STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility failed to assure the responsible party was notified regarding a change	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of	8/21/15

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

Electronically Signed | 08/07/2015

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F 157	Continued From page 1 in condition for one (Resident # 1) of two sampled residents whose families were interviewed. The findings included: Review of Resident # 1 ' s closed record revealed the resident resided at the facility from his most recent readmission date of 2/13/15 until 7/13/15 upon which date he was discharged home. The resident had multiple diagnoses which included but were not limited to the following: Diabetes Mellitus Type 2; Gout; Neuropathy, Congestive Heart Failure, Chronic Airway Obstructive Disease, Depression, and Lung Cancer. The resident was also documented as having problems with edema and mild venous stasis changes in his lower extremities. Review of interdisciplinary notes revealed different notations related to the resident ' s cognitive abilities. Specifically on 7/9/15 at 12:07 AM a nurse documented that the resident was " alert and oriented X 3. " On 7/12/15 at 3:25 AM another nurse documented that the resident " is alert and oriented to self and facility. He is forgetful and makes poor decisions. Able to make needs known but must rely on staff to anticipate some of his needs i.e. changes of cloths ... ... " Review of the record revealed the resident had a family member who was identified on his record to be his responsible party. Review of the resident ' s record revealed a physician ' s telephone order, dated 7/12/15, that arrangements were to be made for the resident to be seen by a consulting physician concerning his foot wound. Review of the resident ' s nursing notes and interdisciplinary notes from the date of 7/7/15 through 7/13/15 revealed no documentation that the resident had a foot wound, its condition, that wound care was being provided to the resident, or that the family member was notified that the resident had a foot	F 157	the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Corrective action accomplished for those residents found to have been affected by the alleged deficient practice: Resident #1 was discharged home with his wife on 7/13/15. 2. How corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice: a. On 7/24/15 appointment scheduler audited all appointments scheduled for the following two weeks to confirm all residents' responsible parties were notified of appointment. All responsible parties were notified. b. DON/ADON/Unit Manager/Nursing Supervisor will review 24 hour nursing reports from 6/23/15 to present to identify all residents with a change of condition by 8/21/15. Notification of all responsible parties by licensed nurse of any identified change of condition not notified previously. 3. Measures put into place to ensure that the alleged deficient practice will not recur: a. Appointment scheduler/nurse to notify responsible party of appointments at least two weeks prior to scheduled appointment or as soon as practicable. Appointment scheduler to keep log of resident appointment date, name of responsible	

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F 157	Continued From page 2 wound and was scheduled for a consult. Record review revealed the resident was seen at a wound clinic on 7/13/15 and identified to have a necrotic toe ulcer with a maggot in it. The wound consulting physician documented, " This is an insulin dependent diabetic patient with some necrosis at the dorsal aspect of third right toe. Multiple maggots were found in his shoes and another one inside the toe ulcer. " The consulting physician further documented that there was " moderate " tunneling of the ulcer and that the maggots had debrided the ulcer. The wound physician was interviewed by phone on 7/24/15 at 10:15 AM. The wound physician stated that on 7/13/15 he had found multiple maggots on the resident. He stated he removed a couple from his ulcer and that there were maggots on his clothes and in his right shoe. The resident ' s family member, who was listed as the resident ' s responsible party, was interviewed on 7/23/15 at 11:45 AM by phone. The resident ' s family member stated she arrived to take the resident home on 7/13/15 because there was a plan for him to be discharged that date. The family member stated when she arrived at the facility the resident was gone. The family member stated she was asked to have a seat in the lobby and shortly thereafter the resident arrived in the transport van. The family member stated that as the resident was assisted from the van into the facility, the resident told her that he had been to a doctor because he had maggots in his toe. The family member stated that the resident told her that he knew his toe was swollen but that he also had gout and that he had attributed the swelling of his toe to the gout. The family member stated that this was the first knowledge that she had there was a problem with his toe or about there being maggots in the ulcer. The family member	F 157	party and date notified of scheduled appointment. b. All nurses will be educated by the DON/ADON/administrative nurses on the protocol for resident's change of condition and notification of responsible party. Any nurse not receiving education by 8/21/15 will not be allowed to work until they have received the education. All new nurses to the facility will receive education during orientation. c. Nurses will notify MD/DON/ADON/Unit Manager of all residents' change of condition. d. Weekly audit of documentation of notification of responsible party for any resident with a change of condition by DON/ADON/Unit Manager. Any discrepancies noted at that time will be reviewed with employee with appropriate intervention as deemed necessary by the DON. e. Responsible party will be notified by nurse of resident's change of condition and document notification in resident's medical record. f. DON/ADON/Unit Manager/Nursing Supervisor will review daily (including weekends) all residents with a change of condition, notification of responsible party and documentation. If not completed, follow-up will be done immediately and nurse responsible will be counseled. 4. How the facility plans to evaluate the effectiveness of the corrective action. DON/ADON will submit summary of audits to monthly Quality Assurance and Performance Improvement meeting x3 months then quarterly thereafter.	

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F 157	Continued From page 3 stated that the facility staff had not informed her about any problems with the resident ' s toe or that he had maggots. Interviews were conducted with the following staff at the following times: NA (Nurse Aide) # 1 was interviewed on 7/23/15 at 1:05 PM; Nurse # 2 was interviewed on 7/24/15 at 12 noon; Nurse # 1 was interviewed on 7/24/15 at 9:50 AM; and Nurse # 3 was interviewed on 7/23/15 at 3:10 PM. The interview with NA # 1 revealed that on 7/12/15 the resident had greenish drainage around his toes and a lot of maggots crawled out from between his toes when she began to clean them. NA # 1 stated she had immediately told both Nurse # 1 and Nurse # 2. The interviews with Nurse # 1 and # 2 revealed their assistance had been obtained because the NA reported the maggots to them. During the interview with Nurse # 2, the nurse acknowledged that she also saw " dead bugs " on the resident ' s bed. Nurse # 2 stated Nurse # 3 was the hall nurse assigned to the resident that day and she thought Nurse # 3 called the family after the order was obtained to make arrangements for the resident to be seen at the wound clinic. Nurse # 3 stated during her interview that she thought Nurse # 2 called the family because Nurse # 2 was the one who cared for the resident ' s foot and was designated as supervisor on that date. Interview with the Director of Nursing and administrator on 7/24/15 at 8:10 AM revealed they also had not informed the family member about the condition of the resident ' s toes when maggots were discovered between his toes on 7/12/15. Both of these staff members stated they had been made aware of the resident ' s condition on 7/12/15 by Nurse # 1.	F 157	Revisions to this plan will be determined by the QA Committee.	
F 226	483.13(c) DEVELOP/IMPLMENT	F 226		8/21/15

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F 226 SS=D	Continued From page 4 ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, family interview and resident interview the facility failed to implement their neglect policy to assure a completed investigation was done for one (Resident # 1) of three sampled residents. The findings included: Review of the facility ' s policy on neglect revealed that the policy identified neglect as the " failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. " The policy directed that the facility staff would investigate neglect and formulate their findings into a report. The following information gathered from the resident ' s medical record and interviews revealed the facility failed to complete an investigation into the development of Resident # 1 ' s toe ulcer which was found to have maggots in it when it was initially identified by staff members to need treatment. Specifics details of the medical review and interviews are as follows. Review of Resident # 1 ' s closed record revealed the resident resided at the facility from his most recent readmission date of 2/13/15 until 7/13/15 upon which date he was discharged home. The resident had multiple diagnoses which included but were not limited to the following: Diabetes Mellitus Type 2; Gout; Neuropathy, Congestive	F 226	1. Corrective action accomplished for those residents found to have been affected by the alleged deficient practice: Resident #1 was discharged home with his wife on 7/13/15. Administrator was retrained on the Abuse and Neglect Policy on July 23, 2015 by the Regional Director of Operations. Investigation of alleged wound started on July 23, 2015 by DON and Administrator and was completed by 7/28/15. 2. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All incidents for the past 60 days were reviewed on 7/28/15 for completion and thoroughness by the DON/ADON/Unit Manager. All incidents investigations were complete and thorough. 3. Measures put into place to ensure that the alleged deficient practice will not recur: a. Nurses educated to report all incidents with outcomes requiring investigation including but not limited to falls with injury, resident altercations, allegations of abuse and neglect, elopements and identification	

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F 226	Continued From page 5 Heart Failure, Chronic Airway Obstructive Disease, Depression, and Lung Cancer. The resident was also documented as having problems with edema and mild venous stasis changes in his lower extremities. Interview with the DON (Director of Nursing) and administrator on 7/24/15 at 8:10 AM regarding the resident ' s diagnoses and medical status revealed that upon discharge the resident was optimistic about his future and hoped to live at home for an extended period of time and was considered stable in relation to his Lung Cancer. Review of the resident ' s most recent MDS (Minimum Data Set) assessment, dated 7/8/15, revealed the resident ' s abilities and status were coded in the following way: The resident was coded as having a score of 15 for his BIMS (Brief Interview for Mental Status) indicating he did not have cognitive impairment at the time of the interview; as not rejecting staff care during the assessment period; as being independent with bed mobility, transfers, and locomotion; as needing limited assistance with dressing; as needing supervision assistance for personal hygiene needs, and as needing physical help with part of his bathing. Review of the resident ' s care plan, last reviewed on 5/18/15, revealed the resident was identified to be at risk of skin breakdown secondary to impaired mobility, Diabetes, Gout, decreased range of motion in his left hand and because he had thin fragile skin. The care plan included multiple interventions which included but were not limited to the following: Skin Inspections routinely; treatment as ordered if indicated; and preventative skin care. Review of interdisciplinary notes revealed different notations related to the resident ' s cognitive abilities. Specifically on 7/9/15 at 12:07	F 226	of new pressure ulcers to DON/ADON in person or by phone and document on 24 hour report and on facility incident report began on 7/29/15. DON/ADON will report all incidents with outcomes requiring investigation to Administrator in person or by phone. Any nurse not receiving education by 8/21/15 will not be allowed to work until they have received education. b. DON/ADON/Unit Manager/Nursing Supervisor will review nurses 24 hour report daily for all incidents. Administrator will review facility incident reports Monday-Friday to ensure investigations are completed as needed. c. DON/ADON/SW to initiate investigation immediately. All investigations to be completed thoroughly and accurately within 5 days of incident. d. DON to maintain log of all incident dates, date investigation was initiated and date of completion of investigation with outcome. 4. How the facility plans to evaluate the effectiveness of the corrective action: DON/ADON will submit summary of immediate notification of incident to monthly Quality Assurance and Performance Improvement meeting x3 months then quarterly thereafter. Revisions to this plan will be determined by the QA Committee.	

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AM a nurse documented that the resident was " alert and oriented X 3. " On 7/12/15 at 3:25 AM another nurse documented that the resident " is alert and oriented to self and facility. He is forgetful and makes poor decisions. Able to make needs known but must rely on staff to anticipate some of his needs i.e. changes of cloths ... ... " Review of the resident ' s record revealed a physician ' s telephone order, dated 7/12/15, that arrangements were to be made for the resident to be seen by a consulting physician concerning his foot wound. Review of the resident ' s nursing notes and interdisciplinary notes from the date of 7/7/15 through 7/13/15 revealed no documentation that the resident had a foot wound, its condition, or that wound care was being provided to the resident. Review of the resident ' s June and July treatment records revealed no documentation that the resident had a wound of any nature. Review of the resident ' s June and July " skin inspection report " revealed that nurses had documented that the resident ' s skin was " intact " on 6/12/15, 6/16/15, 6/19/15, 6/26/15, 6/30/15, and 7/7/15. These entries were made by five different nurses. On one of the same days that a nurse noted the skin was intact, 6/12/15, the resident was also seen by a podiatrist. The podiatrist documented that the resident was developing ulceration to his right number 4th toe with mild erythema surrounding the area and some discharge noted. The podiatrist also noted " will treat per protocol. " Review of the attending physician ' s progress reports revealed that the resident ' s primary physician saw the resident on 6/19/15 and made no documentation that the resident had a skin wound or lesion. Interview with the DON on 7/24/15 at 8:10 AM revealed the podiatrist ' s protocol for wound treatment had never been

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obtained from the podiatrist or initiated by the facility on 6/12/15. The DON stated she called on 7/23/15 and obtained the protocol. Review of the protocol revealed that the podiatrist noted on 6/12/15 that the resident had an " ulceration developing to R # 4 dorsal toe " and that the wound care nurse should evaluate and treat the area with the approval from the primary physician.
The attending physician was interviewed on 7/24/15 at 8:45 AM and stated he saw the resident on 6/19/15. The physician stated that he routinely took a resident ' s socks off and looked at their feet and would have noted in his last progress report if the resident had a toe ulcer which he felt needed treatment. The physician was asked about the podiatrist notation of 6/12/15 which noted an ulceration was developing. The attending physician stated that with the diagnoses of venous insufficiency and Diabetes that the resident could have had some erythema and color changes which were noted by the podiatrist, but that as the attending physician he had not seen any wound during his exam on 6/19/15 which needed treatment.
Review of the 7/13/15 wound consultation report revealed the consulting physician noted Resident # 1 had a right third toe necrotic ulcer with a maggot found to be within the ulcer. The wound consulting physician documented, " This is an insulin dependent diabetic patient with some necrosis at the dorsal aspect of third right toe. Multiple maggots were found in his shoes and another one inside the toe ulcer. " The consulting physician further documented that there was " moderate " tunneling of the ulcer and that the maggots had debrided the ulcer.
The wound physician was interviewed by phone on 7/24/15 at 10:15 AM. The wound physician stated that on 7/13/15 he had found multiple

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maggots on the resident. He stated he removed a couple from his ulcer and that there were maggots on his clothes and in his right shoe. The physician stated the maggots were big. The physician stated he was not an expert on maggots but from his observation they appeared advanced in their stage of development. The wound physician stated that he would estimate them to be three or four days old. The wound physician stated that no test had been done or expert opinion gathered on that date to further verify the stage of the maggots.
The resident ' s family member, who was listed as the resident ' s responsible party, was interviewed on 7/23/15 at 11:45 AM by phone. The family member voiced concerns that the Diabetic resident ' s feet were not being assessed and felt the facility staff may have been negligent in his care. The family member stated that no one had been able to tell her how the resident had obtained the toe ulcer and how long it had been there. The family member stated she had no knowledge there was a toe ulcer or maggots within his ulcer prior to the date of 7/13/15. The family member stated that she went to the facility on the morning of 7/13/15 because the resident was supposed to be discharged home that day. The family member stated when she arrived to get the resident that she found the resident was not at the facility. The family member stated she was asked to have a seat in the lobby and shortly thereafter the resident arrived in the transport van. The family member stated that as the resident was assisted from the van into the facility, the resident told her that he had been to a doctor because he had maggots in his toe. The family member stated that the resident told her that he knew his toe was swollen but that he also had gout and that he had attributed the swelling

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of his toe to the gout. The family member stated that the resident also told her that the maggots had been found in his toe by a facility NA (Nurse Aide) prior to 7/13/15 and that a " whole bunch of things climbed out of his toe " when the NA had cared for him. The family member stated that after the resident told her about the issue, she went to the resident ' s room to collect his belongings and that she stopped to talk to Nurse # 1. The family member stated she asked Nurse # 1 how the resident ' s foot got to be in the condition it was found that day, and was told by the nurse that the resident ' s foot could get that way in a twenty four hour period. The family member stated that the nurse further stated that the maggots had been found in his house shoes he wore and that the resident would not let the staff check his feet every day.

The resident was interviewed also via phone on 7/23/15 directly following the interview with the family member. The resident stated that he thought it was Friday, which would have corresponded to 7/10/15, when his toe was hurting. He stated he was about to put his shoes on to go outside and his NA (nurse aide) looked at his toes before he put them on. The resident stated he knew his toe was swollen and hurt but that he couldn ' t see it that well. The resident stated he thought gout was causing the swelling and pain. The resident stated that when his NA checked his toe that things crawled out of it and that the NA left the room screaming. The resident stated that a nurse, whom he could describe but whom he could not identify by name, came and dressed his toe. The resident stated that he thought this same nurse checked on it Saturday and then changed it Sunday. The resident then stated he went to the wound clinic on Monday, 7/13/15, and it was found that a lot of black things

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were crawling in his shoe when they took the shoe off at the wound clinic.
Review of the resident ' s records revealed he last received a shower on the evening shift of 7/10/15. NA # 2, who was assigned to provide his shower assistance on that date, was interviewed on 7/23/15 at 2:55 PM. NA # 2 stated that on 7/10/15 the resident was not ready for his shower when she approached the resident on multiple times during the first part of her shift. NA # 2 stated the resident appeared irritated that she kept approaching him and offering. NA # 2 stated that when the resident became ready for his shower that he did almost all of the shower by himself. NA # 2 stated the resident sat in a shower chair but could stand independently to reach parts of his body which he needed to access to clean and that he stretched to bathe the lower part of his body while sitting in the chair. NA # 2 stated the only assistance she provided him was with washing his back. NA # 2 was asked if the resident washed between his toes and stated she didn ' t recall because she really didn ' t watch closely given the resident ' s independence in his care. Following the shower, NA # 2 stated the resident dried and dressed himself independently.
According to staffing records, NA # 1 was the dayshift NA assigned to care for Resident # 1 on Saturday (7/11/15) and Sunday (7/12/15). NA # 1 was interviewed on 7/23/15 at 1:05 PM. The NA stated that Resident # 1 was usually up when she arrived to work. NA # 1 stated that it had been Sunday, 7/12/15, on which the resident was first identified to have a problem with his toe. NA # 1 stated that the resident had turned on his call light for assistance on that date and when she answered his light, the resident told her that his toe was hurting and he needed to see the nurse.

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NA # 1 stated that she asked the resident if she could look at it so she could better inform the nurse of his need prior to getting her. NA # 1 stated that the resident was agreeable and when she looked at his foot that it appeared " gunky " between his 3rd and 4th toe; " like green stuff you get in your eyes when you sleep sometimes. " The NA stated she got a cleansing wipe in order to clean between his toes before getting the nurse. The NA stated as she was moving the wipe in and out from between his toes that " a whole lot of them " came out from between his toes. The NA clarified that she was referring to maggots when she stated " them. " The NA stated that she got sick on her stomach but did not want to upset the resident and so she covered the resident and went to get Nurse # 1 (the unit manager) and Nurse # 2 (the nurse assigned to do treatments for that day). NA # 1 was questioned if an administrative staff member had talked to her prior to the day on which she was speaking to the surveyor about what happened. The NA responded, " not until today. " NA # 1 stated that the Director of Nursing had called her to come to the facility, informed her she needed to write a statement and speak to the surveyor.

Nurse # 2 was interviewed by phone on 7/24/15 at 12 noon. Nurse # 2 stated that NA # 1 had asked her and Nurse # 1 to come and look at Resident # 1 ' s foot on Sunday, 7/12/15. Nurse # 2 stated that she and Nurse # 1 entered the room at the same time. Nurse # 2 stated when they entered the room that the resident had his shoe off and his pants on. Nurse # 2 stated she placed a towel beneath the resident ' s foot while he was on the bed and that she did not see anything crawling or moving. She looked between his toes and saw that he had a crusted area on his third

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toe which the nurse described as clean, intact, and not discolored. Nurse # 2 stated she helped to wash and dry the resident ' s feet. Nurse # 2 stated the resident did not appear to be in pain and she asked the hall nurse to call the physician. Nurse # 2 stated the hall nurse called the physician and obtained an order to have the resident evaluated the next day at the wound clinic. Nurse # 2 stated that there were two or three little black bugs on the bed but they were dead and not on the resident. The hall nurse stated she saw no more than the two dead ones. Nurse # 2 stated that after washing the resident ' s feet, she removed the towel from underneath the resident ' s feet and she placed the two dead bugs in the used towel. The nurse stated she then disposed of the towel by throwing it away in a sealed trash bag in the dirty laundry room. Nurse # 2 stated she did not know if the resident ' s bed linens were changed. Nurse # 2 stated she asked the resident if he had noticed anything when he put his shoes on that day and he had told her he had not. Nurse # 2 stated she did not look in his shoes on that date. Nurse # 2 described the resident as cooperative. Nurse # 2 was questioned by the surveyor if administrative staff members had talked to her prior to the date of the survey about what happened. Nurse # 2 stated she thought " yesterday " (7/23/15) was the first day they had tried to call and speak to her about the resident and what had transpired. The nurse stated that the Director of Nursing had called her and left a message.

Nurse # 1, who managed the unit on which Resident # 1 resided, was interviewed on 7/24/15 at 9:50 AM. Nurse # 1 stated that on Sunday, 7/12/15, NA # 1 had come to get both Nurse # 2 and her at the same time. Nurse # 1 stated that NA # 1 appeared upset and she talked to her a

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few minutes before entering the resident ' s room. Nurse # 1 stated when she entered that Nurse # 2 had already started to soak the resident ' s foot. Nurse # 1 stated that she looked at the resident ' s foot and did not see maggots on it. Nurse # 1 stated the resident ' s toe was pale-reddish and his skin was flaky, but there was no open area or drainage. Nurse # 1 stated she saw only one maggot on the bed. Nurse # 1 stated she asked the resident if he had bumped it or someone had rolled over his toe and Nurse # 1 stated the resident did not know. Nurse # 1 was asked if she had looked in the resident ' s shoes and stated that she had placed all her attention on the resident and his feet and had not looked in his shoes. Nurse # 1 stated the resident usually wore fuzzy slippers and would spend the majority of his time outside while wearing the slippers. Nurse # 1 stated Resident # 1 typically would be outside when she arrived at 7 AM and would be outside around 5 PM when she left for the day. Nurse # 1 was questioned by the surveyor if she had talked to the resident about whether the nurses had been checking his feet, and Nurse # 1 stated she did not ask the resident. Nurse # 1 stated she called and informed the Director of Nursing and the Administrator about the maggots on Sunday, 7/12/15.

Review of staffing sheets revealed Nurse # 3 was assigned as Resident # 1 ' s dayshift hall nurse for the dates of 7/11/5 and 7/12/15. Nurse # 3 was interviewed on 7/23/15 at 3:10 PM. Nurse # 3 stated that on Sunday, 7/12/15, the nurse supervisor (Nurse # 2) was doing wound care for all of Nurse # 3 ' s residents that day. Nurse # 3 stated that Nurse # 2 came and got her on that date and asked her to look at Resident # 1 ' s toe ulcer. Nurse # 3 stated Nurse # 2 kept saying there were bugs in his ulcer. Nurse # 3 stated that

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Nurse # 2 spread the resident ' s toes to show her and that there was a " bug. " Nurse # 3 stated Nurse # 2 instructed her to call the physician and Nurse # 3 stated she called and obtained an order for the resident to be seen by the wound clinic. Nurse # 3 stated that Nurse # 1 took care of the resident ' s foot that day and that she did nothing more in relation to foot care other than viewing his foot and calling to get an order for him to be seen at the wound clinic. Nurse # 3 described the resident as " sweet " and stated he would allow for his feet to be checked when they needed to be checked. Nurse # 3 stated that the Director of Nursing had asked her about the incident but that the supervisor was the one doing the care that day and she had limited knowledge of what had transpired.

As noted above the resident ' s attending physician was interviewed on 7/24/15 at 8:45 AM. During the interview the attending physician stated that the resident had a lot of predisposing medical conditions which might make an ulcer worsen quickly. The physician pointed out Diabetes, Gout, Mild Venous Stasis, and Edema as some examples of these. The physician stated he did not see the maggots when they were identified and therefore he could not comment on the maggots which had gotten into the resident ' s wound.

The DON (Director of Nursing) and administrator were interviewed on 7/23/15 at 1 PM. The DON stated that she talked to staff about the incident and would provide documentation of investigation into the matter. The DON stated she had found that the resident was assisted with his shower on 7/10/15 and there was no evidence of maggots on that date. The DON provided the surveyor with three statements; one from Nurse # 3; one from NA # 1 and one from NA # 2. As noted above

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during the interview with NA # 1 on 7/23/15 at 1:05 PM, NA # 1 informed the surveyor that 7/23/15 was the first date she had been requested to give a statement and questioned about the incident. During the survey, there was no further documentation of a completed investigation into the potential negligent care provided other than the three statements.
On 7/23/15 at 5 PM the resident ' s skin inspection report was reviewed with the DON. As noted above the review of this skin inspection sheet revealed five different nurses had documented that the resident ' s skin was " intact " during weekly skin assessments. Also as noted above one of the nurses had documented this entry on the date of 6/12/15; the same date on which the podiatrist had documented the resident had a wound on his 4th toe. The DON was questioned regarding whether she had spoken to that nurse about the discrepancy in her documented assessment versus the podiatrist and whether she had talked to the other nurses about the findings of their weekly skin assessments. The DON stated she had not talked to any of the nurses yet who had been responsible for the resident ' s weekly skin audits while investigating the incident. The DON was asked if she had determined by her investigation what had transpired between the date of 7/12/15 and 7/13/15 and why the maggots were not fully removed from the resident when they were initially identified on 7/12/15. The DON stated she would have to look into that.

The DON and administrator were interviewed on 7/24/15 at 8:10 AM. The DON and administrator stated that on Sunday, 7/12/15, they did not come into the building and look at the resident or maggots because Nurse # 1 had been present

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F 226	Continued From page 16 and made arrangements for the resident to be seen at the wound clinic the next morning. The administrator and DON stated that by 7/13/15 the resident was sent out very early to the wound clinic and upon his arrival back to the facility he had been discharged home. The Administrator and DON stated they had not talked to the resident or his family member about the situation and were not aware that the resident thought the issue had begun on 7/10/15. The administrator and DON stated they also had not talked to the wound physician to gather information related to the resident and his care or tried to identify what stage the maggots had been in when initially found.	F 226		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, resident, and family interviews for one (Resident # 1) out of five sampled residents the facility failed to provide the necessary care of assessing skin changes and treating a Diabetic resident ' s ulcer found to have maggots within it. The findings included: Review of Resident # 1 ' s closed record revealed the resident resided at the facility from his most	F 309	1. Corrective action accomplished for those residents found to have been affected by the alleged deficient practice: Resident #1 was discharged home with his wife on 7/13/15. 2. How corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice:	8/21/15

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F 309	Continued From page 17 recent readmission date of 2/13/15 until 7/13/15 upon which date he was discharged home. The resident had multiple diagnoses which included but were not limited to the following: Diabetes Mellitus Type 2; Gout; Neuropathy, Congestive Heart Failure, Chronic Airway Obstructive Disease, Depression, and Lung Cancer. The resident was also documented as having problems with edema and mild venous stasis changes in his lower extremities. Review of the resident ' s most recent MDS (Minimum Data Set) assessment, dated 7/8/15, revealed the resident ' s abilities and status were coded in the following way: The resident was coded as having a score of 15 for his BIMS (Brief Interview for Mental Status) indicating he did not have cognitive impairment at the time of the interview; as not rejecting staff care during the assessment period; as being independent with bed mobility, transfers, and locomotion; as needing limited assistance with dressing; as needing supervision assistance for personal hygiene needs, and as needing physical help with part of his bathing. Review of interdisciplinary notes revealed different notations related to the resident ' s cognitive abilities. Specifically on 7/9/15 at 12:07 AM a nurse documented that the resident was " alert and oriented X 3. " On 7/12/15 at 3:25 AM another nurse documented that the resident " is alert and oriented to self and facility. He is forgetful and makes poor decisions. Able to make needs known but must rely on staff to anticipate some of his needs i.e. changes of cloths ... ... " Review of the resident ' s nursing notes and interdisciplinary notes from the date of 7/7/15 through 7/13/15 revealed no documentation that the resident had a foot wound, its condition, or that wound care was being provided to the	F 309	a. Skin assessments of all residents was completed by nurses with documentation on Skin Assessment Form on 7/24/15. Attending physician and responsible party were notified of residents found to have any skin breakdown. b. All nurses will be educated on completing skin assessments and documentation. Any nurse not receiving education by 8/21/15 will not be allowed to work until they have been educated. All new nurses to the facility will receive education during orientation. c. All nursing assistants will be retrained by DON/ADON regarding identification of skin issues and timely reporting of any skin issues identified while providing care to residents. Any nursing assistant who is not able to attend the required training by 8/21/15 will not be allowed to work until retraining is completed. All new nursing assistants to the facility will receive education during orientation. 3. Measures put into place to ensure that the alleged deficient practice will not recur: a. Nurses will complete skin assessments and documentation on all residents weekly. b. DON/ADON/Unit Manager will audit weekly skin assessments and documentation to ensure completion. Any nurse that does not complete the assigned assessment and documentation timely will be counseled. c. Ambassador Rounds will be completed by designated staff including department managers Monday-Friday and manager-on-duty Saturday-Sunday to	

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F 309	Continued From page 18 resident. Review of the resident ' s June and July treatment records revealed no documentation that the resident had a wound of any nature. Review of the resident ' s June and July " skin inspection report " revealed that nurses had documented that the resident ' s skin was " intact " on 6/12/15, 6/16/15, 6/19/15, 6/26/15, 6/30/15, and 7/7/15. These entries were made by five different nurses. On one of the same days that a nurse noted the skin was intact, 6/12/15, the resident was also seen by a podiatrist. The podiatrist documented that the resident was developing ulceration to his right number 4 toe with mild erythema surrounding the area and some discharge noted. The podiatrist also noted " will treat per protocol. " Review of the attending physician ' s progress reports revealed that the resident ' s primary physician saw the resident on 6/19/15 and made no documentation that the resident had a skin wound or lesion. Interview with the DON on 7/24/15 at 8:10 AM revealed the podiatrist ' s protocol for wound treatment had never been obtained from the podiatrist or initiated by the facility on 6/12/15. The DON stated she called on 7/23/15 and obtained the protocol. Review of the protocol revealed that the podiatrist noted on 6/12/15 that the resident had an " ulceration developing to R # 4 dorsal toe " and that the wound care nurse should evaluate and treat the area with the approval from the primary physician. The attending physician was interviewed on 7/24/15 at 8:45 AM and stated he saw the resident on 6/19/15. The physician stated that he routinely took a resident ' s socks off and looked at their feet and would have noted in his last progress report if the resident had a toe ulcer which he felt needed treatment. The physician was asked about the podiatrist notation of 6/12/15 which noted an ulceration was developing. The	F 309	identify hygiene or environmental areas that may impact a resident. Any areas identified will be addressed immediately with appropriate staff and reported to the Administrator for follow-up with appropriate actions as deemed necessary. 4. How the facility plans to evaluate the effectiveness of the corrective action: a. DON/ADON will randomly complete skin assessments on 6 residents each week to verify the accuracy of the nurse's assessment. Any discrepancies noted at that time will be reviewed with employee with appropriate intervention as deemed necessary by the DON and physician to be notified for further orders as needed. b. DON/ADON will submit summary of audits and the Administrator will submit summary of Ambassador Rounds to monthly Quality Assurance and Performance Improvement meeting x3 months then quarterly thereafter. Revisions to this plan will be determined by the QA Committee.	

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attending physician stated that with the diagnoses of venous insufficiency and Diabetes that the resident could have had some erythema and color changes which were noted by the podiatrist, but that as the attending physician he had not seen any wound during his exam on 6/19/15 which needed treatment. Following 6/12/15, there was no documentation in the resident ' s record noting specifically an assessment of the resident ' s right 4th toe which had been identified to have skin changes. As noted above the nurses continued to document " skin intact " but made no notation about the 4th toe within the record.
Review of the resident ' s record revealed a physician ' s telephone order, dated 7/12/15, that arrangements were to be made for the resident to be seen by a consulting physician concerning his foot wound.
The resident ' s family member, who was listed as the resident ' s responsible party, was interviewed on 7/23/15 at 11:45 AM by phone. The family member stated that she went to the facility on the morning of 7/13/15 because the resident was supposed to be discharged home that day. The family member stated when she arrived to get the resident that she found the resident was not at the facility. The family member stated she was asked to have a seat in the lobby and shortly thereafter the resident arrived in the transport van. The family member stated that as the resident was assisted from the van into the facility, the resident told her that he had been to a doctor because he had maggots in his toe. The family member stated that the resident told her that he knew his toe was swollen but that he also had gout and that he had attributed the swelling of his toe to the gout. The family member stated that the resident also told her that the maggots had been found in his toe by a facility NA (Nurse

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Aide) prior to 7/13/15 and that a " whole bunch of things climbed out of his toe " when the NA had cared for him. The family member stated that after the resident told her about the issue, she went to the resident ' s room to collect his belongings and that she stopped to talk to Nurse # 1. The family member stated she asked Nurse # 1 how the resident ' s foot got to be in the condition it was found that day, and was told by the nurse that the resident ' s foot could get that way in a twenty four hour period.

The resident was interviewed also via phone on 7/23/15 directly following the interview with the family member. The resident stated that he thought it was Friday, which would have corresponded to 7/10/15, when his toe was hurting. He stated he was about to put his shoes on to go outside and his NA (nurse aide) looked at his toes before he put them on. The resident stated he knew his toe was swollen and hurt but that he couldn ' t see it that well. The resident stated he thought gout was causing the swelling and pain. The resident stated that when his NA checked his toe that things crawled out of it and that the NA left the room screaming. The resident stated that a nurse, whom he could describe but whom he could not identify by name, came and dressed his toe. The resident stated that he thought this same nurse checked on it Saturday and then changed it Sunday. The resident then stated he went to the wound clinic on Monday, 7/13/15, and it was found that a lot of black things were crawling in his shoe when they took the shoe off at the wound clinic.

Interviews were conducted with the following facility staff at the following times: NA (Nurse Aide) # 1 was interviewed on 7/23/15 at 1:05 PM; Nurse # 2 was interviewed on 7/24/15 at 12 noon; Nurse # 1 was interviewed on 7/24/15 at 9:50 AM;

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and Nurse # 3 was interviewed on 7/23/15 at 3:10 PM. According to staffing records these staff members roles were as follows: NA #1 was the resident ' s dayshift nurse aide on 7/11/15 and 7/12/15; Nurse # 2 was the dayshift supervisor and was doing wound care on 7/12/15; Nurse # 1 managed the unit on which the resident resided; and Nurse # 3 was the dayshift hall nurse assigned to care for the resident on 7/11/15 and 7/12/15. Information from the interviews is as follows:

The interview with NA # 1 revealed that on 7/12/15 the resident had complained of toe pain and had requested to see a nurse. NA # 1 stated that before she obtained the nurse she asked the resident ' s permission to look at his toe so she could better inform the nurse. NA # 1 stated she observed greenish drainage coming from his 3rd and 4th toes and started to clean between his toes with a cleansing wipe. NA # 1 stated that a lot of maggots crawled out from between the resident ' s toes when she began to clean them and she got sick to her stomach, covered the resident, and left the room. In a written statement which the NA later provided for facility records the NA wrote, " a pile of worms came out " when she cleaned between the resident ' s last toes. NA # 1 stated she immediately told both Nurse # 1 and Nurse # 2. The interviews with Nurse # 1 and # 2 revealed their assistance had been obtained because the NA reported the maggots to them.

During the interview with Nurse # 2, the nurse stated that she also saw two or three " dead bugs " on the resident ' s bed and that she had washed and dried the resident ' s feet and she saw no further evidence of them on the resident or his bed. Nurse # 2 also stated that the resident ' s toe appeared crusted but she saw no open area, and she had instructed the hall nurse

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to call the physician. Nurse # 2 stated there was a towel beneath the resident ' s feet while she provided care and that she had thrown the towel away in a sealed trash bag within the dirty utility room and had placed the dead bugs within it. Nurse # 2 stated she did not know if the resident ' s linens had been changed. Nurse # 2 also stated that she asked the resident if he had noticed anything wrong with his shoes but she did not look in the resident ' s shoes. Nurse # 1 stated Nurse # 2 had already started soaking the resident ' s feet when she entered the room and she did not see maggots when she assessed his feet. Nurse # 1 also stated she did not see an open toe ulcer and described the resident ' s toe as pale-reddish and flakey. Nurse # 1 stated she focused her attention on the resident ' s feet and did not look in his shoes. Nurse # 1 stated the resident routinely wore fuzzy slippers and sat outside a large portion of the day. Nurse # 3 stated she was called into the room on 7/12/15 only to observe the resident ' s toes because Nurse # 2 was the supervisor and was the nurse who had provided all the care. Nurse # 3 stated that Nurse # 2 spread the resident ' s toes on 7/12/15 and told her that the resident had bugs in his toes and to call the physician. Nurse # 3 stated she saw a bug when the resident ' s toes were spread and she called the physician and obtained an order for the resident to be seen at the wound clinic the next day. Nurse # 3 stated Nurse # 2 provided all the treatment to the resident on 7/12/15 and she had limited knowledge about what treatment was done for the resident and therefore thought Nurse # 2 would document the care and services provided. Review of the resident ' s 7/13/15 wound consult revealed the resident ' s 3rd toe was necrotic when it was assessed the following day by the

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wound physician and there was a maggot still in the ulcer. The wound consulting physician documented, " This is an insulin dependent diabetic patient with some necrosis at the dorsal aspect of third right toe. Multiple maggots were found in his shoes and another one inside the toe ulcer. " The consulting physician further documented that there was " moderate " tunneling of the ulcer and that the maggots had debrided the ulcer.

The wound physician was interviewed by phone on 7/24/15 at 10:15 AM. The wound physician stated that on 7/13/15 he had found multiple maggots on the resident. He stated they were in his clothes and his shoe. He stated he removed a couple from his ulcer. The physician stated the maggots were big. The physician stated he was not an expert on maggots but from his observation they appeared advanced in their stage of development. The wound physician stated that he would estimate them to be three or four days old. The wound physician stated that no test had been done or expert opinion gathered on that date to further verify the stage of the maggots.

As noted above the resident ' s attending physician was interviewed on 7/24/15 at 8:45 AM. The physician stated he did not see the maggots when they were identified and therefore he could not comment on the maggots which had gotten into the resident ' s wound.

The DON (Director of Nursing) was interviewed on 7/23/15 at 5 PM and questioned about the treatment and services provided to the resident following the identification of the problem with his toes on 7/12/15. The DON was unable to give details or documentation of the care the resident received and stated she would look into what happened. Interview with the administrator on

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F 309	Continued From page 24 7/24/15 at 12:15 PM revealed it would have been her expectation that linens would have been changed when the maggots were identified and that everything had been washed, but she was not aware why that had not transpired or what had been done.	F 309		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure medical records were complete and accurate for one (Resident # 1) of five sampled residents. The findings included: Review of the facility ' s policy on wound care revealed it directed that staff were to observe for " redness, induration, and purulent drainage ... " The wound care policy also noted that the nurses should " chart findings for comparison, indicate decline vs stability/improvement in wound. " Review of Resident # 1 ' s closed record revealed the resident resided at the facility from his most	F 514	1. Corrective action accomplished for those residents found to have been affected by the alleged deficient practice: Resident #1 was discharged home with his wife on 7/13/15. 2. How corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice: Audit of medical records by DON/ADON/Unit Manager of all residents identified with wounds completed by	8/21/15

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F 514	Continued From page 25 recent readmission date of 2/13/15 until 7/13/15 upon which date he was discharged home. The resident had multiple diagnoses which included but were not limited to the following: Diabetes Mellitus Type 2; Gout; Neuropathy, Congestive Heart Failure, Chronic Airway Obstructive Disease, Depression, and Lung Cancer. The resident was also documented as having problems with edema and mild venous stasis changes in his lower extremities. Review of the resident ' s June and July 2015 orders and treatment records revealed no documentation that the resident had any skin breakdown for which he was receiving treatment prior to the date of 7/12/15. On 7/12/15 a physician ' s telephone order was obtained which directed the staff to make arrangements for the resident to be seen by a consulting physician regarding his foot wound. Review of the 7/13/15 wound consultation report revealed the consulting physician noted Resident # 1 had a right third toe necrotic ulcer with a maggot found to be within the ulcer. The wound consulting physician documented, " This is an insulin dependent diabetic patient with some necrosis at the dorsal aspect of third right toe. Multiple maggots were found in his shoes and another one inside the toe ulcer. " The consulting physician further documented that there was " moderate " tunneling of the ulcer and that the maggots had debrided the ulcer. Interviews were conducted with the following staff at the following times: NA (Nurse Aide) # 1 was interviewed on 7/23/15 at 1:05 PM; Nurse # 2 was interviewed on 7/24/15 at 12 noon; Nurse # 1 was interviewed on 7/24/15 at 9:50 AM; and Nurse # 3 was interviewed on 7/23/15 at 3:10 PM. The interview with NA # 1 revealed that on 7/12/15 the resident had complained of toe pain and she had	F 514	8/14/15 to ensure accurate documentation, complete and up-to-date care plans, nursing assistant care guides, treatment sheets and shower sheets. 3. Measures put into place to ensure that the alleged deficient practice will not recur: a. All nurses to be educated on medical record documentation including timeliness, accuracy and expectations by DON/ADON. Any nurse not educated by 8/21/15 will not be allowed to work until they have been educated. b. Any nurse not documenting accurately in the medical record will be counseled. c. Nurses to enter all newly identified wounds into the Wound Communication Book to be reviewed by DON/ADON/Unit Manager Monday-Friday. d. Accuracy of documentation will be reviewed in the weekly Wound Meetings by DON/ADON/Unit Manager. e. All new and readmission charts to be reviewed in clinical meeting Monday-Friday for accuracy of wound documentation. f. Licensed nurse completing weekly wound rounds with wound care physician. 4. How the facility plans to evaluate the effectiveness of the corrective action: a. DON/ADON/Unit Manager to audit 5 charts daily Monday-Friday for 2 weeks, 10 charts weekly for 2 weeks, then 5 charts weekly thereafter for accurate medical record documentation. b. DON/ADON/Unit manager will submit summary of audits to monthly Quality Assurance and Performance Improvement meeting x3 months then	

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F 514	Continued From page 26 observed greenish drainage around his toes. NA # 1 stated during the interview that a lot of maggots crawled out from between his toes when she began to clean them. NA # 1 stated she had immediately told both Nurse # 1 and Nurse # 2. The interviews with Nurse # 1 and # 2 revealed their assistance had been obtained because the NA reported the maggots to them. During the interview with Nurse # 2, the nurse acknowledged that she also saw " dead bugs " on the resident ' s bed and that she had washed and dried the resident ' s feet and she saw no further evidence of the maggots. Different descriptions of the resident ' s toe were given by the nurses during the interviews. Nurse # 2 described the resident as having an area on his third toe which was crusted but not open during the interview. Nurse # 1 described the resident as having a toe which was pale-reddish and flakey but she stated she did not see an open area. Nurse # 3 stated that Nurse # 2 was the nursing supervisor for the date of 7/12/15 and she thought Nurse # 2 had documented about the resident ' s toes and maggots since she was the one who had provided care. Review of the resident ' s nursing notes and interdisciplinary notes from the date of 7/7/15 through 7/13/15 revealed no documentation that the resident had a foot wound, its condition, or that wound care was being provided to the resident. Review of the resident ' s June and July 2015 treatment records revealed no documentation that the resident had a wound of any nature. Review of the nursing notes and interdisciplinary notes revealed no documentation that the resident had a problem with maggots being found on his body or in his articles of clothing and attire and what measures were taken to address the maggots.	F 514	quarterly thereafter. Revisions to this plan will be determined by the QA Committee.	

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