

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Chowan River Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1341 Paradise Road Edenton, NC 27932	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13030</p> <p>Based on record review, family, staff, and physician interviews the facility failed to provide notification to the physician and responsible party upon initial observance of maggots in and on the dressing of a heel wound for one (Resident #1) of three residents reviewed for notification of a change in condition. Findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with multiple diagnoses some of which included Type 2 Diabetes Mellitus with diabetic peripheral neuropathy, chronic kidney disease, and diabetic foot ulcers.</p> <p>Nurse #2 was interviewed on 5/29/2024 at 12:39 PM and again at 2:33 PM. Nurse #2 revealed the following events as occurring and reconfirmed the events upon a second interview. Nurse #2 stated she worked the 7:00 AM to 7:00 PM shift and was assigned to care for Resident #1. Nurse #2 stated it was approximately 3:30 PM to 4:00 PM and she obtained the assistance of NA #2 to hold up the left lower limb of Resident #1 to perform wound care on a left heel wound. Nurse #2 stated she sprayed wound cleanser on the bandage to soak it and remove the bandage. Nurse #2 stated as she removed the bandage a maggot dropped onto the barrier pad underneath the heel. Nurse #2 stated a family member of Resident #1 walked into the room while wound care was being provided. Nurse #2 stated she did not say anything to NA #2 when the maggot dropped down but looked at NA #2 so as not to alert the family member in the room. Nurse #2 stated she observed ten but less than 20 maggots on the wound and dressing of Resident #1. Nurse #2 stated she cleaned out all the maggots and cleaned the wound well with the wound cleanser before completing the wound care orders and rewrapped the dressing. Nurse #2 stated after leaving the room, she approached NA #2 and told her she saw maggots in the wound of Resident #1 and for her to go and find the DON to tell her. Nurse #2 stated all of this occurred on 5/14/2024. Nurse #2 stated she did notify the DON who told her she, the DON, would take care of everything including talking to the family of Resident #1. Nurse #2 stated she went back to her nursing duties on 5/14/2024 and left the notification of the physician and the family to the DON. Nurse #2 stated the only error she made was in not documenting the notification of the DON of the maggots in the wound and dressing. Nurse #2 stated she recalled the date of 5/14/2024 because she recalled the date on the bandage prior to its removal. Nurse #2 indicated she spoke with the DON again on 5/16/2024 in the morning confirming with her she did perform the dressing change on 5/14/2024 and she did see maggots in the wound and dressing on that day. Nurse #2 stated she did not perform wound care on Resident #1 on 5/16/2024 but, she knew the dressing change and wound care orders were completed after Resident #1 took a shower.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>NA #2 was interviewed on 5/29/2024 at 2:50 PM. NA #2 confirmed on the 3:00 PM to 11:00 PM shift on 5/14/2024 she was assigned to care for Resident #1. NA #2 stated Nurse #2 requested her help in positioning Resident #1 for wound care. NA #2 revealed when she was holding the left leg of Resident #1, a maggot dropped down on the pad below the heel, but she did not know what it was at the time. NA #2 stated she did not look at the heel wound, nor did she see any other maggots. NA #2 reiterated it was her responsibility to hold the left leg and that was what she did. NA #2 confirmed a family member did enter the room during the wound care treatment on that day. NA #2 stated upon completion of the wound care she removed the trash from room. NA #2 revealed Nurse #2 approached her in the hallway and asked her if she knew what it was that dropped onto the pad below the heel. NA #2 told her she did not know, and Nurse #2 told her it was a maggot. NA #2 then revealed Nurse #2 told her to go find the DON and tell her about the maggot. NA #2 stated she looked for the DON, but the DON had already left for the day so, she returned to her nurse aide duties.</p> <p>NA #1 was interviewed on 5/29/2024 at 12:15 PM. NA #1 stated on her initial morning rounds for her 7:00 AM to 3:00 PM shift, as she was assisting Resident #1 with care, she observed a maggot in the bed near the left foot of Resident #1 and one maggot on the floor. NA #1 could not recall what day this occurred. NA #1 revealed she immediately reported this to the Unit Manager (Nurse #1) in the hallway. NA #1 stated Nurse #1 came into the room of Resident #1, saw the maggots, and went to notify the DON while NA #1 stripped the bed and threw the maggots in the garbage. NA #1 could not recall what day this occurred.</p> <p>Nurse #1 was interviewed on 5/29/2024 at 12:37 PM. Nurse #1 stated as soon as she clocked in for the day on 5/16/2024 she was notified by NA #1 of maggots in the room of Resident #1, and she went to the room of Resident #1 and observed a maggot on the bed. Nurse #1 confirmed she notified the DON and accompanied NA #1 to the shower room to assess the wounds of Resident #1 and administer wound care after the shower.</p> <p>The DON was interviewed on 5/29/2024 at 11:35 AM. The DON stated Resident #1 was reported to have a maggot observed on the bed and another one on the floor, but she herself never saw them. The DON explained on 5/16/2024 she was not in the building but was notified Certified Nursing Assistant (NA) #1 found the maggots in the room of Resident #1. The DON revealed she came to the building and was told by NA #1 she observed one maggot on the floor and one on the blanket in the bed on Resident #1 close to his left heel wound. NA #1 reported to the DON she had already thrown the maggots away in the garbage immediately. The DON stated she spoke with Nurse #2, the nurse assigned to care for Resident #1 from 7:00 AM to 7:00 PM on 5/16/2024 and was told she had already completed wound care for Resident #1, and she too had seen the maggots. The DON stated when the RP arrived at the facility, she spoke with him in her office and informed him of the maggot or maggots observed in the bed and on the floor as well as the steps that were being taken to prevent reoccurrence of maggots. The DON stated she then called the physician (MD #1) for Resident #1 to inform him of the maggot observations by the nursing staff.</p> <p>The DON was reinterviewed on 5/29/2024 at 1:50 PM. The DON was adamant she was only made aware of the one maggot on the bed and one on the floor observed by NA #1 on 5/16/2024. The DON stated when she spoke with Nurse #2 on 5/16/2024 she assumed she was talking about performing wound care for Resident #1 on the morning of 5/16/2024 and observing a maggot at that time.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the responsible party (RP) for Resident #1 on 5/29/2024 at 11:13 AM. The RP for Resident #1 revealed the following information. A couple of weeks ago the RP came to visit Resident #1 in the facility in the morning. When the RP arrived at the facility he was notified by the Director of Nursing (DON), a maggot had been observed by the nursing staff on the foot of Resident #1. The RP of Resident #1 asked the DON what the facility was going to do about it and what steps were going to be taken so that it does not happen again. The DON told the RP, Resident #1 was going to be taken to the shower and the room of Resident #1 was going to be deep cleaned to find the source of the maggot or maggots.</p> <p>The Administrator was interviewed on 5/29/2024 at 3:30 PM. The Administrator confirmed Nurse #2 should have called the Director of Nursing and the physician immediately upon visualizing the maggots on 5/14/2024. The Administrator also confirmed that the responsible party for Resident #1 should have notified as soon as possible as well.</p> <p>Documentation in a physician's follow up note dated 5/16/2024 revealed in part, Reviewed most recent wound care notes. Alerted this morning, a few hours ago, of the patient potentially having in his left heel some maggot formation. Since that time, the wound has been inspected and thoroughly cleansed and dressed. It is doing well. On my inspection this afternoon, there is no evidence of any maggot formation. The patient is not septic or toxic. He appears at baseline. He denies any pain. I do not think there is any significant decomposition in his sacral right heel or left heel wounds.</p> <p>MD #1, the physician for Resident #1, was interviewed on 5/30/2024 at 9:30 AM. MD #1 stated he would have wanted to be notified on 5/14/2024 if maggots were found in the left heel wound of Resident #1. MD #1 stated if he had been notified of 5/14/2024 he would have come to the facility to visualize the wound and to make sure the wound was cleaned appropriately. MD #1 stated he came to the facility on [DATE] and observed the left heel wound for Resident #1. MD #1 stated all the wounds to include the left heel wound, looked good and did not appear to be infected. MD #1 stated although historically maggots had been used to debride wounds without causing harm, it was not currently good practice.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13030</p> <p>Based on record review, family, staff, and physician interviews the facility failed to determine if a higher level of care was needed when maggots were observed in a heel wound for one (Resident #1) of three residents reviewed for professional standards of care for wounds. Findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with multiple diagnoses some of which included Type 2 Diabetes Mellitus with diabetic peripheral neuropathy, chronic kidney disease, and diabetic foot ulcers.</p> <p>Resident #1 had a physician's order initiated on 4/8/204 for the left heel ulcer to be cleaned with normal saline/dermal wound cleanser, application of Aquacel Ag to the wound bed, and cover with a dry dressing every other day and as needed. Aquacel Ag is a sterile, soft, non-woven dressing that contains ionic silver, a broad-spectrum antimicrobial agent.</p> <p>Documentation on a wound ulcer flow sheet dated as completed 5/10/2024 revealed Resident #1 had a Stage 4 left heel wound 6.2 inches in length, 7.8 inches in width, and an undefined depth.</p> <p>Documentation on the Treatment Administration Record (TAR) supplementary documentation dated 5/11/2024 at 11:13 PM for Resident #1 revealed wound care for both heels was administered by Nurse #4.</p> <p>Nurse #4 was interviewed on 5/30/2024 at 8:40 AM. Nurse #4 revealed she had worked in the facility on 5/11/2024 and 5/12/2024 for the 7:00 PM to 7:00 AM shift. Nurse #4 revealed she had been told in the report when she arrived at 7:00 PM on 5/11/2024 the facility was in between treatment nurses and there would not be a wound care nurse in the facility to perform wound care for Resident #1 on 5/12/2024 as scheduled. Nurse #4 confirmed she performed wound care for Resident #1 to include his left heel wound on 5/11/2024. Nurse #4 stated she did not see any maggots on the left heel wound and the wound looked good. Nurse #4 stated she did not see Resident #1 again until late on 5/12/2024 when he returned to the facility after a visit out with his family. Nurse #4 stated Resident #1 returned to the facility on [DATE] with his dressing intact and she did not note any concerns.</p> <p>Nurse Aide (NA #1) was interviewed on 5/29/2024 at 5:04 PM. NA #1 revealed she was assigned to care for Resident #1 on 5/12/2024 for the 7:00 AM to 3:00 PM shift. NA #1 stated she assisted Resident #1 in getting dressed on 5/12/2024 prior to leaving with his family at approximately 8:00 AM and he did not return to the facility on her shift that day. NA #1 revealed both dressings were intact because she would have told the nurse if either dressing was not intact prior to Resident #1 leaving the facility on 5/12/2024.</p> <p>Documentation on the TAR dated 5/14/2024 and 5/16/2024 revealed Nurse #2 administered wound care for the left heel of Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse #2 was interviewed on 5/29/2024 at 12:39 PM and again at 2:33 PM. Nurse #2 revealed the following events as occurring and reconfirmed the events upon a second interview. Nurse #2 stated she worked the 7:00 AM to 7:00 PM shift and was assigned to care for Resident #1. Nurse #2 stated it was approximately 3:30 PM to 4:00 PM and she obtained the assistance of NA #2 to hold up the left lower limb of Resident #1 to perform wound care on a left heel wound. Nurse #2 stated she sprayed wound cleanser on the bandage to soak it and remove the bandage. Nurse #2 stated as she removed the bandage a maggot dropped onto the barrier pad underneath the heel. Nurse #2 stated a family member of Resident #1 walked into the room while wound care was being provided. Nurse #2 stated she did not say anything to NA #2 when the maggot dropped down but looked at NA #2 so as not to alert the family member in the room. Nurse #2 stated she observed ten but less than 20 maggots on the wound and dressing of Resident #1. Nurse #2 stated she cleaned out all the maggots and cleaned the wound well with the wound cleanser before completing the wound care orders and rewrapped the dressing. Nurse #2 stated after leaving the room, she approached NA #2 and told her she saw maggots in the wound of Resident #1 and for her to go and find the DON to tell her. Nurse #2 stated all of this occurred on 5/14/2024. Nurse #2 stated she did notify the DON who told her she, the DON, would take care of everything including talking to the family of Resident #1. Nurse #2 stated she went back to her nursing duties on 5/14/2024 and left the notification of the physician and the family to the DON. Nurse #2 stated the only error she made was in not documenting the notification of the DON of the maggots in the wound and dressing. Nurse #2 stated she recalled the date of 5/14/2024 because she recalled the date on the bandage prior to its removal. Nurse #2 indicated she spoke with the DON again on 5/16/2024 in the morning confirming with her she did perform the dressing change on 5/14/2024 and she did see maggots in the wound and dressing on that day. Nurse #2 stated she did not perform wound care on Resident #1 on 5/16/2024 but, she knew the dressing change and wound care orders were completed after Resident #1 took a shower.</p> <p>Review of the nursing notes documentation on 5/14/2024 and 5/16/2024 did not reveal any documentation of the observance of maggots on or near the wounds for Resident #1.</p> <p>NA #2 was interviewed on 5/29/2024 at 2:50 PM. NA #2 confirmed on the 3:00 PM to 11:00 PM shift on 5/14/2024 she was assigned to care for Resident #1. NA #2 stated Nurse #2 requested her help in positioning Resident #1 for wound care. NA #2 revealed when she was holding the left leg of Resident #1, a maggot dropped down on the pad below the heel, but she did not know what it was at the time. NA #2 stated she did not look at the heel wound, nor did she see any other maggots. NA #2 reiterated it was her responsibility to hold the left leg and that was what she did. NA #2 confirmed a family member did enter the room during the wound care treatment on that day. NA #2 stated upon completion of the wound care she removed the trash from room. NA #2 revealed Nurse #2 approached her in the hallway and asked her if she knew what it was that dropped onto the pad below the heel. NA #2 told her she did not know, and Nurse #2 told her it was a maggot. NA #2 then revealed Nurse #2 told her to go find the DON and tell her about the maggot. NA #2 stated she looked for the DON, but the DON had already left for the day so, she returned to her nurse aide duties.</p> <p>NA #1 was interviewed on 5/29/2024 at 12:15 PM. NA #1 stated on her initial morning rounds for her 7:00 AM to 3:00 PM shift, as she was assisting Resident #1 with care, she observed a maggot in the bed near the left foot of Resident #1 and one maggot on the floor. NA #1 could not recall what day this occurred. NA #1 revealed she immediately reported this to the Unit Manager (Nurse #1) in the hallway. NA #1 stated Nurse #1 came into the room of Resident #1, saw the maggots, and went to notify the DON while NA #1 stripped the bed and threw the maggots in the garbage. NA #1 could not recall what day this occurred.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse #1 was interviewed on 5/29/2024 at 12:37 PM. Nurse #1 stated as soon as she clocked in for the day on 5/16/2024 she was notified by NA #1 of maggots in the room of Resident #1, and she went to the room of Resident #1 and observed a maggot on the bed. Nurse #1 confirmed she notified the DON and accompanied NA #1 to the shower room to assess the wounds of Resident #1 and administer wound care after the shower.</p> <p>The DON was interviewed on 5/29/2024 at 11:35 AM. The DON stated Resident #1 was reported to have a maggot observed on the bed and another one on the floor, but she herself never saw them. The DON explained on 5/16/2024 she was not in the building but was notified Certified Nursing Assistant (NA) #1 found the maggots in the room of Resident #1. The DON revealed she came to the building and was told by NA #1 she observed one maggot on the floor and one on the blanket in the bed on Resident #1 close to his left heel wound. NA #1 reported to the DON she had already thrown the maggots away in the garbage immediately. The DON stated she spoke with Nurse #2, the nurse assigned to care for Resident #1 from 7:00 AM to 7:00 PM on 5/16/2024 and was told she had already completed wound care for Resident #1, and she too had seen the maggots. The DON stated she immediately had Resident #1 taken to the shower room to have his entire body cleaned, his wounds assessed, and his wound care treatments redone. The DON stated she had the room of Resident #1 deep cleaned to include the floor, bed, curtains, blinds, and cabinets. The DON said any food or snacks that were open were discarded and any additional food was put in a covered plastic container. The DON stated that in addition, the soft padded boot Resident #1 wore was cleaned. The DON stated when the RP arrived at the facility, she spoke with him in her office and informed him of the maggot or maggots observed in the bed and on the floor as well as the steps that were being taken to prevent reoccurrence of maggots. The DON stated she then called the physician (MD #1) for Resident #1 to inform him of the maggot observations by the nursing staff.</p> <p>An interview was conducted with the responsible party (RP) for Resident #1 on 5/29/2024 at 11:13 AM. The RP for Resident #1 revealed the following information. A couple of weeks ago the RP came to visit Resident #1 in the facility in the morning. When the RP arrived at the facility he was notified by the Director of Nursing (DON), a maggot had been observed by the nursing staff on the foot of Resident #1. The RP of Resident #1 asked the DON what the facility was going to do about it and what steps were going to be taken so that it does not happen again. The DON told the RP, Resident #1 was going to be taken to the shower and the room of Resident #1 was going to be deep cleaned to find the source of the maggot or maggots. The RP requested Resident #1 be taken to the emergency room for assessment of the wound because he was greatly concerned there might be more maggots or wound care was not being done properly at the facility.</p> <p>Documentation in the nursing notes dated 5/16/2024 revealed Resident #1 was sent to the emergency room for an evaluation of his wounds at the request of his RP and returned to the facility with no new orders.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON was interviewed on 6/30/2024 at 8:30 AM. The DON stated she spoke with Nurse #2 and confirmed Nurse #2 had told her she saw 10 but less than 20 maggots on the left heel wound of Resident #1 on 5/14/2024 during wound care. The DON denied Nurse #2 had contacted her to tell her about the maggots seen in the wound of Resident #1 on 5/14/2024 and that the first occurrence of her being notified was on the morning of 5/16/2024. The DON stated that the actions she took on the morning of 5/16/2024 to have the wound assessed by the physician and the deep cleaning of the room to find the source of the maggots would have been completed on 5/14/2024, had she known of the maggots. The DON stated when she spoke with Nurse #2 on 5/16/2024 she assumed Nurse #2 was talking about performing wound care for Resident #1 on the morning of 5/16/2024.</p> <p>Documentation in a physician's follow up note dated 5/16/2024 revealed in part, Reviewed most recent wound care notes. Alerted this morning, a few hours ago, of the patient potentially having in his left heel some maggot formation. Since that time, the wound has been inspected and thoroughly cleansed and dressed. It is doing well. On my inspection this afternoon, there is no evidence of any maggot formation. The patient is not septic or toxic. He appears at baseline. He denies any pain. I do not think there is any significant decomposition in his sacral right heel or left heel wounds.</p> <p>MD #1, the physician for Resident #1, was interviewed on 5/30/2024 at 9:30 AM. MD #1 stated he would have wanted to be notified on 5/14/2024 if maggots were found in the left heel wound of Resident #1. MD #1 stated if he had been notified of 5/14/2024 he would have come to the facility to visualize the wound and to make sure the wound was cleaned appropriately. MD #1 stated he wished he had a picture or at least a written description on 5/14/2024 so that he could determine if the wound was cleaned appropriately and evaluate the treatment that was provided for the removal of the maggots in the left heel wound of Resident #1. MD #1 confirmed he came to the facility on [DATE] and observed the left heel wound for Resident #1. MD #1 stated all the wounds to include the left heel wound, looked good and did not appear to be infected. MD #1 stated although historically maggots had been used to debride wounds without causing harm, it was not currently good practice. MD #1 stated after he evaluated the wounds of Resident #1 on 5/16/2024, the RP for Resident #1 requested Resident #1 be sent to the emergency room for wound evaluation confirming no more maggots or concerns were found.</p>		