STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOWAN RIVER NURSING AND REHABILITATION CENTER	1341 PARADISE ROAD EDENTON, NC 27932

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F 000	INITIAL COMMENTS A complaint investigation was conducted from 5/29/2024 through 5/30/2024. Event ID # I5S011. The following intake was investigated NC00217442. One of the three complaint allegations resulted in a deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		6/14/24

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

Electronically Signed | 06/13/2024

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family, staff, and physician interviews the facility failed to provide notification to the physician and responsible party upon initial observance of maggots in and on the dressing of a heel wound for one (Resident #1) of three residents reviewed for notification of a change in condition. Findings included: Resident #1 was admitted to the facility on 4/4/2024 with multiple diagnoses some of which included Type 2 Diabetes Mellitus with diabetic peripheral neuropathy, chronic kidney disease, and diabetic foot ulcers. Nurse #2 was interviewed on 5/29/2024 at 12:39 PM and again at 2:33 PM. Nurse #2 revealed the following events as occurring and reconfirmed the events upon a second interview. Nurse #2 stated she worked the 7:00 AM to 7:00 PM shift and was	F 580	On 5/16/24, resident #1 was provided a shower and wound care by the nurse with the assistance of the nursing assistant. The physician and resident representative were notified of the wound status. The resident was assessed by the physician and seen at the hospital for a wound check with no changes in treatment orders. Resident #1 no longer resides in the facility. On 5/16/24, the Director of Nursing and the unit manager completed head to toe skin checks on all residents with wounds. This audit was to identify any skin concerns to include wounds with larvae to ensure the physician and resident representative were notified of acute change. There were no other areas of	

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F 580	Continued From page 2 assigned to care for Resident #1. Nurse #2 stated it was approximately 3:30 PM to 4:00 PM and she obtained the assistance of NA #2 to hold up the left lower limb of Resident #1 to perform wound care on a left heel wound. Nurse #2 stated she sprayed wound cleanser on the bandage to soak it and remove the bandage. Nurse #2 stated as she removed the bandage a maggot dropped onto the barrier pad underneath the heel. Nurse #2 stated a family member of Resident #1 walked into the room while wound care was being provided. Nurse #2 stated she did not say anything to NA #2 when the maggot dropped down but looked at NA #2 so as not to alert the family member in the room. Nurse #2 stated she observed ten but less than 20 maggots on the wound and dressing of Resident #1. Nurse #2 stated she cleaned out all the maggots and cleaned the wound well with the wound cleanser before completing the wound care orders and rewrapped the dressing. Nurse #2 stated after leaving the room, she approached NA #2 and told her she saw maggots in the wound of Resident #1 and for her to go and find the DON to tell her. Nurse #2 stated all of this occurred on 5/14/2024. Nurse #2 stated she did notify the DON who told her she, the DON, would take care of everything including talking to the family of Resident #1. Nurse #2 stated she went back to her nursing duties on 5/14/2024 and left the notification of the physician and the family to the DON. Nurse #2 stated the only error she made was in not documenting the notification of the DON of the maggots in the wound and dressing. Nurse #2 stated she recalled the date of 5/14/2024 because she recalled the date on the bandage prior to its removal. Nurse #2 indicated she spoke with the DON again on 5/16/2024 in the morning confirming with her she did perform the dressing	F 580	concern identified during the audit. On 5/29/24, the Director of Nursing initiated skin checks on all residents residing in the facility for signs and symptoms of acute change to include but not limited to new/worsening wounds or wounds with larvae. This audit is to ensure the physician and resident representative were notified of all acute changes. The Director of Nursing and Assistant Director of Nursing will address all concerns identified during the audit to include notification of the physician and resident representative when indicated with documentation in the electronic record and education of staff. The audit was completed by 5/30/24. On 5/29/24, the Administrator initiated questionnaires with all alert and oriented residents regarding acute change with emphasis on changes not reported or previously addressed by staff to include but not limited to new skin concerns to ensure the resident was assessed and the physician/resident representative were notified of the acute change. The Administrator and Director of Nursing will address all concerns identified during the questionnaires to include notification of the physician and resident representative when indicated with documentation in the electronic record and education of staff. The audit was completed by 5/30/24. On 05/29/24, the Director of Nursing reviewed all current residents' progress notes for the past 14 days. The purpose	

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F 580	Continued From page 3	F 580		

change on 5/14/2024 and she did see maggots in the wound and dressing on that day. Nurse #2 stated she did not perform wound care on Resident #1 on 5/16/2024 but, she knew the dressing change and wound care orders were completed after Resident #1 took a shower.

NA #2 was interviewed on 5/29/2024 at 2:50 PM. NA #2 confirmed on the 3:00 PM to 11:00 PM shift on 5/14/2024 she was assigned to care for Resident #1. NA #2 stated Nurse #2 requested her help in positioning Resident #1 for wound care. NA #2 revealed when she was holding the left leg of Resident #1, a maggot dropped down on the pad below the heel, but she did not know what it was at the time. NA #2 stated she did not look at the heel wound, nor did she see any other maggots. NA #2 reiterated it was her responsibility to hold the left leg and that was what she did. NA #2 confirmed a family member did enter the room during the wound care treatment on that day. NA #2 stated upon completion of the wound care she removed the trash from room. NA #2 revealed Nurse #2 approached her in the hallway and asked her if she knew what it was that dropped onto the pad below the heel. NA #2 told her she did not know, and Nurse #2 told her it was a maggot. NA #2 then revealed Nurse #2 told her to go find the DON and tell her about the maggot. NA #2 stated she looked for the DON, but the DON had already left for the day so, she returned to her nurse aide duties.

NA #1 was interviewed on 5/29/2024 at 12:15 PM. NA #1 stated on her initial morning rounds for her 7:00 AM to 3:00 PM shift, as she was assisting Resident #1 with care, she observed a maggot in the bed near the left foot of Resident

of the audit is to ensure that the physician and resident representative were notified of all acute changes with documentation in the electronic record. The Director of Nursing will address all concerns identified during the audit to include notification of the physician and resident representative with documentation in the electronic record when indicated and education of staff. The audit was completed by 5/30/24.

On 5/29/24, the Director of Nursing initiated an in-service with the nurses regarding (1) Observation and Reporting Acute Changes with emphasis (a) a prompt complete assessment of a resident's slight or subtle changes with immediate notification of the physician to ensure adequate management of the resident's acute illness or exacerbation of a chronic illness. (b) notification of the resident representative with any change in resident condition to include but not limited new skin concerns or larvae on skin with documentation in the electronic record (2) Events that Require Notification of the Administrator and DON to include but not limited to larvae in wounds. In-services will be completed by 5/30/24. After 5/30/24, any nurse who has not received this in-service will receive it prior to beginning their next scheduled shift. All newly hired nurses will be in-service during orientation by the Staff Development Coordinator (SDC).

The ADON, Unit Managers and Minimum Data Set (MDS) nurse will review

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F 580	Continued From page 4 #1 and one maggot on the floor. NA #1 could not recall what day this occurred. NA #1 revealed she immediately reported this to the Unit Manager (Nurse #1) in the hallway. NA #1 stated Nurse #1 came into the room of Resident #1, saw the maggots, and went to notify the DON while NA #1 stripped the bed and threw the maggots in the garbage. NA #1 could not recall what day this occurred. Nurse #1 was interviewed on 5/29/2024 at 12:37 PM. Nurse #1 stated as soon as she clocked in for the day on 5/16/2024 she was notified by NA #1 of maggots in the room of Resident #1, and she went to the room of Resident #1 and observed a maggot on the bed. Nurse #1 confirmed she notified the DON and accompanied NA #1 to the shower room to assess the wounds of Resident #1 and administer wound care after the shower. The DON was interviewed on 5/29/2024 at 11:35 AM. The DON stated Resident #1 was reported to have a maggot observed on the bed and another one on the floor, but she herself never saw them. The DON explained on 5/16/2024 she was not in the building but was notified Certified Nursing Assistant (NA) #1 found the maggots in the room of Resident #1. The DON revealed she came to the building and was told by NA #1 she observed one maggot on the floor and one on the blanket in the bed on Resident #1 close to his left heel wound. NA #1 reported to the DON she had already thrown the maggots away in the garbage immediately. The DON stated she spoke with Nurse #2, the nurse assigned to care for Resident #1 from 7:00 AM to 7:00 PM on 5/16/2024 and was told she had already completed wound care for Resident #1, and she	F 580	progress notes 5 x per week x 4 weeks, then monthly x 1 month to identify acute changes in condition to include but not limited to new/worsening wounds or wounds with larvae weekly x 4 weeks then monthly x 1 month, utilizing the Acute Change Audit Tool. This audit is to ensure the resident was assessed for acute change, the physician was notified of all changes in condition to include new/worsening wounds, wounds with larvae or residents who refuse care/treatments for further recommendations and the resident representative was notified of the acute change with documentation in the electronic record. The Unit Managers will address all areas of concern identified during the audit, including assessment of the resident, notification of the physician/resident representative of the acute changes, and staff re-training. The DON will review the Acute Change Audit Tool weekly x 4 weeks to ensure all areas of concern are addressed. The DON will present the findings of the Acute Change Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 580	Continued From page 5	F 580		

too had seen the maggots. The DON stated when the RP arrived at the facility, she spoke with him in her office and informed him of the maggot or maggots observed in the bed and on the floor as well as the steps that were being taken to prevent reoccurrence of maggots. The DON stated she then called the physician (MD #1) for Resident #1 to inform him of the maggot observations by the nursing staff.

The DON was reinterviewed on 5/29/2024 at 1:50 PM. The DON was adamant she was only made aware of the one maggot on the bed and one on the floor observed by NA #1 on 5/16/2024. The DON stated when she spoke with Nurse #2 on 5/16/2024 she assumed she was talking about performing wound care for Resident #1on the morning of 5/16/2024 and observing a maggot at that time.

An interview was conducted with the responsible party (RP) for Resident #1 on 5/29/2024 at 11:13 AM. The RP for Resident #1 revealed the following information. A couple of weeks ago the RP came to visit Resident #1 in the facility in the morning. When the RP arrived at the facility he was notified by the Director of Nursing (DON), a maggot had been observed by the nursing staff on the foot of Resident #1. The RP of Resident #1 asked the DON what the facility was going to do about it and what steps were going to be taken so that it does not happen again. The DON told the RP, Resident #1 was going to be taken to the shower and the room of Resident #1 was going to be deep cleaned to find the source of the maggot or maggots.

The Administrator was interviewed on 5/29/2204 at 3:30 PM. The Administrator confirmed Nurse

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F 580	Continued From page 6 #2 should have called the Director of Nursing and the physician immediately upon visualizing the maggots on 5/14/2024. The Administrator also confirmed that the responsible party for Resident #1 should have notified as soon as possible as well. Documentation in a physician's follow up note dated 5/16/2024 revealed in part, "Reviewed most recent wound care notes. Alerted this morning, a few hours ago, of the patient potentially having in his left heel some maggot formation. Since that time, the wound has been inspected and thoroughly cleansed and dressed. It is doing well. On my inspection this afternoon, there is no evidence of any maggot formation. The patient is not septic or toxic. He appears at baseline. He denies any pain. I do not think there is any significant decomposition in his sacral right heel or left heel wounds." MD #1, the physician for Resident #1, was interviewed on 5/30/2024 at 9:30 AM. MD #1 stated he would have wanted to be notified on 5/14/2024 if maggots were found in the left heel wound of Resident #1. MD #1 stated if he had been notified of 5/14/2024 he would have come to the facility to visualize the wound and to make sure the wound was cleaned appropriately. MD #1 stated he came to the facility on 5/16/2024 and observed the left heel wound for Resident #1. MD #1 stated all the wounds to include the left heel wound, looked good and did not appear to be infected. MD #1 stated although historically maggots had been used to debride wounds without causing harm, it was not currently good practice.	F 580		
F 684 SS=D	Quality of Care	F 684		6/14/24

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F 684	Continued From page 7 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, family, staff, and physician interviews the facility failed to determine if a higher level of care was needed when maggots were observed in a heel wound for one (Resident #1) of three residents reviewed for professional standards of care for wounds. Findings included: Resident #1 was admitted to the facility on 4/4/2024 with multiple diagnoses some of which included Type 2 Diabetes Mellitus with diabetic peripheral neuropathy, chronic kidney disease, and diabetic foot ulcers. Resident #1 had a physician's order initiated on 4/8/204 for the left heel ulcer to be cleaned with normal saline/dermal wound cleanser, application of Aquacel Ag to the wound bed, and cover with a dry dressing every other day and as needed. Aquacel Ag is a sterile, soft, non-woven dressing that contains ionic silver, a broad-spectrum antimicrobial agent. Documentation on a wound ulcer flow sheet dated as completed 5/10/2024 revealed Resident #1 had a Stage 4 left heel wound 6.2 inches in	F 684	On 5/16/24, resident #1 was provided a shower and wound care by the nurse with the assistance of the nursing assistant. The physician and resident representative were notified of the wound status. The resident was assessed by the physician and seen at the hospital for a wound check with no changes in treatment orders. Resident #1 no longer resides in the facility. On 5/16/24, the Director of Nursing and the unit manager completed head to toe skin checks on all residents with wounds. This audit was to identify any skin concerns to include new or worsening wounds or wounds with larvae and to ensure the resident was assessed by the nurse, the physician and resident representative notified of acute change, new orders/interventions initiated when indicated with documentation in the electronic record. There were no other areas of concern identified during the audit.	

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F 684	Continued From page 8 length, 7.8 inches in width, and an undefined depth. Documentation on the Treatment Administration Record (TAR) supplementary documentation dated 5/11/2024 at 11:13 PM for Resident #1 revealed wound care for both heels was administered by Nurse #4. Nurse #4 was interviewed on 5/30/2024 at 8:40 AM. Nurse #4 revealed she had worked in the facility on 5/11/2024 and 5/12/2024 for the 7:00 PM to 7:00 AM shift. Nurse #4 revealed she had been told in the report when she arrived at 7:00 PM on 5/11/2024 the facility was in between treatment nurses and there would not be a wound care nurse in the facility to perform wound care for Resident #1 on 5/12/2024 as scheduled. Nurse #4 confirmed she performed wound care for Resident #1 to include his left heel wound on 5/11/2024. Nurse #4 stated she did not see any maggots on the left heel wound and the wound looked good. Nurse #4 stated she did not see Resident #1 again until late on 5/12/2024 when he returned to the facility after a visit out with his family. Nurse #4 stated Resident #1 returned to the facility on 5/12/2024 with his dressing intact and she did not note any concerns. Nurse Aide (NA #1) was interviewed on 5/29/2024 at 5:04 PM. NA #1 revealed she was assigned to care for Resident #1 on 5/12/2024 for the 7:00 AM to 3:00 PM shift. NA #1 stated she assisted Resident #1 in getting dressed on 5/12/2024 prior to leaving with his family at approximately 8:00 AM and he did not return to the facility on her shift that day. NA #1 revealed both dressings were intact because she would have told the nurse if either dressing was not intact prior to Resident #1	F 684	On 5/29/24, the Director of Nursing initiated skin checks on all residents residing in the facility for signs and symptoms of acute change to include but not limited to new/worsening wounds or wounds with larvae. This audit is to ensure all residents identified as having an acute change have been assessed by the nurse, the physician and resident representative notified of acute change, new orders/interventions initiated when indicated with documentation in the electronic record. The Director of Nursing and Assistant Director of Nursing will address all concerns identified during the audit to include assessment of the resident, notification of the physician and resident representative, initiation of new orders/interventions when indicated and education of staff. The audit was completed by 5/30/24. On 5/29/24, the Administrator initiated questionnaires with all alert and oriented residents regarding acute change with emphasis on changes not reported or previously addressed by staff to include but not limited to new skin concerns. The Administrator and Director of Nursing will address all concerns identified during the questionnaires to include assessment of the resident, notification of the physician and resident representative, initiation of new orders/interventions when indicated and education of staff. The audit will be completed by 5/30/24. On 05/29/24, the Director of Nursing reviewed all current residents' progress	

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F 684	Continued From page 9 leaving the facility on 5/12/2024. Documentation on the TAR dated 5/14/2024 and 5/16/2024 revealed Nurse #2 administered wound care for the left heel of Resident #1. Nurse #2 was interviewed on 5/29/2024 at 12:39 PM and again at 2:33 PM. Nurse #2 revealed the following events as occurring and reconfirmed the events upon a second interview. Nurse #2 stated she worked the 7:00 AM to 7:00 PM shift and was assigned to care for Resident #1. Nurse #2 stated it was approximately 3:30 PM to 4:00 PM and she obtained the assistance of NA #2 to hold up the left lower limb of Resident #1 to perform wound care on a left heel wound. Nurse #2 stated she sprayed wound cleanser on the bandage to soak it and remove the bandage. Nurse #2 stated as she removed the bandage a maggot dropped onto the barrier pad underneath the heel. Nurse #2 stated a family member of Resident #1 walked into the room while wound care was being provided. Nurse #2 stated she did not say anything to NA #2 when the maggot dropped down but looked at NA #2 so as not to alert the family member in the room. Nurse #2 stated she observed ten but less than 20 maggots on the wound and dressing of Resident #1. Nurse #2 stated she cleaned out all the maggots and cleaned the wound well with the wound cleanser before completing the wound care orders and rewrapped the dressing. Nurse #2 stated after leaving the room, she approached NA #2 and told her she saw maggots in the wound of Resident #1 and for her to go and find the DON to tell her. Nurse #2 stated all of this occurred on 5/14/2024. Nurse #2 stated she did notify the DON who told her she, the DON, would take care of everything including talking to the family of Resident #1.	F 684	notes for the past 14 days. The purpose of the audit is to ensure that all documented acute changes in condition were assessed by the nurse, the resident representative and physician were notified, new orders/interventions initiated when indicated with documentation in the electronic record. The Director of Nursing will address all concerns identified during the audit to include assessment of the resident, notification of the physician and resident representative, initiation of new orders/interventions when indicated and education of staff. The audit was completed by 5/30/24. On 5/29/24, the Director of Nursing initiated an in-service with the nurses regarding (1) Observation and Reporting Acute Changes with emphasis on immediate notification of the physician for acute changes to include but not limited to new or worsening wounds or wounds with larvae for further recommendations, assessment of the resident, initiating interventions when indicated, notification of the resident representative with documentation in the electronic record (2) Treatments with emphasis on responsibility of completing treatments per physician order in the absence of a treatment nurse, completion of assessments when indicated, notification of the physician if resident refuses treatment or treatment cannot be completed as ordered and documentation of treatment on the eTAR. The in-service also included that when a resident is out of the facility for an appointment, the	

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	345164	A. BUILDING _____ B. WING _____	C 05/30/2024

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F 684	Continued From page 10 Nurse #2 stated she went back to her nursing duties on 5/14/2024 and left the notification of the physician and the family to the DON. Nurse #2 stated the only error she made was in not documenting the notification of the DON of the maggots in the wound and dressing. Nurse #2 stated she recalled the date of 5/14/2024 because she recalled the date on the bandage prior to its removal. Nurse #2 indicated she spoke with the DON again on 5/16/2024 in the morning confirming with her she did perform the dressing change on 5/14/2024 and she did see maggots in the wound and dressing on that day. Nurse #2 stated she did not perform wound care on Resident #1 on 5/16/2024 but, she knew the dressing change and wound care orders were completed after Resident #1 took a shower. Review of the nursing notes documentation on 5/14/2024 and 5/16/2024 did not reveal any documentation of the observance of maggots on or near the wounds for Resident #1. NA #2 was interviewed on 5/29/2024 at 2:50 PM. NA #2 confirmed on the 3:00 PM to 11:00 PM shift on 5/14/2024 she was assigned to care for Resident #1. NA #2 stated Nurse #2 requested her help in positioning Resident #1 for wound care. NA #2 revealed when she was holding the left leg of Resident #1, a maggot dropped down on the pad below the heel, but she did not know what it was at the time. NA #2 stated she did not look at the heel wound, nor did she see any other maggots. NA #2 reiterated it was her responsibility to hold the left leg and that was what she did. NA #2 confirmed a family member did enter the room during the wound care treatment on that day. NA #2 stated upon completion of the wound care she removed the	F 684	nurse should complete treatment upon return to the facility unless otherwise ordered by the physician and (3) Events that Require Notification of the Administrator and DON to include but not limited to larvae in wounds. In-services will be completed by 5/30/24. After 5/30/24, any nurse who has not received this in-service will receive it prior to beginning their next scheduled shift. All newly hired nurses will be in-service during orientation by the Staff Development Coordinator (SDC). On 05/29/4, the Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), and weekend supervisor initiated an in-service with all nursing assistants regarding Observation and Reporting Acute Changes to include (1) Examples of acute changes to include but not limited to new skin concerns or pests noted on or around wounds, wound dressings, or residents (2) immediately reporting acute changes to the nurse. In-service will be completed by 05/30/24. After 05/30/24, any nursing assistant who has not worked or completed the in-service will complete upon next scheduled work shift. All newly hired nursing assistants will be in-service during orientation regarding Observation and Reporting Acute Changes. The ADON, Unit Managers will review progress notes 5 x per week x 4 weeks, then monthly x 1 month utilizing the Acute Change Audit Tool. This audit is to identify acute changes in condition to include but	

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F 684	Continued From page 11 trash from room. NA #2 revealed Nurse #2 approached her in the hallway and asked her if she knew what it was that dropped onto the pad below the heel. NA #2 told her she did not know, and Nurse #2 told her it was a maggot. NA #2 then revealed Nurse #2 told her to go find the DON and tell her about the maggot. NA #2 stated she looked for the DON, but the DON had already left for the day so, she returned to her nurse aide duties. NA #1 was interviewed on 5/29/2024 at 12:15 PM. NA #1 stated on her initial morning rounds for her 7:00 AM to 3:00 PM shift, as she was assisting Resident #1 with care, she observed a maggot in the bed near the left foot of Resident #1 and one maggot on the floor. NA #1 could not recall what day this occurred. NA #1 revealed she immediately reported this to the Unit Manager (Nurse #1) in the hallway. NA #1 stated Nurse #1 came into the room of Resident #1, saw the maggots, and went to notify the DON while NA #1 stripped the bed and threw the maggots in the garbage. NA #1 could not recall what day this occurred. Nurse #1 was interviewed on 5/29/2024 at 12:37 PM. Nurse #1 stated as soon as she clocked in for the day on 5/16/2024 she was notified by NA #1 of maggots in the room of Resident #1, and she went to the room of Resident #1 and observed a maggot on the bed. Nurse #1 confirmed she notified the DON and accompanied NA #1 to the shower room to assess the wounds of Resident #1 and administer wound care after the shower. The DON was interviewed on 5/29/2024 at 11:35 AM. The DON stated Resident #1 was reported to	F 684	not limited to new/worsening wounds or wounds with larvae to ensure the resident was assessed by the nurse, the physician and resident representative notified of acute change, new orders/interventions initiated when indicated with documentation in the electronic record. The ADON and Unit Managers will address all concerns identified during the audit to include assessment of the resident, notification of the physician and resident representative, initiation of interventions when indicated with documentation in the electronic record and re-training of staff. The DON will review the Acute Change Audit Tools 5 x per week x 4 weeks, then monthly x 1 month to ensure all concerns were addressed. The DON will forward the Acute Change Audit Tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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have a maggot observed on the bed and another one on the floor, but she herself never saw them. The DON explained on 5/16/2024 she was not in the building but was notified Certified Nursing Assistant (NA) #1 found the maggots in the room of Resident #1. The DON revealed she came to the building and was told by NA #1 she observed one maggot on the floor and one on the blanket in the bed on Resident #1 close to his left heel wound. NA #1 reported to the DON she had already thrown the maggots away in the garbage immediately. The DON stated she spoke with Nurse #2, the nurse assigned to care for Resident #1 from 7:00 AM to 7:00 PM on 5/16/2024 and was told she had already completed wound care for Resident #1, and she too had seen the maggots. The DON stated she immediately had Resident #1 taken to the shower room to have his entire body cleaned, his wounds assessed, and his wound care treatments redone. The DON stated she had the room of Resident #1 deep cleaned to include the floor, bed, curtains, blinds, and cabinets. The DON said any food or snacks that were open were discarded and any additional food was put in a covered plastic container. The DON stated that in addition, the soft padded boot Resident #1 wore was cleaned. The DON stated when the RP arrived at the facility, she spoke with him in her office and informed him of the maggot or maggots observed in the bed and on the floor as well as the steps that were being taken to prevent reoccurrence of maggots. The DON stated she then called the physician (MD #1) for Resident #1 to inform him of the maggot observations by the nursing staff.

An interview was conducted with the responsible party (RP) for Resident #1 on 5/29/2024 at 11:13

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AM. The RP for Resident #1 revealed the following information. A couple of weeks ago the RP came to visit Resident #1 in the facility in the morning. When the RP arrived at the facility he was notified by the Director of Nursing (DON), a maggot had been observed by the nursing staff on the foot of Resident #1. The RP of Resident #1 asked the DON what the facility was going to do about it and what steps were going to be taken so that it does not happen again. The DON told the RP, Resident #1 was going to be taken to the shower and the room of Resident #1 was going to be deep cleaned to find the source of the maggot or maggots. The RP requested Resident #1 be taken to the emergency room for assessment of the wound because he was greatly concerned there might be more maggots or wound care was not being done properly at the facility.

Documentation in the nursing notes dated 5/16/2024 revealed Resident #1 was sent to the emergency room for an evaluation of his wounds at the request of his RP and returned to the facility with no new orders.

The DON was interviewed on 6/30/2024 at 8:30 AM. The DON stated she spoke with Nurse #2 and confirmed Nurse #2 had told her she saw 10 but less than 20 maggots on the left heel wound of Resident #1 on 5/14/2024 during wound care. The DON denied Nurse #2 had contacted her to tell her about the maggots seen in the wound of Resident #1 on 5/14/2024 and that the first occurrence of her being notified was on the morning of 5/16/2024. The DON stated that the actions she took on the morning of 5/16/2024 to have the wound assessed by the physician and the deep cleaning of the room to find the source of the maggots would have been completed on

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5/14/2024, had she known of the maggots. The DON stated when she spoke with Nurse #2 on 5/16/2024 she assumed Nurse #2 was talking about performing wound care for Resident #1on the morning of 5/16/2024.

Documentation in a physician's follow up note dated 5/16/2024 revealed in part, "Reviewed most recent wound care notes. Alerted this morning, a few hours ago, of the patient potentially having in his left heel some maggot formation. Since that time, the wound has been inspected and thoroughly cleansed and dressed. It is doing well. On my inspection this afternoon, there is no evidence of any maggot formation. The patient is not septic or toxic. He appears at baseline. He denies any pain. I do not think there is any significant decomposition in his sacral right heel or left heel wounds."

MD #1, the physician for Resident #1, was interviewed on 5/30/2024 at 9:30 AM. MD #1 stated he would have wanted to be notified on 5/14/2024 if maggots were found in the left heel wound of Resident #1. MD #1 stated if he had been notified of 5/14/2024 he would have come to the facility to visualize the wound and to make sure the wound was cleaned appropriately. MD #1 stated he wished he had a picture or at least a written description on 5/14/2024 so that he could determine if the wound was cleaned appropriately and evaluate the treatment that was provided for the removal of the maggots in the left heel wound of Resident #1. MD #1 confirmed he came to the facility on 5/16/2024 and observed the left heel wound for Resident #1. MD #1 stated all the wounds to include the left heel wound, looked good and did not appear to be infected. MD #1 stated although historically maggots had been

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F 684	Continued From page 15 used to debride wounds without causing harm, it was not currently good practice. MD #1 stated after he evaluated the wounds of Resident #1 on 5/16/2024, the RP for Resident #1 requested Resident #1 be sent to the emergency room for wound evaluation confirming no more maggots or concerns were found.	F 684		