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	345336	A. BUILDING _____ B. WING _____	C 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/22/22 through 8/25/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #M9LI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/22/22 through 8/25/22. The following intakes were investigated NC00192370, NC00192246, NC00192145, NC00191618, NC00191532, NC00191401, NC00190460, NC00189558, and NC00189297. One of the sixteen allegations was substantiated. Event ID# M9LI11. Past-noncompliance was identified at: F-925. CFR 483.90 at tag F925 at a scope and severity (J)	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code cognition (Resident #57 and Resident #52), dialysis (Resident #40), and Preadmission Screening and Resident Review (Resident #36) for 4 of 21 Minimum Data Set (MDS) assessments reviewed. The findings included:	F 641	F641 Date of compliance 9/20/2022 Corrective Action taken for those residents alleged to have been affected by the deficient practice are: A Quarterly Minimum Data Set (MDS) assessment dated 7/29/22 for resident #57 and a Significant Change MDS dated 7/22/22 for Resident #52 had inaccurate	9/20/22

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

Electronically Signed | 09/14/2022

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F 641	Continued From page 1 1. Resident #57 was admitted to the facility on 8/23/19 with diagnoses that included dementia. Resident #57 ' s quarterly Minimum Data Set (MDS) assessment dated 7/29/22 revealed she was rarely/never understood, and a Staff Assessment for Mental Status should be conducted but was not. During an interview with the MDS Coordinator on 8/24/22 at 3:10 PM she stated if a resident was not interviewable a staff assessment should be completed within the look-back period. She reported she had been on leave and the assessment was not completed while she was out. She further stated she was not able to complete the interview with the resident because the lookback period had already passed. An interview was conducted with the Administrator on 8/25/22 at 3:16 PM who stated staff should have completed the assessment for cognition to correctly complete Resident #57 ' s MDS assessment. 2. Resident #52 was admitted to the facility on 6/7/22 with diagnoses that included dementia. Resident #52 ' s Significant Change in Status Assessment Minimum Data Set (MDS) dated 7/22/22, revealed she was rarely/never understood, and a Staff Assessment for Mental Status should be conducted but was not. During an interview with the MDS Coordinator on 8/24/22 at 3:10 PM she stated if a resident was not interviewable a staff assessment should be completed. She stated the other MDS Nurse	F 641	coding of staff assessment for mental status. These were modified and corrected on 8/24/22. A Quarterly MDS assessment dated 7/1/22, did not indicate Resident #40 had received dialysis. This was modified and corrected on 8/24/2022. Resident #36's most recent Annual MDS assessment dated 11/24/2021 did not indicate there was a PASRR Level II determination. Diagnoses included schizophrenia and noted he had received antipsychotic medication daily. This was modified and corrected on 8/24/2022 Actions taken to identify other residents that may have been affected by the deficient practice are: MDS Assessments were audited on current residents with PASSR Level 2's to ensure accurate MDS coding and this was completed on 9/1/2022 by the facility MDS Coordinator. MDS Assessments were audited on current residents receiving dialysis to ensure accurate MDS coding and this was completed on 9/1/2022 by the facility MDS Coordinator. A Regional Consultant audited current residents' MDS assessments for accurate coding of the staff assessment completion based on the residents' cognition level to	

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F 641	Continued From page 2 completed this assessment prior to her resignation from the facility. An interview was conducted with the Administrator on 8/25/22 at 3:16 PM who stated staff should have completed the assessment for cognition to correctly complete Resident #52 ' s MDS assessment. 3. Resident #40 was admitted to the facility on 1/25/22 with diagnoses that included chronic kidney disease. Resident #40 ' s medical record revealed an order dated 2/9/22 for dialysis Monday, Wednesday, and Friday. Record review revealed Resident #40 attended dialysis on 6/24/22, 6/27/22, 6/29/22, and 7/1/22. A quarterly Minimum Data Set assessment dated 7/1/22, did not indicate Resident #40 had received dialysis. An interview was conducted with the MDS Coordinator on 8/24/22 at 3:10 PM who stated Resident #40 ' s assessment should have included receiving dialysis. She stated it was an oversight. An interview was conducted with the Administrator on 8/25/22 at 3:16 PM who stated Resident #40 ' s assessment should have been completed accurately to reflect her dialysis treatment.	F 641	ensure accurate MDS coding and this was completed on 9/2/2022 The measures the facility will take to ensure the problem will be corrected and will not reoccur: Education: The MDS coordinator was re-educated, by the facility Administrator, regarding the importance of accurately coding the MDS Assessments on 9/1/2022 The Regional MDS Consultant educated the facility MDS Coordinator on accurately cording the MDS related to Level 2 PASSR, staff assessment of mental status, dialysis coding, diagnosis and level of care by 9/14/2022. The MDS coordinator or the Regional MDS Consultant will complete an audit on current residents' MDS assessments to ensure the assessments are coded accurately and modified / corrected as applicable. This audit will be completed 3x a week for 4 weeks, then 2x a week for 2 weeks, then weekly for 4 weeks, and then monthly for 2 months. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: The MDS Coordinator or the MDS Regional Consultant will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3	

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F 641	Continued From page 3 4. Resident #36 had been admitted on 6/26/2020 with a diagnosis of schizophrenia. Preadmission Screening and Resident Review (PASRR, a resident identified as having a serious mental illness as defined by state and federal guidelines) Level II determination letters were observed in Resident #36's medical record. A PASRR Level II determination letter dated 2/23/2021 noted there was no expiration date. A care plan initiated on 8/31/2021 included information regarding Resident #36's PASRR Level II determination. A psychiatric follow up evaluation dated 10/15/2021 included a diagnosis of disorganized schizophrenia. Resident #36's November 2021 Medication Administration Record (MAR) indicated he had received risperidone (an antipsychotic medication) once daily for schizophrenia. Resident #36's most recent annual Minimum Data Set (MDS) assessment dated 11/24/2021 did not indicate there was a PASRR Level II determination. Diagnoses included schizophrenia and noted he had received antipsychotic medication daily. An interview with the MDS Nurse was conducted on 8/24/2022 at 4:05 PM. The MDS Nurse stated PASRR information was part of the resident record and was available for staff to review if needed. She explained she had been aware of Resident #36's PASRR Level II determination,	F 641	months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. The administrator is responsible for ensuring this plan of correction is implemented.	

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F 641	Continued From page 4 was unsure how she had overlooked it, and this had been an error. On 8/25/22 at 1:24 PM an interview with the Director of Nursing (DON) was conducted. The DON stated she would expect MDS assessments to be completed correctly.	F 641		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the	F 660		9/20/22

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F 660	Continued From page 5	F 660		

discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or

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F 660	Continued From page 6 resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review the facility failed to implement an effective discharge planning process that incorporated the resident as an active participant in the development of a discharge plan that focused on the resident ' s discharge goals for 1 of 1 resident reviewed for discharge planning (Resident #4). The findings included: Resident #4 was admitted to the facility on 7/18/19. Review of Resident #4 ' s plan of care last updated 7/13/22 revealed there was no care plan that addressed discharge planning. Resident #4 ' s most recent Minimum Data Set (MDS) assessment dated 8/5/22, a quarterly assessment revealed he was assessed as cognitively intact. He required set-up assistance with all activities of daily living. He was coded as planning on remaining in the facility. Review of the medical record revealed no documentation of discharge planning efforts. An interview was conducted with Resident #4 on 8/25/22 at 1:50 PM. He stated he found out the facility was planning to transfer him to another facility when he was approached by staff from	F 660	F660 Corrective Action taken for those residents alleged to have been affected by the deficient practice are: Resident #4 was admitted to the facility on 7/18/19. Review of Resident #4 ' s plan of care last updated 7/13/22 revealed there was no care plan that addressed discharge planning. Resident #4's most recent Minimum Data Set (MDS) assessment dated 8/5/22, a quarterly assessment revealed he was assessed as cognitively intact. He required set-up assistance with all activities of daily living. He was coded as planning on remaining in the facility. Review of the medical record revealed no documentation of discharge planning efforts. The facility Interdisciplinary team held a care plan meeting with Resident #4 to discuss and include this resident with possible discharge planning back into the community. Facility staff continue to work with resident #4 to find alternate placement into the community. The Care Plan for Resident #4 was modified and corrected by the facility MDS coordinator on 8/24/2022 Actions taken to identify other residents that may have been affected by the deficient practice are:	

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F 660	Continued From page 7 another facility asking him questions and telling him about their facility. Resident #4 stated this occurred three separate times with different staff members from other facilities. He explained the first visit occurred approximately two weeks ago when two staff from another facility approached him at 8:00 in the morning. He stated he believe it was an error. The resident stated visitors from a second facility approached him last week and there were visitors from a 3rd facility on 8/22/22. He stated he was interested in discharging to the community rather than another facility. He stated he had attended his care conferences and discharge planning had not been discussed. An interview was conducted with the Social Worker on 8/25/22 at 2:15 PM. The Social Worker reported she informed Resident #4 that staff from other facilities would be making visits to discuss the possibility of him transferring to their facility. She indicated she provided this information to the resident prior to the first visit occurring. She stated Resident #4 was very high functioning and would do well in an assisted living facility. The Social Worker stated the resident informed her after the visit from the 3rd facility he would prefer to transfer to the community in his own apartment. She acknowledged that there was no care plan that addressed discharge planning and there was no documentation regarding discharge planning in his chart. The Social Worker stated she began her employment at the facility on 7/19/22. She reported typically discharge planning would begin upon admission to the facility. The Social Worker stated she was instructed by the Administrator to work with Resident #4 to find a more suitable placement as he no longer met the criteria for skilled nursing.	F 660	Current in-house residents had the potential to be affected. On 09/02/22 the facility MDS Coordinator (MDSC) reviewed current facility residents to ensure their discharge planning process was incorporated into the residents' care planning process. The measures the facility will take to ensure the problem will be corrected and will not reoccur: It is the responsibility of the IDT to incorporate the Resident in the discharge planning and care plan process. Education: The Director of Nursing, Assistant Director of Nursing, Unit Managers, Dietary Manager, Activity Director, Social Service Director, and the Therapy Program Director were educated on the discharge planning process, documentation requirements, discharge planning policy, F-660 Federal regulation, and requiring an interdisciplinary team (IDT) approach for effective discharge planning by the facility Administrator on 9/6/2022. New admissions will be reviewed by the next business day by the Interdisciplinary Team at the Clinical meeting to ensure the discharge planning process has been started and the resident and or responsible party is an active participant. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Director, or MDSC will audit residents that are planning to discharge	

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F 660	Continued From page 8 During an interview with the Administrator on 8/25/22 at 2:30 PM she stated when she began employment at the facility on 7/1/22 she identified that Resident #4 no longer met the criteria for skilled nursing services. She reported the facility was assisting with finding him a more suitable placement. The Administrator stated she was not sure why discharge planning did not begin when Resident #4 was admitted to the facility. She stated efforts to find placement for Resident #4 should be reflected in his medical record and care plan. The Administrator indicated she expected Resident #4 would be involved in the discharge planning process and the resident ' s goals would be discussed.	F 660	from the facility to ensure the discharge planning process is in place and completed prior to discharge. These audits will be conducted weekly for four weeks and then monthly for three months. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: The audits will be presented to the facility Quality Assurance and Performance Improvement meeting monthly x 3 months. by the Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Services Director, Staff Development, or MDS Coordinator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The administrator is responsible for ensuring this plan of correction is implemented.	
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for	F 661		9/20/22

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F 661	Continued From page 9 release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a recapitulation of stay for 1 of 1 resident reviewed for a planned discharge from the facility (Resident #64). The findings included: Resident #64 was admitted to the facility on 6/20/22 with diagnoses that included hypertension and diabetes mellitus. He was discharged from the facility on 7/1/22 to the community. Review of Resident #64's record revealed he was discharged home on 7/1/22. Review of Resident #64 ' s recapitulation of stay revealed the area for diet and mood and behavior were not addressed. Goals listed in the recapitulation for stay read in part, "Resident will verbalize understanding of dietary regimen and	F 661	F661 Corrective Action taken for those residents alleged to have been affected by the deficient practice are: Resident #64's record revealed he was discharged home on 7/1/22. Review of Resident #64's recapitulation of stay revealed the area for diet and mood and behavior were not addressed. A dietary progress note dated 6/23/22 revealed a recommendation for 30 millimeters of liquid protein to aid with protein replacement. Resident no longer resides in the facility and was safely discharged home.	

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F 661	Continued From page 10 restrictions". A dietary progress note dated 6/23/22 revealed a recommendation for 30 millimeters of liquid protein to aid with protein replacement. An interview was conducted with the facility Social Worker on 8/23/22 at 2:56 PM who stated she was new to the facility and has not had a discharge since she started. She reported the Admissions Coordinator fulfilled the social work responsibilities while the facility was without a social worker. During an interview with the Admissions Coordinator on 8/23 at 3:00 PM she stated the interdisciplinary team completed the recapitulation of stay. She stated she was unsure who would complete the mood/behavior section of the form. An interview with the Unit Manager on 8/24/22 at 11:23 AM stated the reason the dietary recommendation was not placed in the recapitulation of stay was the physician had not reviewed them. She was unsure why there was no dietary information on the recapitulation of stay. The Unit Manager stated she believed the Social Worker would complete the mood/behavior area of the form. An interview was conducted with the Administrator on 8/25/22 at 3:16 PM who stated the recapitulation of stay should be completed for planned discharges. She reported they had some staff turnover and that could be why sections of Resident #64 ' s discharge recapitulation of stay form was not completed.	F 661	Actions taken to identify other residents that may have been affected by the deficient practice are: Current residents planning to be discharged have the potential to be affected. Discharges from 8/25/22 through 09/13/22 have been reviewed, by the Social Services Director, with confirmation of the completion of the discharge summary process addressed. The measures the facility will take to ensure the problem will be corrected and will not reoccur: Education: The Administrator provided education and training to the Social Service Director, Director of Nursing, Assistant Director or Nursing, Unit Managers, MDS Coordinator (MDSC), Admission Coordinator and Staff Development on the Discharge Summary process that includes the IDT approach for discharge summary, documentation, F-661 federal regulation, and requiring of comprehensive summary that shows the discharge plan and a recapitulation of stay on 9/6/2022. Staff Development Coordinator, DON, ADON, or Unit Manager provided education on the discharge summary process and documentation to the Licensed Nurses by 9/16/2022. Education included the review of the sections of the Discharge Summary that are expected to be completed prior to marking complete in the medical record.	

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F 661	Continued From page 11	F 661	Ongoing audits by the Social Services Director, DON, ADON, Unit Managers, MDSC and/or Staff Development Coordinator for observation and review to ensure the discharge summary process is completed and includes current required sections for discharged residents. These audits will be conducted weekly for four weeks and then monthly for three months. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: The audits will be presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Social Services Director, DON, ADON, Unit Manager, or Staff Development. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The administrator is responsible for ensuring this plan of correction is implemented.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:	F 867		9/20/22

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F 867	Continued From page 12 Based on staff interviews and medical record review, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor those interventions the committee put in place following the 10/2/19 recertification survey. This was for a recited deficiency in the areas of accuracy of assessments (F641) and discharge summary (F661). Accuracy of assessments was cited again on the complaint survey of 1/27/21, the complaint survey of 3/4/21, the recertification survey of 6/18/21, and the current recertification survey of 8/25/22. Discharge summary was cited again on the current recertification survey of 8/25/22. The continued failure of the facility during five federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This citation is crossed referenced to: F641 Accuracy of Assessments: Based on staff interviews and record review the facility failed to accurately code cognition (Resident #57 and Resident #52), dialysis (Resident #40), and Preadmission Screening and Resident Review (Resident #36) for 4 of 21 Minimum Data Set (MDS) assessments reviewed. During the recertification survey of 10/2/19 the facility was cited at F641 for failing to accurately code the Minimum Data Set (MDS) assessments for mental cognition for 4 of 27 residents, failed to accurately code for anticoagulants for 1 of 1 resident reviewed and failed to code the diagnosis 1 of 3 residents reviewed for indwelling	F 867	F867 Corrective Action taken for those residents alleged to have been affected by the deficient practice are: Signature Home Office Clinical Staff and Regional Clinical leaders assisted with the review and evaluation of the statement of deficiencies (SOD) and in the development of the plan of correction (POC). Actions taken to identify other residents that may have been affected by the deficient practice are: All residents have the potential to be affected. The measures the facility will take to ensure the problem will be corrected and will not reoccur: On 9/6/22, the Vice President of Regulatory provided education and training to the Facility Administrator regarding the QAPI process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. On 9/06/22 the Administrator provided education and training to the Social Service Director, Director of Nursing, Assistant Director or Nursing, Unit Managers, MDS Coordinator (MDSC), Admission Coordinator and Staff Development on the QAPI process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. on 9/6/2022.	

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F 867	Continued From page 13 catheters. During the compliant survey of 1/27/21 the facility was cited at F641 for failing to accurately code the Minimum Data Set (MDS) assessment in the area of behaviors for 2 of 11 residents whose MDS assessments were reviewed. During the complaint survey of 3/4/21 the facility was cited at F641 for failing to accurately code pressure ulcers and height on the admission Minimum Data Set assessment for 1 of 8 residents reviewed for accuracy of assessments. During the recertification survey of 6/18/21 the facility failed to accurately code the admission Minimum Data Set (MDS) assessment and the annual Minimum Data Set assessment in the areas of Preadmission Screening and Resident Review (PASARR) for 1 of 1 resident reviewed. F661 Discharge Summary: Based on record review and staff interviews the facility failed to complete a recapitulation of stay for 1 of 1 resident reviewed for a planned discharge from the facility (Resident #64). During the recertification survey 10/2/19 the facility was cited at F661 for failing to complete a recapitulation of stay discharge summary for 1 of 1 resident reviewed for discharge. An interview was conducted with the Administrator on 8/25/22 at 3:16 PM. She indicated she was head of the facility ' s QAA Committee. She reported she and the Director of Nursing recently started employment with the facility. She reported there had been some turnover in positions such as the social worker	F 867	Quality Assurance plan to monitor facility performance to make sure corrections are achieved: An Ad Hoc QAPI meeting was held on 9/6/2022, to review the alleged deficient practice cited and implement a Plan of Correction. This meeting included the Administrator, DON, ADON, Unit Manager, MDS Coordinator, Social Services Director, and the Medical Director. The QAPI team will meet weekly for (4) weeks starting on 09/20/22, then monthly until substantial compliance is obtained, to monitor the implementation of the POC, including the education component and the ongoing audit component, to evaluate the effectiveness of the POC and if necessary, provide additional education and request additional audits / reports. The Administrator is responsible for ensuring this plan of correction is implemented.	

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F 867	Continued From page 14 which may have led to the recapitulation of stay not being completed.	F 867		
F 925 SS=J	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on record review, facility staff, Emergency Department Physician's Assistant, Outpatient Clinic Nurse, Dialysis Nurse Manager, and Medical Director interviews, the facility failed to control the presence of flies in the facility resulting in a maggot infestation of a resident's wound for 1 of 6 residents (Resident #263) reviewed for wound care. On 7/30/22 Resident #263's left lower leg wound was infested with maggots. She presented to the emergency department with approximately 60-65 maggots in her left lower extremity wound. The findings include: Resident #263 was admitted to the facility on 5/13/22 with diagnoses that included end stage renal disease (receiving dialysis 3 times weekly), cellulitis (skin infection) of the left lower extremity, diabetes, and peripheral vascular disease (reduced blow flow to limbs). A progress note dated 7/11/22 at 12:35 pm written by Nurse #3 revealed Resident #263 was transported to the emergency department for evaluation of altered mental status. A review of the Pest Control Logs indicated the	F 925	Past noncompliance: no plan of correction required.	

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Pest Control Company visited the facility on 7/18/22. All fly traps in resident hallways were checked. No abnormal findings were noted during the service call.

A progress note dated 7/20/22 at 5:40 pm written by the facility's Corporate Nurse Consultant revealed Resident #263 was admitted back to the facility with an order for a cardiology appointment on 7/29/22.

A Physician's order dated for 7/20/22 revealed an order to cleanse left lower extremity with an antiseptic cleaner, pat dry, apply a petroleum-based dressing to wound bed, and wrap with rolled dressing daily.

The 5-day Minimum Data Set (MDS) assessment dated for 7/27/22 indicated Resident #263 was moderately impaired for cognition and required extensive assistance from 1-2 facility staff members to complete activities of daily living. The Resident was coded as receiving dialysis during the MDS assessment period. She was also coded as being diagnosed with venous ulcers (open areas on skin due to abnormal vein function).

Resident #263's July 2022 Medication Administration Record revealed the wound dressing treatment for the left lower extremity was signed off by the Resident's assigned nurse once daily as ordered by the Physician from 7/20/22-7/30/22.

An interview was completed on 8/24/22 at 3:00 pm with Nurse #4. She indicated she was assigned to Resident #263 on dayshift on 7/28/22. The Nurse stated she provided wound care as prescribed to the Resident's left lower

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extremity. She revealed she did not observe maggots in the wound during the dressing change. Nurse #4 revealed she did observe 2 flies in Resident #263's room. The Nurse stated she did not observe them in the room during the dressing change. She stated she made the Assistance Maintenance Director aware of the discovery after observing the flies. The Nurse stated he visited the room and used a fly swatter to get rid of them.

An interview was completed on 8/24/22 at 3:06 pm with the Assistant Maintenance Director. He indicated he recalled a Nurse (Nurse #4) notifying him of flies in a resident's room around the week of 7/28/22. The Assistant Maintenance Director stated he went to the resident's room and used a fly swatter to rid the room of flies. He was unable to recall what room it was in. He further stated if there had been an abundance of flies, the facility would have had contacted pest control immediately to come into spray.

An interview was completed on 8/22/22 at 11:05 am with Nurse #1. She revealed the nurses assigned to Resident #263 completed the Resident's daily wound dressing treatments because the facility did not have a Wound Treatment Nurse. Nurse #1 stated she completed the Resident's scheduled wound dressing treatment on 7/29/22 during the day shift. The Nurse revealed she did not observe maggots in the Resident's wound during the dressing change. She indicated the previous wound dressing was always intact and never loose prior to removing it to apply a new dressing. She further stated the wound bed contained dark colored tissue with minimal amount of drainage. She indicated she did not observe any flies in the

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room during the Resident's dressing change. Nurse #1 stated it took her approximately 10 minutes to complete the dressing change to Resident #263's left lower extremity. Nurse #1 stated when she provided wound care to the Resident, she had all supplies needed in the Resident's room, and closed the door during the dressing change. She indicated she observed the Resident's room prior to starting wound dressing changes for flies. The Nurse further stated Resident #263 only left her room to attend appointments or go to dialysis. Nurse #1 revealed the facility provided fly swatters at the nurse's station if needed.

An interview was completed on 8/22/22 at 2:28 pm with Nurse #6. The Nurse indicated she was assigned to provide care to Resident #263 during nightshift beginning on 7/29/22 and ending in the morning on 7/30/22. She revealed when she prepared the Resident for transport to dialysis on the morning of 7/30/22 Resident #263's left lower extremity dressing was dry, intact, and secure prior to her leaving the facility. Nurse #6 indicated she did not observe flies in the Resident's room during her shift. She revealed the facility has fly swatters available throughout the facility to use if 1-2 flies are observed. Nurse #6 stated if an increase in flies were observed she notified the Administrator and placed the location in the Pest Control Company's logbook (binder located at each Nurse's station the Pest Control Technician checks each visit for any insect/pest activity).

A progress note dated 7/29/22 at 4:04 pm written by Nurse #1 indicated the Resident was out of the facility at a Vascular appointment.

An interview was completed on 8/23/22 at 9:30

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am with a Nurse from a Heart and Vascular Care outpatient clinic. She indicated Resident #263 had an appointment on 7/29/22. The Nurse further revealed the Resident was being seen for a cardiology appointment. She stated Resident #263's wound was not visualized by the Physician.

A progress note on 7/30/22 at 1:07 pm written by Nurse #3 revealed while prescribed wound dressing treatment was being provided larva (immature form of insect) was observed. The Physician was notified and advised the Nurse to call emergency medical services and send Resident #263 to the emergency department for evaluation and treatment.

An interview was completed on 8/23/22 at 11:11 am with Nurse #3. She indicated she was assigned to provide care to Resident #263 during dayshift on 7/30/22. She stated after Resident #263 returned from dialysis; she went in to change her dressing. Nurse #3 indicated the previous wound dressing to the left lower extremity was dry, intact, and secure and stated when she removed the dressing, she observed 2-3 maggots in the wound bed. The Nurse revealed she cleaned the wound, provided the prescribed wound treatment, and contacted the Physician to make him aware of the Resident's change in condition. The Nurse stated the Physician gave her an order to send the Resident to the emergency department for evaluation and treatment. Nurse #3 indicated she had not observed flies in the Resident's room during her shift.

A review of Resident #263's emergency room record revealed a progress note dated 7/30/22

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indicating
maggot infestation present to her left lower extremity wound. Resident #263 was treated at the hospital for an infection of the left lower extremity wound with intravenous fluids and antibiotics.

An interview was completed on 8/22/22 at 7:30 pm with the admitting Physician Assistant (PA) at the emergency department. The PA indicated Resident #263 arrived at the emergency department with her bilateral wounds covered with dry, intact dressings. He stated when the dressings were removed 60-65 maggots were observed in the left lower extremity wound. The PA stated the maggots were removed, the wound was cleaned, and a wound dressing was applied. He indicated maggots invading a wound had the potential to cause an infection.

A review of the Pest Control Logs indicated the Pest Control Company visited the facility on 8/1/22. The log indicated a fly spray was applied to all entrance/exit doorways and facility hallways. No sanitation issues or pest control concerns were noted during the visit.

An interview was completed on 8/23/22 at 2:16 pm with the Administrator. She indicated the pest control company was contacted the next business day to visit to spray for flies. She stated the company visited on 8/1/22 and sprayed all entrance/exit doorways and facility hallways. The Administrator revealed the Pest Control company last visited on 7/18/22. The technician checked all fly traps in resident hallways. No abnormal findings were noted during the service call. She further indicated the pest control company was contracted to visit the facility monthly to spray for

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pests. The Administrator stated the facility hallways have fly lights located on all the hallways that attract and trap flies and fly swatters for immediate use. She indicated the facility management staff were assigned resident rooms and complete daily morning room rounds. The Administrator stated staff had been educated to immediately notify maintenance and herself of any increase in fly activity. She revealed these rounds consist of checking for insects and any items that would attract insects. The Administrator stated the findings from the room rounds were discussed during the facility's morning meeting and any concerns were handled immediately.

An interview was completed on 8/23/22 at 4:47 pm with the Medical Director. He indicated Resident #263 was admitted to the facility with cellulitis (skin infection) in her left lower extremity and bilateral lower extremity venous ulcers. The Medical Director stated the left lower extremity wound had an odor and he felt this and the multiple trips the Resident made to dialysis, a fly may have been attracted to the dressing and flown under it. He further stated the Resident was diagnosed with venous and arterial insufficiency that had impeded the healing of the wound. The Medical Director indicated he felt the facility had provided proper wound care and had notified him of all changes in the wound and in the Resident's health.

An interview was completed on 8/24/22 at 9:20 am with Nurse #5. She indicated she had observed Resident #263's dressing to her left lower extremity appeared loose once after receiving a dialysis treatment, but she stated it was not recently and was unable to recall the

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dates. Nurse #5 stated she had never observed the wound being exposed when she returned from dialysis. The Nurse continued to state she reinforced the dressing if she was able or removed the loose dressing and applied a new one. The Nurse indicated the Resident did not touch or attempt to remove her dressing. Nurse #5 stated she had never observed flies in Resident #263's room.

An interview was completed on 8/22/22 at 4:28 pm with the Dialysis Nurse Manager. The Nurse indicated she had been able to observe the dressings to Resident #263's bilateral lower extremities during her dialysis treatments. She indicated the dressings were always dry, intact, and secure. The Nurse further stated due to the dialysis process, the Resident's swelling in her lower extremities lessens and may cause the dressings to loosen. She continued to state the wounds were never exposed during her dialysis treatments and she never observed the dressing to be loose.

A review of Resident #263's electronic medical record revealed she resided on the 300 hall during her stay at the facility. An observation was completed on 8/25/22 at 12:05 pm and revealed it was located across from an entrance/exit door.

An observation was completed on 8/25/22 at 12:10 pm of the fly fan above the entrance/exit door located across from the room Resident #263 resided. The fan was blowing out.
An interview was completed on 8/22/22 at 3:30 pm with Resident #53. He indicated there were 2-3 days in the last month that 1-2 flies were in his room. He stated he did not notify staff because he felt it was not a problem.

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An interview was completed on 8/23/22 at 8:39 am with Resident #44. She stated she had 1-2 flies in her room in the last 1-2 months. The Resident indicated facility staff had a fly swatter to get rid of the fly.

An observation was completed on 8/24/22 at 9:30 am of a fly flying out of room 300. A second fly was also observed flying in the Resident hallway. A facility staff member was observed going to get a fly swatter to attend to the fly.

An observation was completed on 8/25/22 at 1:40 pm of a fly swatter located at the 200 hall nurse's station and 300 hall nurse's station.

During an interview on 8/24/22 at 3:06 pm with the Assistant Maintenance Director. The Assistant Maintenance Director stated the flies entered the facility through the entrance/exit doors. He indicated fly lights were located on all facility hallways and fly fans were placed above entrance/exit doors. The Assistant Maintenance Director revealed the Pest Control company visited monthly to inspect the fans and lights. He stated fly swatters were located throughout the facility for staff to use when needed.

An interview was completed on 8/24/22 at 4:25 pm with the Regional Plant Operations Manager. He indicated fly lights were located on each resident hallway. He further stated pest control checks the traps when they visit monthly to determine if any additional spaying for insects needed to be performed during that visit.

The Administrator was notified of Immediate Jeopardy on 8/24/22 at 8:44 am.

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The facility provided the following corrective action plan with a completion date of 8/3/22.
On 7/30/22, Resident noted with foreign matter to the left leg wound bed that appeared to possibly be maggots. Resident had a cardiology appointment on 7/29/22 that she was transported to and from. Resident returned to the facility after the appointment with a progress note related to the visit with no documentation of any maggots being found during the examination. The Resident also goes out for dialysis treatments three days per week.

Element 1 - (Resident(s) Affected) - On 07/30/22 this Resident had left lower extremity wound cleansed per Licensed Nurse, MD notified of findings and ordered resident to be examined at hospital. Resident was sent to the hospital as ordered on 07/30/22. The resident did not return to this facility.

Element 2 - (Other Residents who could have been affected)

a) On 07/30/22 current facility residents received a skin check and residents with skin integrity issues were assessed by licensed staff to visibly observe for any presence of foreign matter present to the impaired skin integrity areas. No concerns were identified. On 07/31/22 and again on 08/01/22 current facility residents received an additional skin check and residents with skin integrity issues were assessed by licensed staff to visibly observe for any presence of foreign matter present to the impaired skin integrity areas. No concerns were identified.

b) On 07/30/22 the provision of treatments was

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	345336	A. BUILDING _____ B. WING _____	C 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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
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validated through direct observation, by licensed staff for the current resident population who had skin integrity issues had treatment completed and ordered dressings intact. No concerns were identified. This was observations validated by the Director of Nursing, Assistant Director of Nursing, and the Unit Manager.

Element 3 - (Action the entity will take to alter the process or system)

a) Pest Control arrived at the facility per request of the facility Administrator for additional prophylactic treatment on 8/1/22. Pest Control did not find any pest activity during the onsite visit on 8/1/22. They also documented there were no sanitation issues that could cause pest control issues. Pest Control comes to the facility monthly for pest control inspection and treatment that is for flies and other insects and or pests.

b) Education was provided to full-time, part time, agency, and as needed staff on 07/30/22 regarding the following: If anyone notices an abundance / increase (such as droppings, infestations, swarms) of insects, flies, gnats will notify maintenance and place in the pest control book and make the Administrator aware. Also, education was provided to full-time, part time, agency, and as needed staff regarding ensuring all foods are closed in containers or in plastic bags and education was provide on the origin of where maggots come from (flies laying eggs) and that it only takes one fly to cause maggots in a wound. This education was provided by the Director of Nursing, the Assistant Director of Nursing, and the Unit Manager. The pest control book is a book located on nursing station one that staff are to log information on any increased pest

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activity. The staff will log the pest, location, time, and person reporting. The pest control service looks at this book at each visit. Air curtains were already in place at the facility along with fly lights and fly traps.

Element 4 - (Quality Assurance and Performance Improvement)

a) Ad Hoc QAPI completed with Medical Director and the facility Administrator, Director of Nursing, and the Unit Manager on 08/01/22.

b) Administrator reviewed audits of skin checks that were done on 07/30/22, 07/31/22, and 08/01/22. No concerns identified.

c) The QAPI team, during monthly QAPI meetings, will discuss any concerns that arise related to (r/t) any maggots being observed or found in the facility and any pest control issues observed or voiced.

d) All staff are alert for monitoring fly presence and will utilize the pest control book and notify the Administrator if any concerns are noted with fly presence.

e) Pest Control comes to the facility monthly. During the monthly pest control visits the pest control service provides the following services r/t flies: observes and changes out the fly lights, observes and changes out glue boards, monitors for any increased sign of flies.
The facility Administrator is responsible for implementing this plan.

Alleged Date of compliance: 08/03/22

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Onsite validation was completed on 8/25/22 through staff interviews, observations, and record reviews. Inservice was confirmed to be provided on identification of flies and areas of concern that would attract flies and notification process. Staff were interviewed to validate the in-service was completed on insect control. Review of education conducted with Nurse #7 regarding steps to take if an increase in flies were observed and what were areas in the facility that may attract flies was completed. Skin checks of residents on 7/30/22, 7/31/22, 8/1/22 were reviewed with no concerns noted. A review of the wound treatment audit completed on 7/30/22 revealed no concerns.

An interview was completed on 8/25/22 at 10: 30 am with Nurse #8. She indicated if she observed a fly in a resident's room, she would use attempt to use a fly swatter to get rid of the fly, notify the maintenance department, and the Administrator.

An interview was completed on 8/25/22 at 2:10 pm with Nursing Assistant #1. She stated the facility had fly swatters available for use. NA #1 indicated if she observed flies in the facility, she would immediately let the Administrator and the maintenance department know and write the location of the flies in the pest control logbook.

An observation was completed on 8/25/22 at 3:00 pm of hallway 300. Fly lights were located on hallway and in working order.

An observation was completed on 8/25/22 at 3:10 pm of hall 100's entrance/exit door. A fly fan was observed attached above the door and blowing out.

An observation was completed on 8/25/22 at 3:15

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F 925	Continued From page 27 pm of the Pest Control Logbook located at the 100 hall nurse's station. An interview was completed on 8/25/22 at 4:08 pm with Nurse #7. She indicated if she observed flies in a resident's room, she would immediately contact the maintenance department. Nurse #7 stated she would then attempt to locate the source that was attracting the flies (open food, drink) and attempt to remove it. The Nurse stated fly swatters were available for use to immediately get rid of the flies. Nurse #7 stated prior to completing a wound dressing change she would observe the room for flies and get rid of them if some were observed. The Nurse also stated she always closed the door during wound dressing changes. The facility's corrective action plan was validated to be completed as of 8/3/22.	F 925		