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	345294	A. BUILDING _____ B. WING _____	C 10/12/2023

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AUTUMN CARE OF SHALLOTTE	237 MULBERRY STREET SHALLOTTE, NC 28459

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F 000	INITIAL COMMENTS An unannounced on site complaint investigation was conducted from 10/11/23 through 10/12/23. Event ID # NU0U11. The following intake was investigated NC00208254. 1 of 1 allegation resulted in deficiency.	F 000		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review, nurse practitioner, and resident and staff interviews, the	F 693	1. On 10/5/2023 the resident was assessed by the wound care nurse and	10/17/23

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

Electronically Signed | 10/23/2023

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F 693	Continued From page 1 facility failed to prevent the presence of maggots at a tube feeding insertion site; and failed to label a tube feeding dispensing bag with a date and time when initially opened for 1 of 2 residents (Resident #1) observed for tube feeding. Findings included: a. Resident #1 was admitted to the facility on 01/17/23. Diagnoses included dysphagia (difficulty swallowing) following a stroke with right sided weakness (hemiplegia), aphasia (difficulty speaking), and gastrostomy (insertion of feeding tube). Review of the physician's orders revealed an order written on 02/03/23 for enteral (nutritional feeding via a tube) feed called Diabeticsource at 70 milliliters (ml) per hour, an order written on 03/02/23 to ensure resident has 2 hour break from continuous tube feeding, an order written on 03/13/23 to cleanse feeding tube site with normal saline and apply split gauze daily and as needed if soiled, and an order written on 08/04/23 for free water flushes of 125 ml every 4 hours via tube. Review of the Medication Administration Records (MAR) from February to October 2023 revealed the orders had been followed as directed. The Minimum Data Set quarterly assessment dated 07/18/23 revealed Resident #1 was cognitively intact and required extensive assistance with two person physical assistance with bed mobility, dressing, and toileting and one person physical assistance with personal hygiene and extensive assistance with one staff physical assistance with meals. Resident #1 had impairment to one side to both upper and lower	F 693	MD. He was sent to the ER and returned to the facility the same day. 10/6/2023 the resident was reassessed and again maggots were noted around the gastric tube site. The MD and the facility Wound Care Provider were notified and the resident was sent back to the hospital. The resident returned to the facility the same day with a new treatment order. 10/11/2023 the nurse removed the tube feeding formula and tubing and rehung a new dated bottle with new tubing. 2. On 10/11/2023 the wound care nurse assessed each wound and gastric tube site in the facility to ensure there were no other residents with maggots in or around their sites. No additional concerns were identified during the audit. 10/11/2023 the wound care nurse ensured there was no additional tube feeding formula that was undated. There were no additional negative findings. 10/13/2023 the Maintenance Director walked each hall and observed each room to ensure there were no flies in the community. There were no flies observed during the facility inspection. 3. DON/Designee educated all staff beginning on 10/11/2023 on reporting all pest, including flies, to the Maintenance Director via work order and removing residents from an area that has pest until the issue can be resolved. The DON/Designee also began educating all nurses on 10/11/2023 on dating all tube feeding formula at the time it is hung. No staff member will be able to work after	

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F 693	Continued From page 2 extremities and had a feeding tube receiving 51% or more of calories via tube feeding and 501 (ml) or more of fluid via tube feeding. Review of Resident #1's care plan dated 07/18/23 revealed a plan of care for a feeding tube related to swallowing impairment with a goal that resident would tolerate the tube feeding without aspiration or other adverse reactions through next review with interventions to include, in part, check residual and placement of tube prior to feeding, medication administration and water flushes, monitor for complications including diarrhea, aspiration and gastric distention and report to physician. A nursing progress note written by Nurse #1 on 10/05/23 at 11:11 AM revealed at 10:45 AM, Nursing Assistant (NA) #1 called this nurse to the resident's room. Resident presented with redness to feeding tube site and maggots coming out from the site and around the tubing. The Physician was present in the building and gave new orders to send resident to the Emergency Department (ED). Nurse #1 updated resident's family member on his condition and gave report to the ED. Emergency Medical Services (EMS) took resident via stretcher to hospital #1. Resident denied pain at the time and vital signs were within normal limits. Review of the hospital Emergency Department record from Hospital #1 dated 10/05/23 revealed nursing staff changed the dressing on the feeding tube and noted some worms or maggots. Feeding tube site noted to have some oozing of clear liquid and some blood, visible small white worms noted. The medical decision making revealed resident had normal vital signs, lab	F 693	10/13/2023 until the education can be completed. All newly hired staff will receive the education during facility orientation. An ad HOC QAPI meeting was completed on 10/13/2023 with the Interdisciplinary team. The Medical Director was notified by the Administrator. 4. The DON or designee will audit all wounds and gastric tube sites weekly to ensure there are no issues with maggots and that all tube feeding formula is dated appropriately. The audits will start 10/16/2023 and continue for 12 weeks. The DON or designee will do twice a week facility inspections to ensure all pest concerns are being reported and addressed. Audits will start 10/16/2023 and continue for 12 weeks. The results of the audits will be forwarded to the facility QAPI for further review and recommendations. The QA team may change the plan of correction or extend the audits to ensure ongoing compliance. The administrator will be responsible for ensuring the plan of correction is followed.	

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studies reassuring, and resident without any issues. Resident was given a dose of intravenous antibiotics here. Recommended admission, but resident refusing this. It was difficult to communicate but resident did have a clear understanding with written communication and continued to refuse. Overall, resident may have some mild cellulitis which was treated with Clindamycin (antibiotic medication). In regard to the worms, it was more of a hygiene issue and will advise skilled nursing facility to manage this with flushes of topical peroxide and close wound care follow up. The ER note indicated there were no signs of any abscess, resident was not in any pain, and he was discharged back to the skilled nursing facility at his request.

Review of the physician orders revealed an order written on 10/05/23 for antibiotic Clindamycin hydrochloride oral capsule 150 milligrams (mg), give 2 capsules by mouth every 6 hours for cellulitis of the skin for 10 days and to cleanse tube feeding site with hydrogen peroxide (a mild antiseptic used to prevent infection) twice daily.

A nursing progress note written on 10/06/23 revealed Nurse #1 spoke with resident about getting treatment for his tube feeding site due to maggots being present. Resident was sent out on 10/05/23 but refused treatment at Hospital #1. Nurse #1 and the Wound Treatment Nurse explained to the resident the importance of getting treatment. Resident's sister also encouraged resident to get treatment. Resident agreed and EMS transported him to Hospital #2 for treatment on 10/06/23. The ED nurse was updated on resident's condition and sister was aware of situation.

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Review of the hospital Emergency Department record from Hospital #2 dated 10/06/23 revealed Resident presented with maggots at the feeding tube site. Resident was seen at other hospital on 10/05/23 and had wound care with hydrogen peroxide done, given a dose of Clindamycin, and discharged back to the skilled nursing facility with increased hygiene recommendations. The assessment revealed the feeding tube site was noted with maggots crawling at the abdominal wall and more maggots came out with manipulation of the feeding tube site. Resident was noted to have trace erythema (redness) surrounding the feeding tube site. The medical decision making ED note indicated no actual issue with feeding tube itself, easily flushed in the ED, the issue primarily was hygiene surrounding the wound. He was seen at the other hospital yesterday and had unremarkable labs. A cat scan of the abdomen and pelvis was done to evaluate for possible intra-abdominal (the area between skin, tissues, and the stomach) wall for deeper infections, abscess, etc. Results were unremarkable. Hydrogen peroxide used to clean the wound as this will kill the maggots but will need frequent application which can be done at the skilled nursing facility. Maggots should be individually removed as best as possible.

A nursing progress note written on 10/06/23 at 11:23 PM revealed resident returned from hospital by EMS, alert and oriented to name and command. Orders were given to clean feeding tube site with peroxide and remove maggots as seen and cover with dressing twice daily. Resident denied pain or distress.

Review of the October TAR on 10/06/23, revealed the order for cleansing the feeding tube site with

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normal saline and applying split gauze daily continued to be done as ordered from 03/13/23 to 10/6/23.

Review of the October MAR on 10/06/23 revealed Resident #1 was received the antibiotic and hydrogen peroxide treatments as ordered from 10/05/23 through 10/11/23.

A review of the weekly skin assessments completed by nurses from 09/08/23 through 10/01/23 revealed there were no new areas of concern noted to Resident #1's skin.

A review of the shower sheet forms from 09/08/23 through 10/04/23 revealed the shower sheet form was noted to have a drawing of a body front and back and asked specifically to check each box if any rash, bruising, redness, edema/swelling, scratches, or blisters were present and a box to check if skin completely intact. Additionally, there was a box to indicate if resident had a shower or bed bath. Each shower sheet form was signed by the Nurse and Nursing Assistant and dated. The shower sheets reviewed revealed Resident #1 refused showers, but had bed baths on 09/08/23, 09/17/23, 09/24/23, 09/27/23, 09/30/23 and 10/04/23 and each shower sheet form indicated Resident #1's skin was completely intact.

An observation of Resident #1 on 10/11/23 at 10:30 AM revealed an alert and oriented resident lying in bed. Resident #1 did not have any clothes on his upper body and a sheet was covering him up to his chest. The tube feeding was noted to be the correct tube feeding formula and infusing via a pump at the correct rate of 70 ml/hr. The resident's head of the bed was

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elevated. There was no sign of any insects including flies, no signs of overflowing trash, torn screens, open windows, or any food that may attract flies.

Resident #1 on 10/11/23 at 10:30 AM. Resident #1 had aphasia and could communicate with shaking his head yes or no and using hand gestures as well as using pad of paper and pen. Resident #1 reported he was aware he had maggots in his tube feed site. He reported he was not upset about it by shrugging his shoulders and nodding his head no. He reported the nursing staff changed his tube feeding site dressing every day and he wrote in his note pad, when asked if he had seen any flies in his room at any time, the word "none." Resident #1 reported he did not have any pain or feel any discomfort such as itching when the maggots were identified. Resident #1 reported he chose not to wear any clothes and only his brief while in bed because it was cooler and more comfortable. He reported he received care daily from the nursing staff including bed baths and chose not to take showers despite being asked.

An interview was conducted with Nurse #1 at 12:30 PM on 10/11/23. Nurse #1 revealed she was very familiar with Resident #1 and she cared for him often. She stated Resident #1 was nonverbal but able to communicate his needs with shaking his head yes or no, making hand gestures and writing on a pad. She stated he had the tube feeding since admission due to a stroke. Nurse #1 stated he received water flushes 4 times a day and it was patent (flushed without difficulty). Nurse #1 explained on the day of 10/05/23 when she went to assess the tube feeding site due to concerns reported by the NA,

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she pulled back the existing dressing, lifted the tube feeding stabilizer disc that rested on the abdomen, and noted the maggots coming out of the tube feeding insertion site and on the dressing. Nurse #1 stated she believed it was about 40 or so maggots. Nurse #1 added the tube feeding site area did not have any drainage or foul odor, but it was red around the insertion site. She explained to the resident what she saw, but he seemed unaffected by it. She stated she notified the family and physician and Resident #1 was sent to the ED where he refused to be admitted and was sent back to the facility. Nurse #1 stated he came back with an order to cleanse the tube feeding site with hydrogen peroxide twice daily which was implemented. She stated she encouraged Resident #1 to go back to the hospital for treatment, but he refused. Nurse #1 added on 10/06/23, she noted he continued to have maggots and she and the Wound Treatment Nurse (WTN) suggested again for him to go back to the hospital for further treatment, but Resident #1 continued to refuse. Nurse #1 stated she finally convinced him he needed to go back and he was sent on 10/06/23. Nurse #1 stated when she read the ED discharge summary from 10/05/23 she was upset because it stated the resident got maggots because of poor hygiene and added, she provided care to Resident #1 every day including changing his tube feed dressing. Nurse #1 stated she had never seen any redness, drainage, etc. Nurse #1 stated she had seen flies in the building when we had a hot spell a couple of weeks ago and they probably were getting in with the doors opening and closing from staff, visitors and residents wanting to go outside. Nurse #1 added she had seen a fly in Resident #1's room and saw one land on the outside of the tube feeding bag and on the

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dressing site but she swished it away about a week or so ago. Nurse #1 stated "I guess the fly crawled underneath the dressing." Nurse #1 stated she had only seen the one random fly and did not observe an influx of flies. She stated if she had, she would have notified the Maintenance Director so that a pest control treatment could be done.

An observation of the Resident #1's tube feeding site was conducted on 10/11/23 at 12:45 PM with Nurse #1. The tube feeding was noted to not be infusing at this time due to physician's order to hold tube feeding for 2 hours per day. The resident was noted to be lying in bed with no clothing to the top half of his body, but a sheet covering him up to his chest including covering the tube feeding site. The tube feeding dressing was intact and the insertion site was noted to be clean and dry and slightly pink in color with no drainage, odor, or maggots.

An interview was conducted with the Facility Maintenance Director (FMD) on 10/11/23 at 12:56 PM. The FMD reported the pest control company came once a week on Friday and treated the kitchen and any other areas of concerns that may have been reported that week. The FMD added once a month the pest control company sprayed the entire facility which included any entry ways into the building, the kitchen, hallways, offices, and all the residents' rooms. The FMD reported for the last 15 years they have had insect light traps positioned at the front door and in the dining room. The insect light traps had a black light which attracted the flies with sticky paper on the bottom so that the flies would not be able to get out once they got in. He stated they were changed quarterly and he added, he would detect

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a few dead flies on the sticky paper, but he added, there was not an abundance of them. The FMD stated he had not received any work orders from staff regarding flies and only had concerns reported to him regarding water bugs in specific resident rooms which were treated on the Friday the pest control company came. The FMD stated he did rounds in the building daily and had not seen any flies in the building that he could recall. He stated a fly or two would get into the building, but he added, he felt the facility did not have a significant fly problem and that the insect light traps and pest control treatments were very effective. The FMD provided documentation to support the pest control company treated the facility on 09/01/23, 09/08/23, 09/15/23, 09/22/23, 09/29/23 and 10/06/23.

An interview was conducted with the Nurse Practitioner (NP) on 10/11/23 at 1:30 PM. The NP stated she was made aware of the maggots that were discovered at Resident #1's tube feeding site. The NP stated when he was sent to hospital #1 they had initiated an antibiotic due to cellulitis since it was red, but Resident #1 refused any further treatment so hospital #1 discharged him back to the facility. The NP stated the last time she had assessed the tube feeding site was August 18, 2023, for a routine visit and there was no drainage or redness seen on the site on this assessment or previous assessments. The NP added there have been no reports of abnormal findings to the site and Resident #1 was tolerating the tube feeding well. The NP stated she had not had any sightings of flies in the resident's room or in the facility and she was in the facility 3 times per week. She stated while wearing a shirt would add an extra level of protection to the tube feeding site for Resident #1, he generally would

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not wear any clothing and used a light sheet to cover himself. She stated flies are attracted to sweet smelling food (tube feeding) and moist areas and somehow one got into his site. The NP added, she did not agree with the hospital point of view that Resident #1 had poor hygiene. She stated she believed that was the only conclusion they could come too. She added, whenever she had seen Resident #1 for a visit he looked as though he was receiving good personal hygiene.

An interview with the Wound Treatment Nurse (WTN) on 10/12/23 at 9:49 AM revealed at the present time the facility had primary surgical wounds and there was only one resident who was being treated for a stage 3 wound to his sacrum which was resolving and did not have any purulent drainage or odor. She stated she did not change the tube feeding dressing sites as part of her wound care responsibilities and that it was the primary nurses' responsibility. The WTN added, she would only begin to manage a tube feeding site if there were any concerns with skin breakdown. She stated she was not made aware of any skin breakdown to Resident #1's tube feeding site until 10/05/23 when she was asked to view the site when a NA identified maggots. The WTN stated she and Nurse #1 assessed the site and noticed the maggots coming out of the tube feeding insertion site. She stated the site did not have any drainage, it was pink in color and there were several maggots noted. She stated she could not say how many. The WTN stated Resident #1 was not being treated for any wounds so she was not often in the room, but she did not recall seeing any flies in his room and only had seen a random fly here and there in the facility. The WTN stated she never saw an

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abundant of them and if she had she would have reported that to the Facility Maintenance Director. She stated on 10/06/23 she was with Nurse #1 when they were encouraging him to go back to the hospital for more treatment and Resident #1 finally agreed to go back.

An interview was conducted with NA #1 on 10/12/23 at 10:16 AM. NA #1 reported she was the one that first identified maggots on Resident #1 and reported it immediately to Nurse #1. She stated she saw what looked like rice on top of his brief and realized it was a maggot crawling. She stated she immediately notified Nurse #1 and she and the WTN and the Director of Nursing (DON) came in to evaluate. NA #1 stated nurse aides are not allowed to take down a dressing at tube feeding site, so she did not view what was under the dressing until Nurse #1 came and removed the dressing. NA #1 stated she then saw more maggots around the tube feeding site. She stated when she provided care for Resident #1 she had never seen any flies in his room. She stated Resident #1 would not usually wear any clothes to his top half or bottom half and would only wear his brief covered with a sheet. She stated that was his choice. NA #1 stated Resident #1 did not seem phased at all or concerned about the maggots that were observed in his tube feeding site when the nurse, WTN and DON were assessing him.

An interview was conducted with the DON on 10/12/23 12:38 PM. He stated he had not seen any flies in the facility or in the resident's room, but he would expect if any staff have identified any flies in residents' rooms, specifically residents with any open areas to their skin, that the staff would be pro-active in notifying the Facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345294	A. BUILDING _____ B. WING _____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SHALLOTTE	237 MULBERRY STREET SHALLOTTE, NC 28459

(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 693	Continued From page 12	F 693		

Maintenance Director and Housekeeping to address it. The DON reported he did not feel Resident #1 had poor hygiene and when he assessed the site on 10/05/23 the site did not have any purulent draining or odor but did appear to be red around the insertion site.

b. An observation of Resident #1 on 10/11/23 at 10:30 AM revealed an alert and oriented resident lying in bed. The tube feeding was noted to be secured at the opening and the ordered tube feeding formula was infusing via a pump at the ordered rate of 70 ml/hr. and there was between 180 and 200 ml remaining. The tube feeding bag was noted to have a label to include the date and time the tube feeding was started. The label was observed to have been blank, or not filled out.

An interview was conducted with Nurse #1 at 12:30 PM on 10/11/23. Nurse #1 stated Resident #1 received Diabeticsource tube feeding in a prefilled bag containing 1,000 milliliters. Nurse #1 stated once the bag was emptied, she disposed of the entire bag and the tubing. She stated nurses would replace it with another prefilled bag and new tubing after 14 hours. She stated she did not usually label and date the tube feeding bag because the feeding runs quickly and they were changing the prefilled feeding bag continuously. Nurse #1 added once the feeding tube was done infusing, another prefilled bag was immediately hung. She stated the last time the current bag was hung up was at 10:00 PM last night per night shift nurse. She stated it was a good practice to date the bag when it was opened and it should have been dated when the nurse hung it last night and she would be sure to date the next bag she hung.

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F 693	Continued From page 13 An interview was conducted with the NP on 10/11/23 at 1:30 PM. She stated anytime there is a tube feeding infusing them should be a date and time on the bag of when it was started so all staff would be aware of the time it was hung and that it was only good for 24 hours once the bag was punctured. An interview was conducted with Nurse #2 via phone on 10/12/23 at 11:11 AM. Nurse #2 confirmed she was assigned to Resident #1 on 10/10/23 from 7:00 AM to 7:00 PM. She stated Resident #1's tube feeding bag finished infusing on her shift on 10/10/23 at around 10:00 PM. She stated she had an orientee with her during her shift and she did not take the time to date and label the new tube feeding bag she hung at 10:00 PM. She added, she quickly hung the bag and moved on with her medication pass. Nurse #2 stated she usually labeled the new bag whenever she hung one. Nurse #2 stated it was important to label and date the feeding tube formula bags because the they were only good for 24 hours. An interview was conducted with the Director of Nursing (DON) on 10/12/23 12:38 PM. The DON stated he expected his nursing staff to always date and time the tube feeding bag whenever it was initiated. He stated the date and time was necessary because the formula and tubing was only good for 24 hours to prevent spoilage.	F 693		