F 684		

Resident #2's care plan dated 4/27/18 revealed goals and interventions for dependent on staff for emotional and social needs, self-care deficit, desired to return to home, fluid volume deficit, poor oral hygiene, diabetes, at risk for falls, bowel incontinence, hemiplegia, potential for pressure ulcer, and actual impairment to skin integrity.

The quarterly Minimum Data Set dated 5/24/18 revealed the resident had adequate hearing, clear speech, and was understood and understands. The resident had an intact cognition. The resident required extensive assistance of 2 persons for all transfers, bed mobility, and locomotion. Dressing, bathing, and personal care required 2 staff members limited assistance.

A nurses' note dated 6/19/18 at 3:31 pm, written by the treatment nurse, revealed the resident had maggots in the abdominal folds.

A Nurse Practitioner (NP) order dated 6/19/18 revealed anti-bacterial wash every day.

A Nurse Practitioner order dated 6/20/19 revealed an order for the resident to receive a shower every day.

A nurses' note dated 6/22/18 revealed the resident felt a shower every day was too much.

A nurses' note dated 6/30/18 revealed the resident had refused some of her every day showers and had requested to go back to the twice a week schedule.

On 7/3/18 at 9:45 am an interview was conducted with the Treatment Nurse (TN) who stated that Resident #2 had maggots on her body and in her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 27	F 684		

bed. The TN stated she observed that Resident #2 had several maggots in her bed with food debris and two in the skin folds of her lower abdomen about 6/20/18. The Nurse Practitioner (NP) was notified and daily showers with anti-bacterial wash were ordered. By about day 3 the resident refused her showers and the nursing assistants provided a bed bath with anti-bacterial wash. Nursing staff was not notified of the refusal. On day 5 the resident had a few maggots again in the same area of her abdominal fold. The TN stated that the maggot issue information was passed verbally during shift change. The staff was verbally directed to look for maggots during routine care.

On 7/3/18 at 11:45 am an interview was conducted with the Assistant Director of Nursing (ADON) who stated that Resident #2 had maggots found on her body shortly after another resident was found to have maggots. The resident was found to have maggots in the folds of her lower abdominal skin. The ADON stated the TN identified the maggots during treatment and was not sure if there was tissue injury. The resident was always dressed and it was unclear how maggots were able to get under her clothing. The NP was called and an order for anti-bacterial wash and shower each day was obtained. The maggots were found on Sunday and the Administrator was verbally informed on Monday of the second incidence of maggots. The ADON expected the treatment nurse assigned for that day to inform her if there were any maggots. The ADON stated that the maggots were mentioned in the Monday morning meeting but not discussed for prevention or new process. The staff were directed to kill any flies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 28	F 684		

On 7/3/18 at 5:45 pm an interview was conducted with Resident #2 who stated there was a quick increase in the number of flies in her room about 1 to 2 weeks ago. The resident stated about a week ago there were maggots on her stomach and in her bed which caused her anxiety. The NP ordered anti-bacterial wash and showers every day which were still in place at this time. The resident stated that during the first five days of the showers there were additional maggots that had hatched. The resident preferred a bed bath and when she refused and had a bed bath instead of a shower the maggots returned. The resident informed the staff that she did not need a shower. The resident stated she was informed by the NP her lymph edema can attract flies and cause maggots and agreed to have a shower.

On 7/5/18 at 8:05 am an interview was conducted with the NP who was very familiar with Resident #2. The resident was alert and oriented and able to make her own decisions. The resident was her own resident representative. The resident was known to resist personal care and preferred a bed bath. Resident #2 had maggots to her right lateral lower abdominal fold and maggots in the bed. The NP stated she ordered daily showers and cleanse with anti-bacterial wash. The resident agreed to daily showers and education was provided why showers were needed. After the first three days the resident started to complain to the nursing assistant that a daily shower was too much for her and began to inform personal care staff that the NP informed the resident she no longer needed a daily shower. The NP stated that the resident manipulated staff. The staff did not inform the NP of the resident's refusal on day three of the order for daily showers and by day five the resident had maggots again in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 29	F 684		

her abdominal folds, same place. The showers were more effective at washing the lymph edema and any potential fly eggs. The resident did not like to transfer via the mechanical lift because of her size and fear of falling which contributed to the shower refusal. The resident had lymph edema which wept fluid continuously and put the resident at increased risk for maggots.

The NP stated that when a resident refused care or treatment her expectation was for staff to re-educate the resident to obtain compliance and if the refusal continued to inform her. The NP has attempted to get resident cooperation to make better choices by explaining why and the consequences. This method had been repeated and sometimes it worked and sometimes it had not.

On 7/5/18 at 10:45 am an interview was conducted with Resident #2 who stated that the resident had a shower this morning and was made aware by the NP the importance of the need for a shower versus her preferred bed bath. The staff used the shower gurney to transfer the resident to the shower and that worked better than the mechanical lift. The resident stated that it was over a five-day period that she had maggots and was very concerned about their returning. The resident had received her usual, daily ant-anxiety medication. The resident commented that the flies were better.

On 7/5/18 at 12:15 pm an interview was conducted with Nursing Assistant (NA) #1 who stated that she was assigned to Resident #2 who received a shower or complete bed bath every day. The resident preferred a bed bath and had to be coaxed to take her shower when it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 30	F 684		

ordered. NA #1 was aware of the maggots and had seen flies in the resident ' s room, but not more than usual. When the NP ordered for the resident to take a shower, the resident refused and said she did not need a shower anymore. NA #1 provided a bed bath and later learned that the shower order continued. NA #1 indicated that she would inform the licensed nurse if the resident refused a shower.

On 7/5/18 at 11:00 am an interview was conducted with the Director of Nursing (DON) who stated that Resident #2 sometimes refused her ordered shower and the staff at times had called the resident's family member to influence the resident to take a shower, which was effective. The resident was in agreement that her family member was called. On day three of the ordered daily shower the resident refused to have a shower and the nursing assistant gave the resident a bed bath. The family member was not called as an intervention. The resident did not receive a shower for two days of the ordered daily shower and maggots appeared again. The DON's expectation was for nursing assistants to inform the nurses of resident refusals and confirmed that the nursing assistants did not inform the nurses of the refused showers, the NP was not aware, and maggots were again observed on the resident on 6/23/18.

The Administrator, Assistant Administrator, Corporate Nurse Consultant and Director of Nursing were notified of the Immediate Jeopardy on 7/5/18 at 12:32 pm.

On 7/6/18 the facility provided an acceptable credible allegation for immediate jeopardy removal that included the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 31	F 684		

The plan of correcting the specific deficiency including the processes that lead to the deficiency cited:

1. a. Resident #1 was admitted to Randolph Health and Rehabilitation on 8/10/17 due to paraplegia secondary to Burkitt's lymphoma. He was assessed as having a Brief Interview Mental Status (BIMS) score of 15 on the following Minimum Data Set (MDS) Assessments with assessment reference dates of: 8/17/17, 8/24/17, 9/7/17, 10/20/17, 11/7/17, 2/7/18, 3/7/18, 6/14/18 and 6/27/18. A BIMS score of 15 indicates the resident is cognitively intact. The BIMS scale goes from 0-15, with 15 being the highest possible score. Resident #1 is alert and oriented to time, person and place. Resident #1 was issued an order by the attending physician on 8/10/17 that he can leave the center on Leave of Absence (LOA) per the resident's discretion. Resident #1 is currently at the hospital. Resident #1 was care planned on 8/23/17 for declination of care including refusing of going to bed, wound care and personal hygiene. Resident #1 went on LOA on 6/1/18, 6/2/18, 6/3/18, 6/4/18, 6/5/18, 6/6/18, 6/8/18 two times, 6/9/18 two times, 6/10/18 three times, 6/11/18, 6/12/18, two times and 6/13/18. On 6/3/18, 6/4/18, 6/5/18, 6/7/18, 6/8/18, 6/9/18, 6/10/18, 6/11/18 and 6/13/18. Resident #1 was out of the center and did not allow Licensed Nursing to perform his treatment. On 6/8/18 Nurse Practitioner documented in progress note that Resident #1 was evaluated for Venous Stasis Ulcer of leg; per progress note Resident #1 was being evaluated by the surgeon for a right lower leg amputation. On 6/11/18 a Weekly Head to Toe Skin Assessment was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 32	F 684		

completed by a Licensed Nurse with no abnormal findings per the resident ' s baseline. On 6/13/18 the center Wound Nurse evaluated Resident #1's wound to the right ischium stage IV pressure ulcers 4.x5.25x0.1 100% epithelialization, no undermining, pink wound bed, scant serous drainage, no odor, surrounding skin normal, no pain, Nurse Practitioner made aware of wound status on 6/13/18. On 6/13/18 the center Wound Care Nurse assessed Resident #1 ' s Right perineum wound Stage IV 4x5.75.1.2 100% granulation tissue, red wound bed, small serous drainage, normal edges, no pain; Nurse Practitioner was made aware of wound status on 6/13/18. On 6/12/18 the center Wound Care Nurse assessed Resident #1 Arterial Wound to the right lower extremity as 19.0x7x3.0cm, 100% black necrotic tissue, strong odor present, heavy brown purulent drainage; Nurse Practitioner was notified and intramuscular antibiotic ordered. On 6/14/18 Resident #1 was noted by charge nurse to have moving objects in his arterial wound to his right lower leg. Resident #1 attending Physician was contacted and resident was immediately sent to the Emergency Department for evaluation of the wound. Resident #1 returned to the center on 6/24/18 with right lower leg amputation. Resident #1 was sent to the Emergency Department on 6/27/18 and was admitted with diagnosis of left foot infection and acute kidney injury. Resident #1 is currently in the hospital.

The facility Interdisciplinary Team (IDT) including the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers and Social Services Director met on 7/4/18 to review of the medical record of Resident #1 to determine the root cause of the processes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 33	F 684		

that lead to the deficiency cited. The team reviewed the number of LOAs and the number of refusals of care related to treatments of the right lower extremity, the center determined that Resident #1's right lower leg arterial wound could have come into contact with the maggots during his thirteen plus incidence of being absent from the facility . The center identified that resident had refused wound treatments to the right lower leg multiple times from June 1-13, 2018. During interviews with the facility staff, it was determined that the center failed to coordinate Resident #1's wound treatment to resident preference. The facility IDT also identified right lower leg wound dressing had fallen off while outside of the facility on 6-10-18 and that facility did not reinforce the right lower wound dressing prior to resident leaving the facility.

b. Resident #2 was admitted to center on 7/28/17 with diagnosis including, but not limited to morbid obesity, Chronic Obstructive Pulmonary Disease, Anxiety, Hemiplegia and Hemiparesis. Resident #1 BIMS on 5/24/18 was 15. Resident #1 BIMS on 4/5/18 was 15. On 6/15/18, a Weekly Skin Assessment was performed with no findings noted. On 6/19/18 Resident #2 was noted to have maggots to her abdominal folds. Resident #2's Nurse Practitioner was notified with orders for anti-bacterial wash received. On 6/20/18, Resident #2's Nurse Practitioner ordered daily showers for Resident #2. Resident #2 refused showers on 6/22/18, 6/25/18, 6/26/18, 6/27/18 and 6/29/18. After review of the medical record for Resident #2, noting the number of refusals of care related to showers, the center failed to implement specific interventions to get the resident to shower.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 34	F 684		

The facility Interdisciplinary Team met on 7/5/18 to review of the medical record of Resident #2 to determine the root cause of the processes that lead to the deficiency cited. A Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 7/5/18 and it was determined that there was not a resident specific plan of care for alternate interventions to offer the resident to help promote the likelihood the resident will comply with showers per physician orders. The IDT determined the center did not educate the resident on the risks of refusals of showers including risk of maggots. Resident #2 had a skin evaluation assessment performed by the Charge Nurse assigned to Resident#2 on 7/6/18; there were no signs of maggots noted. On 7/6/18 the Unit Coordinator interviewed Resident #2 regarding her bed baths. Resident #2 stated she receives good bed baths and denied having any concerns with bed baths.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited:

· On 7/4/18 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor conducted medical record audits to determine any residents who routinely leave the center on LOA and do not receive treatments due to the LOA.

· On 7/5/18 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor will contact the attending physician and orders will be requested to offer treatments to be scheduled as needed based on resident preference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 35	F 684		

· On 7/4/18 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor begin in-servicing the facility nurses regarding reinforcing wound dressing as needed when resident going on leave absences to protect the wound bed.

· On 7/5/18 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor conducted medical record audits to determine any residents who refuse showers and bed baths per physician order. On 7/5/18 the attending physician will be contacted by the Director of Nursing, Assistant Director of Nursing, Unit Coordinators and Unit Managers for clarification of any residents with physician orders for showers and bed baths in order for the shower or bed bath to be scheduled at a time based on resident preference.

All residents in the center had a head to toe skin assessment completed on 7/4/18 by the Unit Coordinators, Unit Managers, Wound Care Nurse, Treatment Nurse and Assistant Director of Nursing; no other residents were identified as having maggots.

Beginning 7/5/18 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor and 11-7 Nurse Supervisor educated the licensed nurses to seek a physician's order to offer treatments to be scheduled as needed based on resident preference for residents who routinely go on LOA or who refuse treatments.

The Director of Nursing, Assistant Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 36	F 684		

Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor and 11-7 Nurse Supervisor educated the licensed nurses beginning 7/5/18 to reinforce dressings as needed when residents go on LOA due to risk of dressing being removed.

The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor and 11-7 Nurse Supervisor educated the licensed nurses beginning 7/5/18 to evaluate the status of the treatment or dressing when residents return from LOA and document any abnormal findings in Resident Progress Notes. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor and 11-7 Nurse Supervisor educated the licensed nurses beginning 7/5/18 that if an as needed dressing change is indicated, the licensed nurse will perform the dressing change and document the status of the wound in the Resident Progress Notes if changes in the wound bed or amount of drainage are noted. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor and 11-7 Nurse Supervisor educated the licensed nurses beginning 7/5/18 if an as needed dressing change is indicated, the licensed nurse will document the treatment or dressing change on the Treatment Administration Record. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor and 11-7 Nurse Supervisor educated the licensed nurses beginning 7/5/18 that if changes in the wound bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 37	F 684		

or drainage are noted, the attending physician will be notified of any changes with the notification documented in the Resident Progress Notes.

The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor and 11-7 Nurse Supervisor educated the licensed nurses beginning 7/5/18 related to complying with physician's orders for showers or bed baths including using alternative approaches to encourage resident compliance and document approaches on Treatment Administration Record and / or Resident Progress Notes. No Licensed Nurse will be permitted to work without first receiving the education. The Nursing Assistants were re-educated by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, 3-11 Nurse Supervisor and 11-7 Nurse Supervisor beginning 7/4/18 regarding if a resident refuses a bed bath or shower that the Charge Nurse is to be informed of the refusal. Beginning 7/5/18 no Nursing Assistants will be allowed to work without first receiving the education.

Of the 48 Licensed Nurses, 30 of the Licensed Nurses have received the education for F684. Six of the Licensed Nurses who have not yet received the education work on an as needed basis. Three of the Licensed Nurses who has yet to receive the education are currently on vacation. One of the Licensed Nurses who has yet to receive the education is on Family Medical Leave Act (FMLA). Each of the Licensed Nurses who have not yet received the education will not be permitted to work until the education is received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 38	F 684		

Newly hired Licensed Nurses will be educated by the Staff Development Coordinator during their classroom orientation to: to seek a physician's order to offer treatments to be scheduled as needed based on resident preference for residents who routinely go on LOA or who refuse treatments; reinforce dressings as needed when residents go on LOA due to risk of dressing being removed; comply with physician's orders for showers or bed baths including using alternative approaches to encourage resident compliance and document approaches on Treatment Administration Record and / or Resident Progress Notes; evaluate the status of the treatment or dressing when residents return from LOA and document any abnormal findings in Resident Progress Notes; that if an as needed dressing change is indicated, the licensed nurse will perform the dressing change and document the status of the wound in the Resident Progress Notes if changes in the wound bed or amount of drainage are noted; if changes in the wound bed or drainage are noted, the attending physician will be notified of any changes with the notification documented in the Resident Progress Notes.

Upon return to the center, Resident #1's attending physician will be contacted to request a physician's order to offer treatments to be scheduled as needed based on resident preference and treatments will be reinforced as needed.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and / or in compliance with the regulatory requirements.

Daily Monday - Friday in the Clinical Morning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 39 Meeting for 12 weeks, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers will audit Treatment Administration Records of residents identified as routinely going on LOA, and / or residents who routinely refuse treatments. If concerns, such as not offering treatments at times suitable to meet the preference of the resident are identified, the affected resident will be interviewed to determine any change in preferred time, physician's order obtained, Treatment Administration Record updated and care plan updated as needed. If concerns such as non-compliance are identified alternative interventions will be attempted to encourage compliance. If alternative interventions are not noted as attempted, the Licensed Nurse identified as not having offered treatments at different times or alternative interventions to encourage compliance will be provided a one to one re-education. Daily Monday - Friday in the Clinical Morning Meeting for 12 weeks, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers will audit Treatment Administration Records of residents with physician orders for showers or bed baths to validate treatments are offered as needed based on resident preference. If concerns such as non-compliance are identified alternative interventions will be attempted to encourage compliance. If alternative interventions are not noted as attempted, the Licensed Nurse identified as not having offered treatments at different times or alternative interventions to encourage compliance will be provided a one to one re-education.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 684	Continued From page 40 The Title of the person responsible for implementing the acceptable plan of correction: The Nursing Home Administrator is responsible for implementing the plan of correction. Immediate Jeopardy removal date: 7/6/18 Validation: Immediate Jeopardy (IJ) was removed on 7/6/18 at 4:15 pm validation was completed of the credible allegation for IJ removal as evidenced by interviews of one licensed and one nursing assistant for each of the 7 facility halls for evidence of in-service completion. Pest control and maintaining a clean facility in-service was completed for 123 staff members on 7/2/18 and 56 staff members on 7/3/18. On 7/6/18 at 8:00 am outside professional pest control was observed to treat the facility grounds with a liquid spray. On 7/6/18 at 9:30 am the Administrator stated that the facility and grounds were treated for flies.	F 684		
F 925 SS=J	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, Nurse Practitioner (NP) interview, resident and staff interviews the facility failed to implement an effective pest control program to contain the presence of flies in the rooms of four (4) of twelve (12) sample residents. (Residents #1, #2, #3, and #5). Residents #1 had live maggots develop in his right lower extremity wound and Resident #2 had	F 925	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by the provision of the Federal & State Law.	7/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 41 live maggots develop in her abdominal folds. Resident #1 was transferred to the hospital for treatment of maggots and Resident #2 received treatment for maggots at the facility. Immediate jeopardy (IJ) began on 6/14/18 when Resident #1 was found with live maggots in his right lower extremity wound. Immediate Jeopardy began on 6/19/18 for Resident #2 when live maggots were found on her abdomen. The facility failed to implement an effective pest control program to control flies in the facility to prevent the development of maggots on Resident #1 ' s wound and on Resident #2 ' s abdomen. The Immediate Jeopardy was removed on 7/6/18 when the facility implemented a credible allegation of IJ removal. The facility will remain out of compliance at a lower scope and severity level of E (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service. Findings included: 1a. Resident #1's quarterly Minimum Data Set dated 6/14/18 revealed the resident had adequate hearing, clear speech, and understood and understands. He had intact cognition, no psychosis, and no behaviors. A nurses' note dated 6/14/18, written by the Treatment Nurse (TN), revealed Resident #1 was observed to have white moving objects coming out of his right lower extremity wound. The NP was informed and an order to transfer the resident to the hospital and to leave the wound open to air was obtained.	F 925	F925 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. On 6/14, Resident #1 was transferred to the hospital. On 6/15 Resident #1's room was deep cleaned and disinfected by Housekeeping Staff. On 6/20 Resident #2 received new orders from Nurse Practitioner for daily showers. On 6/20/18 Maintenance Director conducted audit on all fly fans for normal operations. As a result of the audit there were no negative findings and all fly fans were operating normally. On 6/21/18 Maintenance Director checked all fly lights and replaced sticky paper as needed. On 7/2/18 Assistant Administrator, Maintenance Director, Maintenance Assistant completed an audit of 100% of facility windows to ensure windows closed and latched properly and completely. As a result of the audit, 1 room was found out of compliance and was repaired by Maintenance Director on 7/2/18. On 7/2/18 Assistant Administrator, Maintenance Director, Maintenance Assistant completed an audit of 100% of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 42 Another nurses' note dated 6/14/18 revealed Resident #1 was hospitalized on 6/14/18 for right lower extremity wound infection and white moving objects in his wound. The Nurse Practitioner (NP) ordered for the resident's right lower extremity dressing to be removed and left open to air and transfer to the hospital. The resident was transported by Emergency Medical Services. A Hospital discharge summary dated 6/24/18 revealed Resident #1 was admitted on 6/14/18 for an infection to his right lower extremity and had an above the knee amputation. On 7/3/18 at 9:45 am an interview was conducted with the TN. The TN stated that on 6/14/18 during wound care of Resident #1's right lower extremity white moving objects were observed coming out of the wound which staff and the NP believed to be maggots. The resident was sent immediately to the hospital. Record review revealed Resident #1 was re-hospitalized on 6/27/18 and was not available for interview or observation during the survey. 1b. Review of a quarterly Minimum Data Set (MDS) dated 5/24/18 revealed Resident #2 had adequate hearing, clear speech, and was understood and understands. The MDS specified the resident had an intact cognition. A nurses' note dated 6/19/18 at 3:31 pm, written by the treatment nurse, revealed the resident had maggots in her abdominal folds. On 7/3/18 at 9:45 am an interview was conducted with the Treatment Nurse (TN) who stated that on 6/19/18 she went to place Nystatin powder to	F 925	facility windows screens for integrity and quality. As a result of the audit 22 screens had minor holes in screen. Maintenance Director and Maintenance Assistant repaired all screens on 7/2, 7/3 and 7/5. On 7/4/18 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers, and Nursing Supervisor completed head to toe skin assessments on 100% of the residents. On 7/6/18 Contracted Pest Control Company provided pest control treatment to exterior and interior of facility. Effective 7/6 facility added fly program to current contract with Pest Control Service Provider. This program includes monthly treatment of interior, exterior and exterior campus of facility. On 7/5 the Assistant Administrator educated Maintenance Director and Maintenance Assistant on Notification of Pest Control services when an increase of pest activity is observed. On 7/5 the Assistant Administrator educated Maintenance Director and Maintenance Assistant on checking fly lights twice monthly for three months then monthly thereafter. On 7/6 Assistant Administrator Educated Maintenance Director and Maintenance Assistant on the addition of the fly program to the facility's contract for Pest	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 43 Resident #2's abdominal folds and noticed 2 maggots in the skin fold of her lower right lateral abdomen and 10 maggots in the bed. The TN stated she informed the NP who ordered daily showers with an antibacterial wash to remove the maggots and kill fly eggs. The TN was not aware of any pest control service visit for the flies after identifying the maggots. On 7/3/18 at 5:45 pm an interview was conducted with Resident #2 who stated recently there was a quick increase in the number of flies in her room about 1 to 2 weeks ago. The resident was killing three at a time with a fly swatter and would ask the nursing assistants to assist. The number of flies in her room was an increase. The resident stated other than the fly swatter she was not offered any other method to control the flies in her room. The resident stated that she complained to the nursing assistants on more than one occasion. The resident stated about a week ago there were maggots on her stomach and in her bed. The resident stated that she had a daily shower with an antibacterial wash to prevent any further maggots or hatching of eggs and no longer had maggots. She further stated that maintenance staff did not approach her to inquire about the flies, check her window or provide any other form of pest control other than what was already in place. 1c. Review of a quarterly Minimum Data Set (MDS) dated 4/27/18 revealed Resident #3 had adequate hearing, clear speech, and was understood and understands. The MDS specified the resident had an intact cognition. On 7/2/18 at 9:45 am an observation of Resident #3's room (Room #412) was completed. The	F 925	Control Services. On 7/5/18, the Maintenance Director Activated the 700 Hall Exit Door Alarm and removed alarm reset key. Staff will have to contact maintenance in order to reset alarm. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. On 7/5/18 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers and Nursing supervisor educated 100% of staff to include full-time, part-time, and weekends on not using the 700 hall exit and the process of reporting flies if observed in resident rooms. This in-service also included filling out a work order if any window screens are damaged. On 7/5/18 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers and Nursing supervisor educated 100% of staff to include full-time, part-time, and PRN on maintaining a clean facility. 7/5/18 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, Unit Managers and Nursing supervisor educated 100% of staff to include full-time, part-time, and PRN on the life	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 44 resident's bed was next to the window. There were a few flies noted flying around the resident. The room and the resident were both clean and there was no odor. The flies were observed to land on the bed and the resident's hand and face. The resident was observed to have limited mobility and no ability to swat the flies away. On 7/2/18 at 9:45 am an interview was conducted with Resident #3 who stated he did not like the flies and believed they were coming in the window where the 2 sliding window glass pieces met. The fly increase in flies in his room was recent. The resident stated he could not use a fly swatter. On 7/2/18 at 9:55 am an interview was conducted with Nurse #1 who was assigned to Resident #3. Nurse #1 stated that last Tuesday she informed maintenance about the flies and the residents were offered a fly swatter. Nurse #1 did not believe that a fly swatter was effective for a resident who did not have the ability to use the swatter such as Resident #3. Nurse #1 noted that flies were in Resident #3's room and in the hallway during the interview. On 7/3/18 at 8:55 am an interview was conducted with Resident #3 who stated that maintenance had been in to evaluate his window, did something to the window and killed some flies. The flies were better 1d. Review of a quarterly Minimum Data Set dated 6/15/18 revealed Resident #5 had adequate hearing, clear speech, and was understood and understands. The MDS specified the resident had an intact cognition.	F 925	cycle of a fly and how to identify flies and maggots. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. Beginning 7/5/18, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Social Worker, Medical Records Coordinator, Business Office Director, Admissions Coordinator, Maintenance Director, Human Resources Coordinator, Unit Managers, Unit Coordinators, Transportation Director, Activity Assistant and scheduler will perform and audit of two rooms twice a week for presence of flies. These audits will continue for 12 weeks. Fly lights will be audited by the Maintenance Director, Maintenance Assistant or Assistant administrator twice monthly for three months and monthly thereafter, or as indicated. Maintenance Director, Assistant Maintenance Director or Assistant Administrator will accompany Pest Control Technician during monthly and as needed visits/treatments for a minimum of three months to validate services rendered. Results of these audits will be presented by the Maintenance Director, Assistant Administrator or Administrator for review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 45 On 7/2/18 at 11:40 am an interview was conducted with Resident #5. Resident #5 stated that he had several flies in his room and he did not like flies. He further stated that the increase in flies in his room was recent and he did not know why. The resident stated he was not able to swat the flies. On 7/2/18 at 11:40 am an observation was done of room #712 (Resident #5's room) and 2 flies were observed in the room. The window was not closed completely and light from outside could be seen at the window's edge. On 7/2/18 at 10:10 am an interview was conducted with the Housekeeping Manager (HM) who stated that housekeeping was required to report concerns of flies. The HM stated that there were the usual number of flies in the facility and no concerns were reported. On 7/3/18 at 8:30 am an interview was conducted with the Maintenance Manager (MM) who stated on 6/20/18 he was alerted to flies on Hall #400 and investigated. MM stated he found all measures to control flies operational and intact and no new interventions were added. Pest control was scheduled monthly and returned when called on an as needed basis. MM stated on 6/20/18 that he killed flies with a swatter when informed of the flies and provided swatters to residents that were able to use the swatter. MM felt that the entry for the flies were the entry/exit doors for staff and visitors and that there was a recent heavy rain with increase in temperature and humidity that caused an increase in flies to enter the facility. MM stated that staff were not allowed to use chemicals, the hired pest control	F 925	in Quality Assurance and Performance Improvement Committee monthly for a minimum of three months to validate success of the interventions and recommendations of Quality Assurance and Performance Improvement Committee to assure compliance is sustained ongoing. 4.Title of person responsible for implementing the acceptable POC. a)The Maintenance Director and/or Administrator and/or Assistant Administrator will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)July 21, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 46	F 925		

provided that service. MM stated he did not call for pest control to provide service to the facility. He explained that one particular root cause was not identified. All potentials that MM was aware of were evaluated and the only one identified was the entry/exit doors. MM stated outside pest control will be evaluating the fly issue today as a result of inquiry. The fly issue was a quick change. MM stated that the resident in Room #718 complained of flies and MM swatted and killed the flies, not sure the total amount. MM commented that Hall #700 had more flies than the other halls.

On 7/3/18 at 10:30 am an interview was conducted with MM who stated after disclosure of known maggots that he was informed by the Administrator of two separate occasions where two residents had maggots over the past 2 weeks and to evaluate for potentially more flies relating to residents. MM stated he heard staff discuss maggots on residents, but felt it was hearsay. MM stated that on hall #7 there were more flies than on other halls in the facility. MM changed the sticky paper in the bug light and decided not to call for the outside pest control. MM stated he requested HM to have the resident with maggot's room deep cleaned. MM stated that he observed for flies and did not see any more than usual and that was why he did not request for the outside pest control company to provide service. MM's plan was to abate flies that come in the door and kill the flies in the facility by fly swatter. MM commented that the facility cannot use chemicals or sprays but pest control can. MM commented that he did not think the situation warranted pest control. Pest control treated the facility once a month for prevention that was not specific to flies. MM stated that he felt the facility's current fly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 47	F 925		

control measures could manage the concerns. MM then stated that after the Administrator informed him of the second resident with maggots the circumstance was urgent, but still did not employ the outside pest control to service the facility. MM stated that pest control management was his responsibility.

On 7/3/18 at 11:30 am an interview was conducted with the Assistant Director of Nursing (ADON) who was aware of two residents with maggots on their bodies. The NP was notified and one resident was transferred to the hospital. That resident ' s room was cleaned and no maggots were observed. The staff were informed to kill flies. Staff rounds were required to notify management of any fly concerns and to inform maintenance.

The Administrator, Assistant Administrator, Corporate Nurse Consultant and Director of Nursing were notified of the Immediate Jeopardy on 7/5/18 at 12:32 pm.

The facility provided an acceptable credible allegation for immediate jeopardy removal on 7/6/18 which included the following:

The plan of correcting the specific deficiency including the processes that lead to the deficiency cited:

On 6/14/18 at approximately 11:30 am, the Maintenance Director was notified of maggots in the wound of Resident #1. He immediately went to the room and visually checked for any signs of maggots. At that time none were identified. A physician order was obtained and Resident #1 was sent to the hospital for evaluation. On

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 48	F 925		

6/14/18 the Maintenance Director notified the Housekeeping Supervisor of the need to deep clean Resident #1 ' s room as an added precaution. The room was thoroughly deep cleaned on 6/14/18 with no signs of maggots identified. Pest Control came to center on 6/14/18.

On 6/19/18 Resident #2 was noted to have maggots on her abdomen. At that time her room was deep cleaned as there was spoiled food noted on her over bed table as well as food not properly stored. Resident #2 was provided storage bags to secure her food. Resident #2 was admitted to center on 7/28/17 with diagnosis including, but not limited to morbid obesity, Chronic Obstructive Pulmonary Disease, Anxiety, Hemiplegia and Hemiparesis. On 6/15/18 a Weekly Skin Assessment was performed with no findings noted. On 6/19/18 Resident #2 was noted to have maggots to her abdominal folds. Resident #2 Nurse Practitioner was notified with orders for Hibiclens 4% received. On 6/20/18 Resident #2 Nurse Practitioner ordered Daily Showers.

Resident #2 refused showers on 6/22/18, 6/25/18, 6/26/18, 6/27/18 and 6/29/18. After review of the medical record for Resident #2 noting the number of refusals of care related to showers, the center failed to implement specific interventions to encourage the resident to comply with the physician ' s order to shower.

The breakdown in the process occurred because the Maintenance Director was not aware that the Pest Control Company treated flies. Additionally, the Maintenance Director was not aware that maggots are fly larva. On 7/5/18 the Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 49	F 925		

Home Assistant Administrator provided a one to one in-service education for the Maintenance Director regarding services provided by the Pest Control Company and that maggots are fly larva that can potentially mature to flies.

The Interdisciplinary Care Team (IDT) including the Nursing Home Administrator, the Director of Nursing, Maintenance Director, Minimum Data Set Coordinators, Social Workers and Evening Nurse Supervisor met on 7/5/18 and determined the root causes the pest control program breakdown. One of the Root Cause determined by the IDT was there was a delay of the Maintenance Director notifying the Pest Control Company to perform pest services on 6/19/18 or again on 6/22/18 when maggots were noted in the center. Another Root Cause determined by the IDT was flies entered the center due to staff using the 700 hall exit door, which does not have an air curtain. The staff is using the 700 Hall Exit Door to come and go in and out of the facility after 5:00 PM.

The Nursing Home Administrator educated the Maintenance Director and one of two Maintenance Assistants on 7/5/18 to notify the Pest Control to come do a center visit and treatment as indicated when any observations or notifications of pests occur. On 7/5/18 the Maintenance Director activated an alarm on the 700 Hall exit door to alert if when the door is utilized for non-emergencies. Another of the Root Cause determined was flies entered the center through tears in the window screens. The Assistant Administrator conducted a 100% facility audit for screen integrity on 7/2/18. On 7/2/18 the Maintenance Director and Maintenance Assistants repaired or replaced the window

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 50 screens noted with tears. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The Nursing Home Administrator educated the Maintenance Director and one of two Maintenance Assistants on 7/5/18 to notify the Pest Control to come do a center visit and treatment as indicated when any observations or notifications of pests occur. The Nursing Home Administrator educated the Maintenance Director and one of two Maintenance Assistants on 7/5/18 that fly sticky paper should be checked and changed as needed twice monthly for three months and monthly thereafter, or as indicated. The remaining Maintenance Assistant is on vacation and is scheduled to return to work on 7/10/18. On 7/10/18 the remaining Maintenance Assistant will be educated to notify the Pest Control to come do a center visit and treatment as indicated when any observations or notifications of pests occur and that fly sticky paper should be checked and changed as needed twice monthly for three months and monthly thereafter, or as indicated. The Pest Control Company treated the interior and exterior of the center with pesticide and bait on 7/6/18. On 7/6/18 the Pest Control Company added monthly exterior bait service for flies. Pest Control visits and treats the center on a monthly basis and will visit and treat as needed per monitoring regimen. Pest Control will monthly visits will not have a gap in treatment more 35 days.	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 51 · Residents residing on the 700 hall have the potential to be affected. On 6/20/18, the Maintenance Director noticed a fly in two resident rooms on his Ambassador Rounds. He went to obtain a fly-swatter and returned to the rooms and killed both flies. The Ambassador Program is designed to enhance customer satisfaction and responsiveness through biweekly contact with residents by facility staff. Responsibilities of the Ambassador include: - Reaching out proactively to residents to address concerns and answer questions two times a week or more frequently if needed - Ambassadors are advocates for our residents and perform resident visits as well as room observations two times a week or more frequently if needed. On 7/5/18 Room observations were added to the Ambassador Rounds for cleanliness, safety and pests. If the Ambassador notes concerns, they will be documented on a concern form and / or work order as needed for follow up / resolution. On 6/21/18, Maintenance Director completed inspection on all fly fans and operations were normal. Additionally, the Maintenance Director checked all fly lights for proper function and installed new fly sticky paper, which was not effective because of reoccurrence of maggots for Resident#2. On 6/28/18, room inspections identified two flies in one room. Maintenance staff eliminated both flies and a fly swatter was provided for residents in the room per their request. A visual sweep of the halls was completed with no additional signs of flies on 6/28/18. A 100% audit was completed on facility windows	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 52	F 925		

for closure, screen integrity, and quality. Three window screens were repaired on 7/2/18. On 7/3/18, Pest control arrived and performed a facility assessment. On 7/5/18, Pest Control was called and requested to come back to the facility for assessment with treatment of pesticides and bait provided on 7/6/18.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and / or in compliance with the regulatory requirements.

Beginning 7/5/18, during the Ambassador Rounds conducted by Assistant Director of Nursing, Staff Development Coordinators, Minimum Data Set Coordinators, Social Workers, Medical Records Coordinator, Business Office Director, Admissions Coordinator, Maintenance Director, Human Resources Coordinator, Unit Managers, Unit Coordinators, Transportation Director, Activities Assistants, Scheduler, the staff will perform two random observations for flies twice weekly for 12 weeks in resident care areas. If flies or maggots are noted, the Ambassador will attempt to eradicate as appropriate, notify the Charge Nurse and complete a work order.

Fly sticky paper will be checked and changed by the Maintenance Director as needed twice monthly for three months and monthly thereafter, or as indicated. Maintenance Director will observe fly sticky paper weekly during the summer months to determine if fly sticky paper needs to be changed.

Maintenance Director or Assistant Administrator will accompany Pest Control Technician during monthly and as needed visits / treatments for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 53	F 925		

minimum of three months to validate services rendered.

Beginning 7/5/18 all staff education provided by the Staff Development Coordinator, 3- 11 Nurse Supervisor, 11-7 Nurse Supervisor, Unit Coordinators, Unit Managers, Assistant Director of Nursing, Dietary Manager, Rehab Manager, Housekeeping Manager was initiated to educate staff they are not to enter or exit through the 700 Hall door, complete a work order for torn window screens and to attempt to eradicate, notify the Charge Nurse and complete a work order if flies, maggots or pests are noted.

Results of the audits will be presented by the Nursing Home Administrator for review in the Quality Assurance and Performance Improvement Committee monthly for a minimum of three months to validate success of the interventions and recommendations of Quality Assurance and Performance Improvement Committee to assure compliance is sustained ongoing.

The Title of the person responsible for implementing the acceptable plan of correction: The Nursing Home Administrator is responsible for the implementation of the plan of correction.

Immediate Jeopardy removal date: 7/6/18

Validation:
Immediate Jeopardy (IJ) was removed on 7/6/18 at 4:15 pm validation was completed of the credible allegation for IJ removal as evidenced by interviews of one licensed and one nursing assistant for each of the 7 facility halls for evidence of in-service completion. Pest control

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 925	Continued From page 54 and maintaining a clean facility in-service was completed for 123 staff members on 7/2/18 and 56 staff members on 7/3/18. On 7/6/18 outside professional pest control was observed to treat the facility grounds with a liquid spray. On 7/6/18 the Administrator stated that the facility and grounds were treated for flies.	F 925		