STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

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F 000	INITIAL COMMENTS A complaint survey was conducted from 12/08/2022 through 12/13/2022. Event ID: 6GKY11. Immediate Jeopardy was identified at: CFR 483.40 at tag F742 at a scope and severity (K) CFR 483.90 at tag F925 at a scope and severity (J) The tag F742 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/16/2022 and was removed on 12/10/2022. A partial extended survey was conducted. The following intakes were investigated NC00195654 and NC00195745. 3 of the 3 complaint allegations were not substantiated.	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,	F 580		12/13/22

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

Electronically Signed | 01/06/2023

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F 580	Continued From page 1 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 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, staff, and family interviews, the facility failed to notify the family when a resident (Resident #1), with a known mental health diagnosis, had an increase in a	F 580	Maple Grove Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that	

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F 580	Continued From page 2	F 580		

behavior of refusing activities of daily living (ADL) care needs and refused pressure ulcer treatment to a stage 4 sacral pressure ulcer for greater than two weeks. This occurred in 1 of 1 resident reviewed for notification of change.

The findings included:

Resident #1 was admitted to the facility on 6/10/2019 with diagnoses that included, bipolar disorder, juvenile rheumatoid arthritis with systemic involvement, chronic obstructive pulmonary disease, and type II diabetes mellitus. The Resident was 58 years old.

A review of the quarterly Minimum Data Set (MDS) assessment dated 9/20/2022 indicated Resident #1 was cognitively intact for decision making, was always incontinent of bowel and bladder, required extensive assistance of one staff member for bed mobility and dressing, and was totally dependent on staff for toilet use and bathing. The Resident had documented behaviors of rejection of care, 1 to 3 days, during the lookback period. The assessment further indicated Resident #1 two stage 2 pressure ulcers and one stage 4 pressure ulcer.

Resident #1's care plan, dated 10/20/2022, had a focus area that read, Resident # 1 had a problematic manner in which she acts, characterized by inappropriate behavior, resistive to treatment/care related to activities of daily living (ADL), refusing incontinence care, medications, being weighed, medical procedures, showers, and grooming of hair. The interventions included to document the care being resisted per facility protocol and to elicit family input for best approaches.

the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.

Maple Grove Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F580 Notify of Changes

• On 12/3/22 at approximately 9:30 am, Resident #1 had a change in condition, with a decreased level of consciousness, shallow respirations, and a temperature of 99.9. The nurse made the physician aware with an order to send the resident to the emergency room for evaluation. The resident's daughter and responsible party was called to be notified of the transfer and a message was unable to be left due to voice mail was full. EMS arrived at the facility at approximately 10:15 am on 12/3/22 to transport the resident to the emergency department.
• On 12/7/2022, and 12/9/22 the

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F 580	Continued From page 3 A review of the Treatment Administration Record (TAR) for Resident #1 had documented Resident #1 refused all treatments for the stage 4 sacral pressure ulcer from 11/16/2022 through discharge on 12/3/2022. The wound care to the bilateral lower extremities was documented as administered. An interview was conducted, on 12/08/2022 at 4:12 p.m., with Nurse #1 and she revealed she had provided wound treatments for Resident #1 for several months. She stated during the last part of October 2022 the Resident had begun to refuse the wound care constantly. She revealed when the Resident was readmitted on 11/12/2022 she allowed the unit manager to assess the wound on 11/15/2022. After that assessment, the Resident refused all dressing changes to her sacral stage 4 pressure ulcer. The Nurse added she felt like she had to beg the Resident to do any care for her and sometimes came back 6 times a day to request permission to complete dressing changes. She indicated success with the lower extremity leg wraps/dressing changes but no success with the sacral dressing changes. The Resident had been refusing almost all ADL care and this was an increase in the frequency of the Resident's previous refusal pattern. She added the physician and family had been made aware in the past of the refusal. She added the family had been successful in the past when the Resident refused but she had not personally called the family since the 11/12/2022 admission. An interview was conducted with the Director of Rehabilitation (DOR) on 12/08/2022 at 3:43 p.m. and she reported the Occupational therapy and physical therapy department had been working	F 580	Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Treatment Nurse reviewed wound documentation, progress notes, point of care documentation for activities of daily living (ADL) care x 30 days for all residents to identify residents that are at risk related to non-compliance with wound care, and ADL care. The purpose of the audit is to ensure the physician, family, and psychiatry services has been notified of residents with consistent refusals of wound care treatment and change of condition. The audit was completed on 12/9/22. • On 12/9/2022, 100% in-service was initiated by the Staff Development Coordinator with the Nurses and Nursing Assistants regarding refusals of care, changes in condition, alternatives to treatment, notifications to family and physician, referrals to psych services with notification of behaviors, and documentation. In-service will be completed by 12/9/2022. On 12/9/22, the in-services were sent by the Nursing Home Administrator to the remaining facility staff who had not worked via care feed (an electronic communication system for facility staff). All staff will be required to sign an in-service sheet on arrival to their next scheduled shift. The Staff Development Coordinator will review the education and validate staff knowledge and understanding of the education. All contracted staff including agency that has not worked, will receive the in-service upon the next scheduled shift. Staff Development Coordinator will monitor the	

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F 580	Continued From page 4 with Resident #1. She added they had worked with the Resident in the past and had picked her back up for therapy after her last readmission, on 11/12/2022. She revealed, prior to 11/12/2022, the staff would update the Resident in the morning that she would have therapy that day. The therapist would then check with the nursing assistant and nurse to see if they would assist the Resident to be ready for her therapy appointment. The Resident would refuse therapy in the past, but the therapist had usually been able to work with her on bed mobility, rolling side to side, and other bed bound areas. She reported that since the last hospital stay and readmission, the refusals had gotten worse and the resident was refusing to be changed, dressed, groomed or anything. She added the facility had recently changed her mattress, but it took several staff members to convince the Resident she needed a fresh mattress because of the urine saturation. An interview was conducted with Resident #1's family member, on 12/09/2022 at 11:19 a.m. She revealed the staff do not update the family on her mother's condition. She reported the last time she received a phone call from the facility was when her mother was going to be transferred to the hospital on 12/3/2022. At that time, she had not received a phone call regarding her mother's refusal of care or to update the family on her status, since the previous hospital admission and discharge. She stated she had not been informed that her mother had an increase in the number of refusals for care and had not been called during November regarding the refusals. She indicated that the staff would call her, in the past, and request she speak with her mother to convince her to allow care, and this had not occurred in a while. She stated the talks with a family member	F 580	schedule for new assigned agency staff to ensure they are educated prior to their scheduled shift. All new hire nurses and certified nursing assistance will receive training during orientation and annually thereafter. • On 12/12/22 monitoring began using the Change in Condition Audit Tool, progress notes will be reviewed 5 x's a week during the Cardinal Interdisciplinary Team Meeting for any resident identified with a change in condition to ensure the Attending Physician, Nurse Practitioner, responsible party and resident family have been notified of any change in condition and notified of what the plan of care will be to address the change. All identified areas of concerns will be addressed immediately during the audit by the Director of Nursing/ Nursing Home Administrator (NHA). The Director of Nursing/ NHA will review and audit the audit tool 5x's weekly x 2 months to ensure completion and that all areas of concerns were addressed. The Director of Nursing/ Administrator will forward the results of the Change of Condition Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI committee will meet monthly for 2 months and review the Change of Condition Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. • Date of corrective action completion 12/13/2022	

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F 580	Continued From page 5 had previously been successful. She revealed the family desired to be kept updated and if she was not available at the time a call was placed, the family had provided multiple emergency contacts. A review of Resident #1's electronic emergency contact list included three emergency contacts provided by the Resident. An interview was conducted with the facility Social Worker on 12/09/2022 at 2:08 p.m. and revealed staff had not informed her the refusals occurring in November 2022, for Resident #1, were an increase from her prior refusals. She added she had not informed the family of the refusals of care and wound care treatment and had only spoken with the family regarding Resident #1's desire to begin a discussion about Palliative care.	F 580		
F 742 SS=K	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on record review, staff, family, and the Psychiatric Mental Health Nurse Practitioner (PMHNP) interviews, the facility failed to provide care and treatment to a resident who had a	F 742	F0742 • On 12/3/22 at approximately 9:30 am, Resident #1 had a change in condition,	12/13/22

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F 742	Continued From page 6	F 742		

mental health diagnosis and had an increase in a behavior of refusing food, activities of daily living care (ADL), and pressure ulcer treatments for greater than two weeks. The facility did not actively pursue options to address the mental health issue when the resident had an increase in the refusal of food, ADL care, and treatment of the pressure ulcer. The increase in the refusals continued until the Resident was discovered to be unresponsive on 12/3/2022 and was sent to an acute care hospital. During the transfer of the Resident to the hospital the Resident was discovered to have maggots in her bed and in her skin folds that included the sacral pressure ulcer. The Resident was diagnosed with sepsis at the hospital and required intubation (the insertion of an artificial airway), antibiotics, and had an unplanned weight loss. The facility did not obtain a psychiatric review of the Resident's decision-making status or intent of self harm for 1 of 3 residents (Resident #1) reviewed for pressure ulcers.

The immediate jeopardy started on 11/16/2022 when Resident #1 refused all pressure ulcer dressing changes to a stage 4 sacral pressure ulcer. Immediate Jeopardy was removed on 12/10/2022 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of E (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the monitoring of the systems put into place and to complete facility employee training.

The findings included:

Resident #1 was admitted to the facility on

with a decreased level of consciousness, shallow respirations, and a temperature of 99.9. The nurse made the physician aware with an order to send the resident to the emergency room for evaluation. The resident's daughter and responsible party was called to be notified of the transfer and a message was unable to be left due to voice mail was full. EMS arrived at the facility at approximately 10:15 am on 12/3/22 to transport the resident to the emergency department. The Administrator instructed housekeeping to deep clean Resident #1's room and replace the mattress to ensure there were no larvae in the room.

• On 12/7/2022, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Treatment Nurse reviewed wounds, meal intake for 72 hours, and Activities of Daily Living (ADL) documentation for all residents, including residents with mental disorders and/or who have a history of trauma and/or post-traumatic stress disorder that are at risk related to non-compliance with wound care, meal intake and ADL care to the point of extreme detriment up to including potential self-harm and self-injurious behavior. The purpose of the audit is to ensure all identified residents are receiving the necessary treatment. There were no identified areas of concern. The audit was completed on 12/7/22.
Effective 12/7/22 The Director of Nursing or Assistant Director of Nursing will meet with the psychiatric Nurse Practitioner before resident visit to discuss newly

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6/10/2019 with diagnoses that included, bipolar disorder, juvenile rheumatoid arthritis with systemic involvement, chronic obstructive pulmonary disease, and type II diabetes mellitus. The Resident was 58 years old.

A review of the Psychiatry notes revealed Resident #1 was seen for an initial visit on 8/26/2022 for psychiatric medication management. The PMHNP documented the staff reported no behavioral concerns at that time. The Resident reported no depression, no auditory visual hallucinations, and denied suicidal ideation and homicidal ideation. The Resident reported her sleep and appetite were appropriate. The Resident reported a history of emotional and verbal abuse by her ex-husband. The medication reviewed was Cymbalta, a medication used to treat depression and generalized anxiety. This was the only Psychiatry consult visit in the electronic medical record.

A review of the physician orders included Cymbalta HCL capsule delayed release 30 milligram (mg) give one capsule by mouth two times a day for depression related to bipolar disorder.

A review of Resident #1's Medication Administration Record (MAR) for November 2022 documented the Cymbalta 30 mg dose was administered as ordered.

The electronic medical record documented Resident #1 weighed 225.0 pounds on 9/14/2022. She did not have another documented weight since 7/7/2020, 223.2 pounds.

A review of the quarterly Minimum Data Set

referred residents and residents already on case load, with potential for self-harm and self-injurious behavior, to ensure psychiatric services understands the urgency and the behaviors are addressed.

• On 12/9/2022, 100% in-service was initiated by the Staff Development Coordinator with the Nurses, Treatment Nurse and Nursing Assistants regarding refusals of care, alternatives to treatment, notifications, recognizing mental disorders, referrals to psychiatric services, and documentation. The focus of the in-services is to train staff to address early refusals of care, worsening mental health issues, providing alternatives to treatment, and proper notification through documentation of refusals prior to a resident displaying self-harm and self-injurious behavior. In-service was completed by 12/9/2022. On 12/9/22, the in-services were sent by the Administrator to the remaining staff who had not worked via care feed (an electronic communication system for staff). All contracted staff including agency that has not worked, will receive the in-service upon the next scheduled shift. All staff will be required to sign an in-service sheet on arrival to their next scheduled shift. The Staff Development Coordinator will review the education and validate staff knowledge and understanding of the education. All contracted staff including agency that has not worked, will receive the in-service upon the next scheduled shift. Staff Development Coordinator will monitor the schedule for new assigned agency staff to ensure they are educated

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F 742	Continued From page 8 (MDS) assessment dated 9/20/2022 indicated Resident #1 was cognitively intact for decision making, was always incontinent of bowel and bladder, required extensive assistance of one staff member for bed mobility and dressing, and was totally dependent on staff for toilet use and bathing. The Resident had documented behaviors of rejection of care, 1 to 3 days, during the lookback period. The assessment further indicated Resident #1 had two stage 2 pressure ulcers and one stage 4 pressure ulcer. Resident #1's care plan, dated 10/20/2022, had focused areas with interventions as follows: 1) Resident #1 had a problematic manner in which the Resident acts characterized by inappropriate behavior: Resistive to treatment/care related to activities of daily living (ADL), refusing incontinence care, refuses medication, refuses to be weighed, refuses medical procedures, refuses showers, refuses grooming of hair. The interventions included to document care being resisted per facility protocol and notify physician of patterns in behavior. 2) Actual development of pressure ulcers related to episodes of resisting care from staff with examples of ADL care, repositioning, and wound care. Risk of further decline of wounds due to treatment refusal. Interventions included to notify appropriate personnel of changes in eating or drinking patterns. 3) Resident has a PASRR (preadmission screening and resident review) that does not expire due to a diagnosis of Bipolar. The goal read, the facility will monitor as needed to identify any changes in condition through the next review and the interventions were to monitor. 4) Resident has psychotropic drugs with the	F 742	prior to their scheduled shift. All new hire nurses and certified nursing assistance will receive training during orientation and annually thereafter. • Behaviors including refusals will be monitored through the Cardinal Interdisciplinary Team Meeting (IDT) using the Behavioral Monitoring Audit Tool by review of the progress notes and behavior documentation 5 x per week x 2 months by the Director of Nursing and Assistant Director of Nursing and referrals will be made by social services to psychiatric services related to consistent refusals and self-injurious behaviors. The Social Worker is in attendance of the IDT meeting where the discussion will take place on the urgency of the referral. All identified areas of concerns will be addressed immediately during the audit by the Director of Nursing/ Nursing Home Administrator (NHA). The Director of Nursing/ NHA will review and audit the audit tool 5x's weekly x 2 months to ensure completion and that all areas of concerns were addressed. The Director of Nursing/ NHA will forward the results of the Behavior Monitoring Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI committee will meet monthly for 2 months and review the Behavior Monitoring Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. • Date of corrective action completion 12/13/2022	

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potential for or characterized by side effects of cardiac, neuromuscular, gastrointestinal systems, or due to a diagnosis of bipolar disorder. The goal read; the Resident would show minimal/no side effects of medications taken through the next review. The interventions included to observe the Resident's mental status functioning on an ongoing basis.

An interview was conducted with Administrator #2 on 12/08/2022 at 3:20 p.m. and she reported she was an Administrator at another location but in October 2022 she was covering for Administrator #1 while he was out of work. She explained she became aware Resident #1 had been refusing all care and had refused Activities of Daily living (ADL) care with urine dripping onto the floor. At that time, she met with the Resident to discuss that refusing care was within her rights but allowing the room to become so unsanitary that it can become a health risk to other residents was not acceptable. She stated she listened to the Resident and negotiated an acceptable time the Resident would be ready to have her ADL care and wound care conducted. She further revealed, when the staff came to provide the care, the Resident's oxygen saturation dropped very low, and emergency medical services had to be called. The Resident was transferred to the hospital. She stated she was not working at the facility when the Resident returned.

Resident #1 was discharged to the hospital on 10/20/2022 and readmitted to the facility on 10/25/2022.

A review of the hospital discharge record dated 10/25/2022, documented Resident #1 was sent to the emergency department on 10/20/2022 for an

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evaluation of her sacral wound and hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions). The reported history from the facility was the Resident had been refusing wound care checks for the last two weeks. On the day of the admission, when the facility staff rolled the Resident to address her sacral wound, her oxygen saturation dropped to 50% on 5 liters of oxygen. At the hospital, the emergency room staff reported foul-smelling purulent drainage from the stage 4 sacral wound.

Resident #1 was discharged to the hospital on 11/06/2022 and was readmitted to the facility on 11/12/2022.

A review of the hospital discharge record dated 11/12/2022 documented, according to the report from the skilled nursing facility, Resident #1 had a recent history of refusing all sacral pressure ulcer care at the facility.

A review of Resident #1's physician orders for treatments included 1) clean sacrum, apply calcium alginate with silver, cover with a proximal dressing every Monday, Wednesday, and Friday until healed. The order was started on 11/14/2022 with an indefinite stop date, 2) Cleanse bilateral lower extremities with normal saline, apply xeroform to open areas, cover with ABD, wrap with Kerlix and Coban three times a week, on Monday, Wednesday, and Friday.

A review of the Treatment Administration Record (TAR) for Resident #1 had documented Resident #1 refused all treatments for the stage 4 sacral pressure ulcer from 11/16/2022 through discharge on 12/3/2022. The wound care to the bilateral lower extremities was documented as

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administered.

An interview was conducted with Resident #4, on 12/8/2022 at 2:52 p.m. Resident #4 had moderate cognitive impairment. She was the roommate of Resident #1. She revealed she had observed flies in the facility since she had moved to her current room and had seen a lot of fruit flies at night. She added that Resident #1 does not eat very much, and staff sometimes leave her meal tray in the room overnight. The flies like to fly around her food and stuff. She added Resident #1 would not let the staff give her any care, that included turning her, changing her sheets, and wound care. She stated she informed staff that she did not like the smell in the room.

An interview was conducted, on 12/08/2022 at 4:12 p.m., with Nurse #1 and she revealed she had provided wound treatments for Resident #1 for several months. She stated during the last part of October 2022 the Resident had begun to refuse the wound care constantly. She revealed when the Resident was readmitted on 11/12/2022 she allowed the unit manager to assess the wound on 11/15/2022. After that assessment, the Resident refused all dressing changes to her sacral stage 4 pressure ulcer. The Nurse added she felt like she had to beg the Resident to do any care for her and sometimes came back six times a day to request permission to complete dressing changes. She indicated success with the lower extremity leg wraps/dressing changes but no success with the sacral dressing changes. The Resident had been refusing almost all ADL care and this was an increase in the frequency of the Resident's previous refusal pattern. She added the physician and family had been made aware in the past of the refusal. When asked if

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the Physician or Psychiatry provider had been updated since the last admission, she stated the refusals would be documented on the chart. She added the family had been successful in the past when the Resident refused but she had not personally called the family since the 11/12/2022 admission. She reported the family had brought the Resident food, trying to get her to eat because the Resident would refuse to eat her meal trays.

An interview was conducted with the Director of Rehabilitation (DOR) on 12/08/2022 at 3:43 p.m. and she reported the Occupational therapy and physical therapy department had been working with Resident #1. She added they had worked with the Resident in the past and had picked her back up for therapy after her last readmission, on 11/12/2022. She revealed, prior to 11/12/2022, the staff would update the Resident in the morning that she would have therapy that day. The therapist would then check with the nursing assistant and nurse to see if they would assist the Resident to be ready for her therapy appointment. The Resident would refuse therapy in the past, but the therapist had usually been able to work with her on bed mobility, rolling side to side, and other bed bound areas. She reported that since the last hospital stay and readmission, the refusals had gotten worse and the resident was refusing to be changed, dressed, groomed or anything. She added the facility had recently changed her mattress, but it took several staff members to convince the Resident she needed a fresh mattress because of the urine saturation.

An interview was conducted with the primary care provider (PCP), on 12/08/2022 at 5:21 p.m. and he revealed Resident #1 had refused care for her

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wounds in the past and that she would make perfectly good sense when talking with her but when he began to discuss wound care, she would immediately begin to refuse care. He stated education regarding the consequences of refusal of care were provided to the Resident on multiple occasions that included the risk of infection or death. When asked if he had been informed the Resident had an increase in refusals of care during November 2022, he stated he had been informed in the past and he could not say if he had or had not been informed in November.

An interview was conducted with Resident #1's daughter, on 12/09/2022 at 11:19 a.m. She revealed the staff do not update the family on her mother's condition. She reported the last time she received a phone call from the facility was when her mother was going to be transferred to the hospital on 12/3/2022. At that time, she had not received a phone call regarding her mother's refusal of care or to update the family on her status, since the previous hospital admission and discharge. She stated she had not been informed that her mother had an increase in the number of refusals for care and had not been called during November regarding the refusals. She indicated that the staff would call her, in the past, and request she speak with her mother to convince her to allow care, and this had not occurred in a while. She stated the talks with a family member had previously been successful.

An interview was conducted with the PMHNP on 12/09/2022 at 1:07 p.m. and she revealed she had seen Resident #1 on 8/26/2022 and this had been her last appointment with the Resident. She added the staff had not contacted her in October 2022 or November 2022 to provide an update

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that the Resident had an increase in a behavior of refusing care. She revealed if she had been made aware the Resident was refusing wound care treatments for a stage 4 pressure ulcer, greater than 2 weeks, she would have reviewed the medications and considered recommending an inpatient treatment to have her mental status be evaluated. She stated she had serious concerns when she was not updated regarding psychiatric behavior changes, even if the behavior was a known previous behavior but had increased in frequency because this can lead to a decline in overall health. Sometimes adding interventions or treatments for anxiety can help. She stated a resident refusing wound care for even one week, with a stage 4 pressure ulcer could lead to severe infections and a decline in health, and for an oriented resident this would be considered self-harm and required an inpatient evaluation.

An interview was conducted with the facility Social Worker on 12/09/2022 at 2:08 p.m. and revealed she had not informed the psychiatry provider of a need to visit Resident #1 because staff had not informed her the refusals occurring for the Resident were an increase from her prior refusals. She added that the Psychiatric provider services were discontinued on 11/19/2022 and a new provider was implemented. She stated she had requested the clinical nursing staff to provide her a list of what residents should be seen by the new provider and Resident #1 was not included on the list.

A review of the electronic medical record for Resident #1 documented she was discovered unresponsive by staff on 12/3/2022 and 911 was called. The Resident was sent to an acute care

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hospital.

A review of the Emergency Medical Services (EMS) documentation was conducted for Resident #1 for the date of service on 12/3/2022. The Resident was moved onto the stretcher bed and during the transfer, the EMS staff observed a strong stench like necrotic tissue (the death of body cells or tissue through disease or injury). The sheet under the Resident was soiled with red and yellow stains. During the transfer maggots fell onto the mattress from the Resident's sheets.

An interview was conducted with EMS staff #1 on 12/12/2022 at 1:27 p.m. and revealed on 12/3/2022 the team arrived at the facility to pick up a resident that was not responding. He stated upon arrival the room had a strong odor. He added when the team transferred Resident #1 to the stretcher, maggots fell off of the sheet back onto the bed.

A review of the hospital discharge records revealed Resident #1 was admitted on 12/3/2022 with a diagnosis of Sepsis, altered mental status, and staff documented observing maggots on the Resident's abdominal pannus, buttocks, perineum, and every fold of the groin. She required intubation for her respiratory status and was admitted to the critical care unit. The Resident's weight for the hospital admission was 91.7 kilograms (201.74 pounds).

An interview was conducted with Hospital Nurse #1 on 12/12/2022 at 3:22 p.m. and revealed he had been the nurse assigned to Resident #1 on 12/3/2022. He indicated he was in the room while two emergency room technicians rolled the resident to remove the sheets from the nursing

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facility. He was able to visualize a stage 4 sacral pressure ulcer with no dressing in place, open to air, and maggots were present on her skin folds, buttocks, and in the wound. He added the respiratory status of the Resident was the priority because she was being treated as a "code sepsis" (sepsis is defined as the body's overwhelming and life-threatening response to an infection that can lead to tissue damage, organ failure, and death. Code sepsis was designed to facilitate early recognition of severe sepsis and rapidly deliver a bundle of care) and therefore the wound care to remove the maggots from her skin and wound was conducted in the critical care area.

An interview was conducted with Administrator #1 on 12/09/2022 at 3:00 p.m. and he revealed he had not been aware the refusals of behavior had increased from the Resident's history, and it was his expectation that psychiatry services be consulted for all residents with a known history of mental illness with a change in behavior.

The Administrator was notified of immediate jeopardy on 12/09/2022 at 5:00 p.m.

Credible Allegation of IJ removal:

Recipients who have suffered or are likely to suffer, a serious adverse outcome as a result of the non-compliance.
Resident #1 who has a Diagnosis of Bipolar Disorder, had an increase in behaviors of refusing care including incontinence care from 1-3 days per week. Resident had a daily refusal of wound care for 17 days, from November 16, 2022, through December 3, 2022. The resident developed maggots in the wound that she

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consistently refused care for, and she was noted to have decrease in meal intake, resulting in weight loss. Psychiatry services and the family were not notified of the consistent refusals and self-injurious behaviors.

The facility did not coordinate with the psychiatry provider, related to the resident's unresolved self-injurious behaviors of refusals of ADL care, incontinence care and wound care, to establish new interventions and the facility's failure to implement fly reduction measures including ensuring doors are not propped open resulted in development of maggots on the groin pannus skin folds, buttocks, wound, and perineal area on 12/3/2022.

On 12/3/22, at approximately 9:30 am, Resident #1 had a change in condition, with a decreased level of consciousness, shallow respirations, and a temperature of 99.9. The nurse made the physician aware with an order to send the resident to the emergency room for evaluation. EMS arrived at the facility to transport the resident to the emergency department. The emergency medicine technician notified Nurse #1 that there were maggots on resident #1 sheets. The nurse notified the Administrator. The Administrator instructed housekeeping to deep clean resident #1's room and replace the mattress. On 12/3/22, the Administrator initiated an investigation to determine the root cause of the maggots. The emergency room notes indicate that maggots were identified in the resident's groin pannus skin folds, buttocks, wound, and perineal area.

All residents with mental disorders and/or who have a history or trauma and/or post-traumatic

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stress disorder that are at risk related to non-compliance with wound care, ADL care, and nutritional intake have the potential to be affected.

On 12/7/2022, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Treatment Nurse reviewed wounds for all residents, including residents with mental disorders and/or who have a history of trauma and/or post-traumatic stress disorder that are at risk related to non-compliance with wound care to the point of extreme detriment up to including potential self-harm and self-injurious behavior. The purpose of the audit is to ensure all identified residents are receiving the necessary treatment. There were no identified areas of concern. The audit was completed on 12/7/22.

On 12/7/2022, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Treatment Nurse assessed all residents including residents with mental disorders and/or who have a history of trauma and/or post-traumatic stress disorder that are at risk related to non-compliance with ADL care. The purpose of the audit is to ensure all identified residents are receiving the necessary treatment. There were no identified areas of concern. The audit was completed on 12/7/22.

On 12/9/2022, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Treatment Nurse reviewed meal intake for 72 hours to identify residents' mental disorders and/or who have a history of trauma and/or post-traumatic stress disorder that are at risk related to non-compliance with nutritional intake. The purpose of the audit is to ensure all identified residents are receiving the necessary

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treatment. The Director of Nursing will ensure all residents identified with concerns will be referred to psych services, nutritional services, and physician notification.

* Actions taken to alter the process or system failure to prevent a serious adverse outcome for occurring or recurring

On 12/9/2022, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Treatment Nurse reviewed progress notes x 30 days and current diagnosis to identify residents with mental disorders and/or who have a history of trauma and/or post-traumatic stress disorder that are at risk related to non-compliance with wound care, ADL care, and nutritional intake, to the point of extreme detriment up to including potential self-harm and self-injurious behavior. The purpose of the audit is to ensure all identified residents are receiving the necessary physical and mental health treatment.

The Director of Nursing or Assistant Director of Nursing will meet with the psych NP before resident visit to discuss newly referred residents and residents already on case load, with potential for self-harm and self-injurious behavior, to ensure psych services understands the urgency and the behaviors are addressed.

Behaviors including refusals will be monitored through the morning clinical meetings by review of the progress notes and behavior documentation 5 x per week by the Director of Nursing and Assistant Director of Nursing and referrals will be made by social services to psych services related to consistent refusals and

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self-injurious behaviors. The Social Worker is in attendance of the morning clinical meeting where the discussion will take place on the urgency of the referral.

On 12/9/2022, 100% in-service was initiated by the Staff Development Coordinator with the Nurses, Treatment Nurse and Nursing Assistants regarding refusals of care, alternatives to treatment, notifications, recognizing mental disorders, referrals to psych services, and documentation. The focus of the in-services is to train staff to address early refusals of care, worsening mental health issues, providing alternatives to treatment, and proper notification through documentation of refusals prior to a resident displaying self-harm and self-injurious behavior. In-service will be completed by 12/9/2022. On 12/9/22, the in-services were sent by the Administrator to the remaining staff who had not worked via care feed (an electronic communication system for staff). All contracted staff including agency that has not worked, will receive the in-service upon the next scheduled shift. All staff will be required to sign an in-service sheet on arrival to their next scheduled shift. The Educator will review the education and validate staff knowledge and understanding of the education. All contracted staff including agency that has not worked, will receive the in-service upon the next scheduled shift. Staff Development Coordinator will monitor the schedule for new assigned agency staff to ensure they are educated prior to their scheduled shift.

* Date of corrective action completion 12/10/2022

On 12/13/2022 the facility's credible allegation for Immediate Jeopardy removal was validated. The

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F 742	Continued From page 21 validation was evidenced by record review of in-services given to staff, and audits completed by staff management. Validation was also evidenced by interview of staff members from different departments. The facility's in-service records were available and reviewed. There was documentation that in-services had been completed per the facility's alleged credible allegation of compliance. The facility's audits were also reviewed. There was documentation that audits had been completed. Different staff members from different departments were interviewed and reported that they had attended in-service training on residents who are non-compliant or refuse treatment. Their signatures were verified on the in-service training records. Staff members were able to report specific details of the training they had received. The immediate jeopardy was removed on 12/10/2022.	F 742		
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 and staff, Hospital Nurse, Emergency Medical Services Staff and Pest Control Representative interviews the facility failed to implement fly reduction measures to protect vulnerable residents with wounds from the development of maggots and failed to ensure doors to the outside were not left	F 925	F0925 F 925 Maintains Effective Pest Control Program • On 12/3/22, at approximately 9:30 am, Resident #1 had a change in condition, with a decreased level of	12/13/22

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open allowing the entry of flies into the facility. This resulted in 1 of 3 residents (Resident #1) reviewed for wound care developing maggots on her abdominal pannus (the area of excess skin and fat that hangs over the pubic region), buttocks, perineum (the thin layer of skin between the vaginal opening and anus), every fold of the groin, and sacral wound.

Immediate Jeopardy began on 12/3/2022, when Resident #1 was discovered to have maggots on her mattress, sheets, abdominal pannus, buttocks, perineum, every fold of the groin, and stage IV sacral wound. The Immediate Jeopardy was removed on 12/10/2022 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the monitoring systems put into place are effective and education was completed.

The findings included:

Resident #1 was admitted to the facility on 6/10/2019 with diagnoses that included, bipolar disorder, juvenile rheumatoid arthritis with systemic involvement, chronic obstructive pulmonary disease, obesity, and type II diabetes mellitus.

A review of the quarterly Minimum Data Set (MDS) assessment dated 9/20/2022 indicated Resident #1 was cognitively intact, was always incontinent of bowel and bladder, required extensive assistance of one staff member for bed mobility and dressing, and was totally dependent

consciousness, shallow respirations, and a temperature of 99.9. The nurse made the physician aware with an order to send the resident to the emergency room for evaluation. EMS arrived at the facility to transport the resident to the emergency department. The emergency medicine technician notified Nurse #1 that there were larvae on resident #1 sheets. The nurse notified the Administrator. The Administrator instructed housekeeping to deep clean resident #1's room and replace the mattress to ensure there were no larvae in the room. On 12/7/2022, the Administrator contacted the Pest Control Company for additional treatment of Resident #1 room and the facility.

• On 12/3/2022, a 100% audit of all resident rooms, common areas, and all entrances to the facility was completed by the Maintenance Director to identify any concerns related to pest control. There were no other areas of concern identified during the audit. On 12/7/2022, the Administrator contacted Support Services to order air curtains for the main entrance and both courtyards used for smoking, to aid in the prevention of flies entering the center. The Administrator will oversee the process to ensure the timely completion of the receipt and installation of the air curtains. On 12/8/2022, the contracted pest control company arrived, inspected the facility for pests, and treated the perimeter of the building with a chemical solution to kill and deter flies.

Wall-mounted fly lights were ordered on 12/8/2022 by the pest control company to be placed near the four courtyard doors,

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on staff for toilet use and bathing. The assessment further indicated Resident #1 had two stage 2 pressure ulcers and one stage 4 pressure ulcer.

A review of Resident #1's electronic medical record revealed, on December 3, 2022, the Resident was transferred to an acute care hospital due to a change in the level of consciousness.

A review of the Emergency Medical Services (EMS) documentation was conducted for Resident #1 for the date of service on 12/3/2022. The Resident was moved onto the stretcher bed and during the transfer, the EMS staff observed a strong stench like necrotic tissue (the death of body cells or tissue through disease or injury). The sheet under the Resident was soiled with red and yellow stains. During the transfer maggots fell onto the mattress from the Resident's sheets.

An interview was conducted with EMS Staff #1 on 12/12/2022 at 1:27 p.m. and revealed on 12/3/2022 the team arrived at the facility to pick up a resident that was not responding. He stated upon arrival the room had a strong odor. He added when the team transferred Resident #1 to the stretcher, maggots fell off of the sheet back onto the bed.

A review of the Hospital records for Resident #1 revealed she arrived at the emergency room on 12/3/2022 and staff observed maggots on the Resident's abdominal pannus, buttocks, perineum, and every fold of the groin.

An interview was conducted with Hospital Nurse #1 on 12/12/2022 at 3:22 p.m. and revealed he

the exit door nearest Resident #1 room, near the lobby entrance, and the 500/700 hallway. The Administrator will oversee the process to ensure the timely completion of the receipt and installation of the wall-mounted fly lights. On 12/8/22, the Administrator conducted a resident council meeting with 16 residents in attendance with the discussion of pest prevention, including not propping doors open. On 12/9/22, the education was reviewed with all other alert and oriented residents that did not attend the resident council meeting by the Administrator. On 12/8/22, the Administrator checked all exit doors to ensure no doors were propped open for a point of entry for pests. There were no other identified areas of concern. On 12/9/22, the Maintenance Director placed an alarm on the courtyard #1 door (the door that's 40 feet from the Resident #1 room) to alert staff when residents access the courtyard so they can ensure doors are closed to prevent the point of entry for pests. On 12/9/22, the Maintenance Director adjusted the courtyard #2 door closure to ensure the door closes properly and sealed to prevent the point of entry for pests.

• On 12/7/2022, 100% in-service was initiated by the Staff Development Coordinator with the Administrator, Medical Records, Accounts Receivable, Nurses, Nursing Assistants, Housekeeping staff, Social Worker, Accounts Payable, Therapy Staff, Maintenance Staff, receptionist, Medical Records or Supply Clerk in regards to Pest Control to include (1) Prevention of

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had been the nurse assigned to Resident #1 on 12/3/2022. He indicated he was in the room while two emergency room technicians rolled the resident to remove the sheets from the nursing facility. He was able to visualize a stage 4 sacral pressure ulcer with no dressing in place, open to air, and maggots were present on her skin folds, buttocks, and in the wound. He added the respiratory status of the Resident was the priority because she was being treated as a "code sepsis" (sepsis is defined as the body's overwhelming and life-threatening response to an infection that can lead to tissue damage, organ failure, and death. Code sepsis was designed to facilitate early recognition of severe sepsis and rapidly deliver a bundle of care) and therefore the wound care to remove the maggots from her skin and wound was conducted in the critical care area.

An observation was conducted of the facility on 12/8/2022 at 2:10 p.m. and a recreational room was located between the 100 hall and the 200 hall. A door to the courtyard was open with a ½ inch gap open to the outside. The doors to enter the recreational room from the hall, were open. No flies were observed in the recreational room.

An interview was conducted with Resident #3 on 12/8/2022 at 2:31 p.m. The Resident was cognitively intact. When asked if he had seen any flies at the facility, he stated he had seen flies multiple times in the last month but had not seen any during the current week due to the cooler and wet weather. When the Resident was asked if he had seen where the flies came from, he stated to look at the meal tray situation. He lifted a meal tray and stated it was from the previous night. The tray was observed to be in a Styrofoam food

pest control concerns and (2) reporting pest control concerns into the Maintenance Work Order tracking System and notification of Administrator, Director of Nursing and the Maintenance Director and regarding to ensure the point of entry for pests including doors are not left open by staff or residents. In-service will be completed by 12/8/2022. After 12/8/2022, the Administrator will ensure the in-services are mailed to any remaining staff who has not worked and not received the in-service with instructions to review, sign the in-service, and return to the Staff Development Coordinator or Director of Nursing prior to next scheduled work shift. All contracted staff including agency that has not worked, will receive the in-service upon the next scheduled shift. Staff Development Coordinator will monitor the schedule for new assigned agency staff to ensure they are educated prior to their scheduled shift. All new hire nurses and certified nursing assistance will receive training during orientation and annually thereafter.

• On 12/9/22, 100% audit of all rooms and common areas will be inspected by the housekeeping and/or nursing staff weekly x 4 weeks then monthly x 1 month for signs of pests utilizing the Pest Control Audit Tool. All areas of concern will be immediately addressed by the Maintenance Director or Administrator. The Administrator will review and initial the Pest Control Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the results of

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F 925	Continued From page 25 container with the lid closed. The Resident opened the tray and it contained a sandwich and broccoli and cheddar soup. Another tray with two sandwiches was present and he revealed it was from two days ago. The Resident resided on the same hall as Resident #1 on the opposite side of the nursing station and was not in close proximity to Resident #1's room. An observation was conducted of the 200 hall on 12/8/2022 at 2:50 p.m. and a Geri chair was stored in the hall, maroon in color. In the back storage area of the chair a crushed piece of food that looked like bread, the size of the palm of a hand was in the compartment with a soiled washcloth that had yellow dried stains and a dried out wet wipe. An interview was conducted with Resident #4, on 12/8/2022 at 2:52 p.m. Resident #4 had moderate cognitive impairment. She was the roommate of Resident #1. She revealed she had observed flies in the facility since she had moved to her current room and had seen a lot of fruit flies at night. She added that Resident #1 did not eat very much, and staff sometimes left her meal tray in the room overnight. The flies like to fly around her food and stuff. She added that a staff member came around on 12/8/2022 spraying the hall area but did not enter their room. An observation of Resident #1's room was conducted on 12/8/2022 at 2:52 p.m. and there were no flies present. Resident #1 was not present in the facility at the time of the investigation. An interview was conducted on 12/8/2022 at 4:12 p.m. with Nurse #1 and she indicated the family	F 925	the Pest Control Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 1 month. The QAPI committee will meet monthly x 1 month and review the Pest Control Audit Tools 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. • Date of corrective action completion----12/13/2022	

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of Resident #1 would bring the Resident food, trying to get her to eat, and then the meal trays would be left in the room. She added the Resident would yell loudly if staff removed the food trays. She added that she had seen flies in the room on several occasions for the last three months and Resident #1 owned her own fly swatter that her family provided.

An observation was conducted on 12/8/2022 at 4:30 p.m. of the 300 hall that connected to the 100 hall. A door to the courtyard was observed to be propped open. Nurse #1 was present during the observation, and she revealed some of the independent smokers of the facility would enter the courtyard from the day room side, closer to the nursing station on the 200 hall. She added this was a longer walk so when the residents leave the courtyard, they exit through the door on the 300 hall. This door was observed propped open at that time. She assisted in counting the square foot tiles to Resident #1's room and it was 40 feet from the Resident's room. She added that the smokers had been educated in the past to not prop open the doors, but it had continued to occur.

A review of the pest reports for September - November 2022 revealed:

September 27, 2022: five pest summary locations had miscellaneous flies found and totaled 155. The exterior of the facility assessment had a recommendation to reroute the downspouts to prevent standing water and attraction by pest. The status was listed as pending with an initial date of 8/23/2022.

October 24, 2022: five pest summary locations

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had miscellaneous flies found and totaled 100. The general comments area identified two missing fly traps. The exterior of the facility had a recommendation to reroute the downspouts to prevent standing water and attraction by pest. The status was listed as pending with an initial date of 8/23/2022.

November 22, 2022: five pest summary locations had miscellaneous flies found and totaled 120. The exterior recommendation continued to state, downspouts not directed away from the foundation. Please reroute downspouts to prevent standing water and attraction by pest. The status was listed as pending with an initial date of 8/23/2022.

An interview was conducted with the pest control representative on 12/8/2022 at 5:13 p.m. He revealed he visited the facility monthly and does an exterior inspection, recommended treatment as needed and then would do an interior inspection with a pest control treatment. He stated he had electronic fly traps present in the facility and since the facility had begun construction, three fly traps had been missing. He demonstrated, by walking to the locations, the three missing fly traps. One was beside the door in the recreational room, and one was on the opposite side of the courtyard, by the door to the 300 hall. He pointed to the two screws that were present on the wall where the fly trap device hung previously. An electrical outlet was beneath the area of the missing fly trap. The third device that was missing, was in an area that residents are not currently residing. He added that he had not identified a pest issue with flies in the facility.

An interview was conducted with the

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Administrator on 12/8/2022 at 4:58 p.m. and he revealed he had been employed at the facility a few months. He stated he had been made aware of maggots at the facility for Resident #1 on 12/6/2022 when the Admission Coordinator logged into the hospital system to review when the Resident might be returning. He stated at that point, the team became aware of the maggots and deep cleaned Resident #1's room. He stated no flies were present at that time. He revealed education to the staff and residents would be conducted immediately to not prop doors open. The Administrator provided copies of the pest control visit reports for the previous three months and stated a Maintenance Director would normally be the person working with the Pest control representative and reviewing the reports, but the facility did not have a Maintenance Director and he was covering that role.

A follow up interview was conducted with the Administrator on 12/8/2022 at 5:42 p.m. and he revealed he ordered eight fly traps to replace the missing ones on 12/7/2022 by telephone to the pest control representative.

An interview was conducted with the Administrator and Corporate consultant on 12/9/2022 at 3:00 p.m. and the corporate consultant stated the missing fly traps cannot be installed until an electrician reviews the devices.

The Administrator was notified of immediate jeopardy on 12/09/2022 at 5:00 p.m.

Alleged date of IJ removal: 12/10/2022

Credible Allegation of IJ removal:

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F 925	Continued From page 29 * Recipients who have suffered or are likely to suffer, a serious adverse outcome as a result of the non-compliance. On 12/3/22, at approximately 9:30 am, Resident #1 had a change in condition, with a decreased level of consciousness, shallow respirations, and a temperature of 99.9. The nurse made the physician aware with an order to send the resident to the emergency room for evaluation. EMS arrived at the facility to transport the resident to the emergency department. The emergency medicine technician notified Nurse #1 that there were larvae on resident #1 sheets. The nurse notified the Administrator. The Administrator instructed housekeeping to deep clean resident #1's room and replace the mattress. On 12/3/22, the Administrator initiated an investigation to determine the root cause of the larvae. The facility's failure to implement fly reduction measures including ensuring doors are not propped open resulted in development of larvae on the groin pannus skin folds, buttocks, wound, and perineal area on 12/3/2022. All residents with wounds have the potential to be affected related to non-compliance with maintaining an effective pest control system. On 12/7/2022, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Treatment Nurse initiated an audit to visualize all current residents with wounds. This audit was to ensure there were no signs and symptoms of worsening of the wound and no larvae in the wound bed. There were no other areas of concern identified during the audit. The audit was completed on 12/7/22. * Actions taken to alter the process or system	F 925		

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failure to prevent a serious adverse outcome for occurring or recurring
On 12/3/2022, a 100% audit of all resident rooms, common areas, and all entrances to the facility was completed by the Maintenance Director to identify any concerns related to pest control. There were no other areas of concern identified during the audit. On 12/3/22, the maintenance director did not observe any doors propped open.

On 12/7/2022, the Administrator contacted the Pest Control Company for additional treatment.

On 12/7/2022, the Administrator contacted Support Services to order air curtains for the main entrance and both courtyards used for smoking, to aid in the prevention of flies entering the center. Support Services indicated that the air curtains would arrive by approximately 12/13/2022 due to being a special order, with subsequent installation by Support Services after receipt of items. The

Administrator will oversee the process to ensure the timely completion of the receipt and installation of the air curtains.

On 12/8/2022, the contracted pest control company arrived, inspected the facility for pests, and treated the perimeter of the building with a chemical solution to kill and deter flies. Wall-mounted fly lights were ordered on 12/8/2022 by the pest control company to be placed near the four courtyard doors, the exit door nearest resident #1 room, near the lobby entrance, and the 500/700 hallway. The pest control company indicated the wall-mounted fly lights would arrive approximately 12/12/2022, and the Support Services will install the wall-mounted

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fly lights once received. The Administrator will oversee the process to ensure the timely completion of the receipt and installation of the wall-mounted fly lights

On 12/8/22, the Administrator conducted a resident council meeting with 16 residents in attendance with the discussion of pest prevention, including not propping doors open. On 12/9/22, the education was reviewed with all other alert and oriented residents that did not attend the resident council meeting by the Administrator.

On 12/8/22, the Administrator checked all exit doors to ensure no doors were propped open for a point of entry for pests. There were no other identified areas of concern.

On 12/9/22, the Maintenance Director placed an alarm on the courtyard #1 door (the door that's 40 feet from the affected resident's room) to alert staff when residents access the courtyard so they can ensure doors are closed to prevent the point of entry for pests.

On 12/9/22, the Maintenance Director adjusted the courtyard #2 door closure to ensure the door closes properly and sealed to prevent the point of entry for pests.

On 12/7/2022, 100% in-service was initiated by the Staff Development Coordinator with the Administrator, Medical Records, Accounts Receivable, Nurses, Nursing Assistants, Housekeeping staff, Social Worker, Accounts Payable, Therapy Staff, Maintenance Staff, receptionist, Medical Records or Supply Clerk in regards to Pest Control to include (1) Prevention

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of pest control concerns and (2) reporting pest control concerns into the Maintenance Work Order tracking System and notification of Administrator, Director of Nursing and the Maintenance Director. In-service will be completed by 12/8/2022. After 12/8/2022, the Administrator will ensure the in-services are mailed to any remaining staff who has not worked and not received the in-service with instructions to review, sign the in-service, and return to the Staff Development Coordinator or Director of Nursing prior to next scheduled work shift. All contracted staff including agency that has not worked, will receive the in-service upon the next scheduled shift. Staff Development Coordinator will monitor the schedule for new assigned agency staff to ensure they are educated prior to their scheduled shift.

On 12/9/2022, 100% in-service was initiated by the Staff Development Coordinator with the Administrator, Medical Records, Accounts Receivable, Nurses, Nursing Assistants, Housekeeping staff, Social Worker, Accounts Payable, Therapy Staff, Maintenance Staff, receptionist, Medical Records and Supply Clerk regarding to ensure the point of entry for pests including doors are not left open by staff or residents. In-service will be completed by 12/9/2022. After 12/9/2022, the Administrator will ensure the in-services are mailed to any remaining staff who has not worked and not received the in-service with instructions to review, sign the in-service, and return to the Staff Development Coordinator or Director of Nursing prior to next scheduled work shift. All staff will be required to sign an in-service sheet on arrival to their next scheduled shift. The Educator will review the education and validate staff knowledge

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and understanding of the education. All contracted staff including agency that has not worked, will receive the in-service upon the next scheduled shift. Staff Development Coordinator will monitor the schedule for new assigned agency staff to ensure they are educated prior to their scheduled shift.

On 12/9/22, the Administrator began daily courtyard door monitoring for the identified doors to ensure the doors are not propped opened.

*Date of corrective action completion 12/10/2022

On 12/13/2022 the facility's credible allegation for Immediate Jeopardy removal was validated. The validation was evidenced by record review of in-services given to staff, and audits completed by staff management. Pest control invoices were available showing extra services conducted. Installation of air curtains and fly lights were seen already installed or being installed. Validation was also evidenced by interview of staff members from different departments.

Observations made on 12/13/2022 from 1:00 pm until 3:00 pm revealed that no pests were found in the facility. Three new air curtains were either installed or being installed on tour, bringing that number to five. New fly lights were installed bringing the number of such lights to 13. A door that residents could prop open had an alarm installed on it to prevent this from being done.

The facility's in-service records were available and reviewed. There was documentation that in-services had been completed per the facility's alleged credible allegation of compliance. The facility's audits were also reviewed. There was

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 34 documentation that audits had been completed. Different staff members from different departments were interviewed and reported that they had attended in-service training on Pest Control. Their signatures were verified on the in-service training records. Staff members were able to report specific details of the training they had received. The immediate jeopardy was removed on 12/10/2022.	F 925		