	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			TE SURVEY
			A. DOILDING			С
		345164	B. WING		c	5/30/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	)E	
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER		1341 PARADISE ROAD		
				EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	D		
		the three complaint				
F 580 SS=D	Notify of Changes (In CFR(s): 483.10(g)(14	jury/Decline/Room, etc.) )(i)-(iv)(15)	F 58	0		6/14/24
	consult with the resid consistent with his or representative(s) whe (A) An accident involve results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-the clinical complications (C) A need to alter tree a need to discontinue treatment due to advec commence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and provi- physician. (iii) The facility must a	rediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring n; ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or ); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any,				

**Electronically Signed** 

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

06/13/2024

		ID HUMAN SERVICES MEDICAID SERVICES			FC	FED: 06/27/2024 RM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		345164	B. WING			C 05/30/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
		REHABILITATION CENTER		1341 PARADISE ROAD		
CHOWAN	RIVER HORSING AND I			EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE / CROSS-REFERENCED 1	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 580	State law or regulation (e)(10) of this section (iv) The facility must in update the address (in phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite di §483.5) must disclose its physical configural locations that comprise part, and must specific room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record rev physician interviews for notification to the phy upon initial observant dressing of a heel wor three residents review change in condition. If Resident #1 was adm	10(e)(6); or ent rights under Federal or ins as specified in paragraph trecord and periodically mailing and email) and resident osite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced iew, family, staff, and the facility failed to provide riscian and responsible party ce of maggots in and on the pund for one (Resident #1) of wed for notification of a	F 5		was provided a by the nurse with rsing assistant. ent representative nd status. The by the physician for a wound n treatment	
	peripheral neuropath and diabetic foot ulce Nurse #2 was intervie PM and again at 2:33	ewed on 5/29/2024 at 12:39 8 PM. Nurse #2 revealed the		On 5/16/24, the Director the unit manager comple skin checks on all reside This audit was to identify concerns to include wou	eted head to toe ents with wounds. y any skin inds with larvae to	
	events upon a secon	ccurring and reconfirmed the d interview. Nurse #2 stated AM to 7:00 PM shift and was		ensure the physician and representative were not change. There were no	fied of acute	

Facility ID: 923018

If continuation sheet Page 2 of 16

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		TE SURVEY
						С
		345164	B. WING			)5/30/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
				1341 PARADISE ROAD		
CHOWAN	RIVER NURSING AND F	REHABILITATION CENTER		EDENTON, NC 27932		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLETIO DATE
F 580	Continued From page	e 2	F 58	0		
		Resident #1. Nurse #2 stated 3:30 PM to 4:00 PM and she		concern identified during th	ne audit.	
		nce of NA #2 to hold up the		On 5/29/24, the Director of	Nursing	
		ident #1 to perform wound		initiated skin checks on all	residents	
		ound. Nurse #2 stated she		residing in the facility for si	-	
		iser on the bandage to soak		symptoms of acute change		
		ndage. Nurse #2 stated as		not limited to new/worsenir	-	
		dage a maggot dropped		wounds with larvae. This a		
		underneath the heel. Nurse ember of Resident #1 walked		ensure the physician and r representative were notifie		
	into the room while w			changes. The Director of N		
	provided. Nurse #2 s	<b>U</b>		Assistant Director of Nursir		
	-	nen the maggot dropped		all concerns identified durin	•	
		A #2 so as not to alert the		include notification of the p	-	
	family member in the	room. Nurse #2 stated she		resident representative wh	en indicated	
		s than 20 maggots on the		with documentation in the		
	-	of Resident #1. Nurse #2		record and education of sta		
		ut all the maggots and		was completed by 5/30/24.		
		ell with the wound cleanser		Or  (20/24) the Administra	ton initiated	
		e wound care orders and ng. Nurse #2 stated after		On 5/29/24, the Administra questionnaires with all aler		
		e approached NA #2 and told		residents regarding acute of		
	-	s in the wound of Resident		emphasis on changes not		
		and find the DON to tell her.		previously addressed by st	•	
		f this occurred on 5/14/2024.		but not limited to new skin		
		did notify the DON who told		ensure the resident was as		
	her she, the DON, we	ould take care of everything		physician/resident represe		
		e family of Resident #1.		notified of the acute chang		
		went back to her nursing		Administrator and Director	-	
		and left the notification of the		address all concerns identi	-	
		nily to the DON. Nurse #2		questionnaires to include n		
	stated the only error	fication of the DON of the		the physician and resident when indicated with docum	•	
	-	d and dressing. Nurse #2		electronic record and educ		
	stated she recalled th	-		The audit was completed b		
		I the date on the bandage			, <u></u>	
		Iurse #2 indicated she spoke		On 05/29/24, the Director	of Nursing	
	-	on 5/16/2024 in the morning		reviewed all current resider	-	
		he did perform the dressing		notes for the past 14 days.		

Facility ID: 923018

		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		( )	E SURVEY IPLETED
						С
		345164	B. WING		0	5/30/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CHOWAN	RIVER NURSING AND F	REHABILITATION CENTER		1341 PARADISE ROAD EDENTON, NC 27932		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	FCORRECTION	(X5)
PREFIX TAG	1	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLÉTIO DATE
F 580	Continued From pag	e 3	F 58	30		
	change on 5/14/2024	l and she did see maggots in		of the audit is to ensure the	nat the physician	
		ing on that day. Nurse #2		and resident representativ	ve were notified	
		rform wound care on		of all acute changes with		
		2024 but, she knew the		in the electronic record. T		
		wound care orders were		Nursing will address all co		
	completed after Resi	dent #1 took a shower.		identified during the audit notification of the physicia		
	NA #2 was interview	ed on 5/29/2024 at 2:50 PM.		representative with docur		
		the 3:00 PM to 11:00 PM		electronic record when in		
		le was assigned to care for		education of staff. The au		
		stated Nurse #2 requested		completed by 5/30/24.		
		g Resident #1 for wound				
	care. NA #2 revealed	when she was holding the		On 5/29/24, the Director of	of Nursing	
		1, a maggot dropped down		initiated an in-service with		
		heel, but she did not know		regarding (1) Observation		
		ne. NA #2 stated she did not		Acute Changes with emp		
		nd, nor did she see any other		prompt complete assessr		
	maggots. NA #2 reite			resident's slight or subtle immediate notification of the second		
		the left leg and that was confirmed a family member		ensure adequate manage		
	did enter the room du			resident's acute illness or		
	treatment on that day	•		a chronic illness. (b) notifi		
	-	und care she removed the		resident representative w		
		#2 revealed Nurse #2		resident condition to inclu		
	approached her in th	e hallway and asked her if		limited new skin concerns	or larvae on	
		s that dropped onto the pad		skin with documentation i		
		2 told her she did not know,		record (2) Events that Re		
		er it was a maggot. NA #2		of the Administrator and [		
		#2 told her to go find the		but not limited to larvae in		
		out the maggot. NA #2 stated		In-services will be comple		
		ON, but the DON had already returned to her nurse aide		After 5/30/24, any nurse v received this in-service w		
	duties.			to beginning their next sc		
				newly hired nurses will be		
	NA #1 was interview	ed on 5/29/2024 at 12:15		during orientation by the		
		her initial morning rounds		Development Coordinator		
		00 PM shift, as she was			. ,	
		1 with care, she observed a		The ADON, Unit Manager	rs and Minimum	
	maggot in the bed ne	ear the left foot of Resident		Data Set (MDS) nurse wil	l review	

Facility ID: 923018

If continuation sheet Page 4 of 16

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE	CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		COMF	PLETED
			D MINIO				С
		345164	B. WING			05	/30/2024
NAME OF P	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
CHOWAN	RIVER NURSING AND R	REHABILITATION CENTER			341 PARADISE ROAD DENTON, NC 27932		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	:	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETIO
F 580	Continued From page	e 4	F 5	80			
		on the floor. NA #1 could not			progress notes 5 x per week x 4 week	(S.	
		occurred. NA #1 revealed she			then monthly x 1 month to identify act		
		l this to the Unit Manager			changes in condition to include but no		
		way. NA #1 stated Nurse #1			limited to new/worsening wounds or		
		of Resident #1, saw the			wounds with larvae weekly x 4 weeks		
		o notify the DON while NA #1			monthly x 1 month, utilizing the Acute		
		threw the maggots in the			Change Audit Tool. This audit is to en	sure	
	occurred.	d not recall what day this			the resident was assessed for acute change, the physician was notified of	all	
					changes in condition to include	all	
	Nurse #1 was intervie	ewed on 5/29/2024 at 12:37			new/worsening wounds, wounds with		
	PM. Nurse #1 stated	as soon as she clocked in			larvae or residents who refuse		
	for the day on 5/16/20	024 she was notified by NA			care/treatments for further		
		room of Resident #1, and			recommendations and the resident		
	she went to the room				representative was notified of the acu	te	
	observed a maggot o				change with documentation in the		
	confirmed she notifie	to the shower room to			electronic record. The Unit Managers address all areas of concern identified		
	assess the wounds o				during the audit, including assessmen		
	administer wound car				the resident, notification of the		
					physician/resident representative of th	ne	
	The DON was intervi	ewed on 5/29/2024 at 11:35			acute changes, and staff re-training. T		
	AM. The DON stated	Resident #1 was reported to			DON will review the Acute Change Au	ıdit	
		rved on the bed and another			Tool weekly x 4 weeks to ensure all a	reas	
		she herself never saw them.			of concern are addressed.		
		on 5/16/2024 she was not in			The DON will proceed the finding of the	ha	
	•	notified Certified Nursing Ind the maggots in the room			The DON will present the findings of t		
		DON revealed she came to			Acute Change Audit Tool to the Qualit Assurance Performance Improvemen		
		told by NA #1 she observed			(QAPI) committee monthly for 2 month		
	-	oor and one on the blanket in			for review to determine trends and/or		
		#1 close to his left heel			issues that may need further intervent	tions	
		ed to the DON she had			put into place and to determine the ne	ed	
		aggots away in the garbage N stated she spoke with			for further frequency of monitoring.		
	Nurse #2, the nurse a						
	Resident #1 from 7:0						
	5/16/2024 and was to	-					
	completed wound car	re for Resident #1, and she					

Facility ID: 923018

If continuation sheet Page 5 of 16

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 06/27/2024 MAPPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345164	B. WING			_		C 30/2024
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER			341 PARADISE ROAD			
				E	DENTON, NC 27932			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 580	the RP arrived at the f in her office and inform maggots observed in well as the steps that reoccurrence of magg then called the physic to inform him of the m nursing staff. The DON was reintern PM. The DON was reintern PM. The DON was reintern PM. The DON was ac aware of the one mag the floor observed by DON stated when she 5/16/2024 she assum performing wound car morning of 5/16/2024 that time. An interview was comparty (RP) for Resider AM. The RP for Resider AM. The RP for Resider following information. RP came to visit Resi morning. When the R was notified by the Di maggot had been obs on the foot of Resider #1 asked the DON wit do about it and what s	gots. The DON stated when facility, she spoke with him med him of the maggot or the bed and on the floor as were being taken to prevent gots. The DON stated she tian (MD #1) for Resident #1 haggot observations by the viewed on 5/29/2024 at 1:50 damant she was only made got on the bed and one on NA #1 on 5/16/2024. The e spoke with Nurse #2 on ed she was talking about re for Resident #1on the and observing a maggot at ducted with the responsible nt #1 on 5/29/2024 at 11:13	F	580				
	the RP, Resident #1 v shower and the room be deep cleaned to fir or maggots. The Administrator was	was going to be taken to the of Resident #1 was going to nd the source of the maggot s interviewed on 5/29/2204 inistrator confirmed Nurse						

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345164	B. WING			C / <b>30/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER		1341 PARADISE ROAD EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	<ul> <li>#2 should have called the physician immedia maggots on 5/14/202/ confirmed that the res #1 should have notifie well.</li> <li>Documentation in a p dated 5/16/2024 reve most recent wound ca morning, a few hours potentially having in h formation. Since that inspected and thoroug It is doing well. On my there is no evidence of The patient is not sep baseline. He denies a is any significant deco heel or left heel woun</li> <li>MD #1, the physician interviewed on 5/30/2 stated he would have 5/14/2024 if maggots wound of Resident #1 been notified of 5/14/2 to the facility to visual sure the wound was of #1 stated he came to and observed the left MD #1 stated all the v heel wound, looked g be infected. MD #1 stated</li> </ul>	the Director of Nursing and ately upon visualizing the 4. The Administrator also sponsible party for Resident ed as soon as possible as hysician's follow up note aled in part, "Reviewed are notes. Alerted this ago, of the patient his left heel some maggot time, the wound has been ghly cleansed and dressed. y inspection this afternoon, of any maggot formation. tic or toxic. He appears at any pain. I do not think there omposition in his sacral right ds."	F 58	30		
F 684 SS=D		, it was not currently good	F 68	34		6/14/24

If continuation sheet Page 7 of 16

TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345164	B. WING		0	C 5/30/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
СНОМАИ		REHABILITATION CENTER		1341 PARADISE ROAD		
ononan				EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	TION SHOULD BE COMPLETI THE APPROPRIATE DATE	
F 684	applies to all treatment facility residents. Bas assessment of a resident that residents receive accordance with profe practice, the compre- care plan, and the residence This REQUIREMENT by:	are ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered sidents' choices.	F 68			
	physician interviews t if a higher level of car maggots were observ (Resident #1) of three professional standard Findings included: Resident #1 was adm 4/4/2024 with multiple included Type 2 Diab peripheral neuropath and diabetic foot ulce Resident #1 had a ph 4/8/204 for the left he	ved in a heel wound for one e residents reviewed for ds of care for wounds. hitted to the facility on e diagnoses some of which etes Mellitus with diabetic y, chronic kidney disease, ers. hysician's order initiated on eel ulcer to be cleaned with		On 5/16/24, resident #1 was p shower and wound care by the the assistance of the nursing a The physician and resident re- were notified of the wound star resident was assessed by the and seen at the hospital for a check with no changes in trea orders. Resident #1 no longer the facility. On 5/16/24, the Director of Nut the unit manager completed h skin checks on all residents w This audit was to identify any s concerns to include new or wounds	e nurse with assistant. presentative tus. The physician wound tment resides in rrsing and ead to toe ith wounds. skin prsening	
	of Aquacel Ag to the of dry dressing every of Aquacel Ag is a steril that contains ionic silv antimicrobial agent. Documentation on a of dated as completed 5	wound cleanser, application wound bed, and cover with a her day and as needed. e, soft, non-woven dressing ver, a broad-spectrum wound ulcer flow sheet 5/10/2024 revealed Resident heel wound 6.2 inches in		wounds or wounds with larvae ensure the resident was asses nurse, the physician and resid representative notified of acut new orders/interventions initia indicated with documentation electronic record. There were areas of concern identified dur audit.	ssed by the ent e change, ted when in the no other	

If continuation sheet Page 8 of 16

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	G		E SURVEY PLETED
			A. DOILDING	·		С
		345164	B. WING		05	5/30/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
0.10.10.1				1341 PARADISE ROAD		
CHOWAN	RIVER NURSING AND F	REHABILITATION CENTER		EDENTON, NC 27932		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED DEFIC		COMPLETIO DATE
F 684	Continued From page	e 8	F 68	34		
	length, 7.8 inches in	width, and an undefined		On 5/29/24, the Directo	r of Nursing	
	depth.			initiated skin checks on		
		<b>.</b>		residing in the facility fo		
		e Treatment Administration		symptoms of acute cha	•	
		mentary documentation 1:13 PM for Resident #1		not limited to new/worse wounds with larvae. Thi	-	
	revealed wound care			ensure all residents ide		
	administered by Nurs			an acute change have b		
				the nurse, the physiciar		
	Nurse #4 was intervie	ewed on 5/30/2024 at 8:40		representative notified of		
		ed she had worked in the		new orders/intervention		
		and 5/12/2024 for the 7:00		indicated with documen		
		Nurse #4 revealed she had		electronic record. The E		
	-	rt when she arrived at 7:00		and Assistant Director of	-	
		facility was in between I there would not be a wound		address all concerns ide audit to include assessr	•	
		lity to perform wound care		resident, notification of		
		12/2024 as scheduled.		resident representative,		
		she performed wound care		orders/interventions wh		
	for Resident #1 to inc	clude his left heel wound on		education of staff. The a	audit was	
		stated she did not see any		completed by 5/30/24.		
		eel wound and the wound				
		#4 stated she did not see		On 5/29/24, the Adminis		
		ntil late on 5/12/2024 when cility after a visit out with his		questionnaires with all a residents regarding acu		
		ed Resident #1 returned to		emphasis on changes r	•	
		024 with his dressing intact		previously addressed b		
	and she did not note	-		but not limited to new sl	•	
				Administrator and Direc		
		vas interviewed on 5/29/2024		address all concerns ide	-	
		vealed she was assigned to		questionnaires to includ		
		on 5/12/2024 for the 7:00		the resident, notification		
		NA #1 stated she assisted		and resident representation		
		g dressed on 5/12/2024 prior nily at approximately 8:00		and education of staff.		
	-	turn to the facility on her shift		completed by 5/30/24.		
		aled both dressings were				
	-	ould have told the nurse if		On 05/29/24, the Direct	or of Nursing	
		not intact prior to Resident #1		reviewed all current res		

Facility ID: 923018

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVE	8-03 Y
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	COMPLETED	
					С	
		345164	B. WING		05/30/20	24
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
CHOWAN	RIVER NURSING AND R	REHABILITATION CENTER		1341 PARADISE ROAD		
_		-		EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE COM	(X5) PLETIC DATE
F 684	Continued From page	e 9	F 68	4		
	leaving the facility on	5/12/2024.		notes for the past 14 da	ays. The purpose	
				of the audit is to ensure		
		e TAR dated 5/14/2024 and		documented acute cha		
		lurse #2 administered		were assessed by the i		
	wound care for the le	ft heel of Resident #1.		representative and phy		
	Numer #2 uses intervie	wed an 5/20/2024 at 12:20		notified, new orders/int		
		ewed on 5/29/2024 at 12:39 3 PM. Nurse #2 revealed the		when indicated with do		
		ccurring and reconfirmed the		electronic record. The l will address all concerr		
	-	d interview. Nurse #2 stated		the audit to include ass	Ū.	
		AM to 7:00 PM shift and was		resident, notification of		
		Resident #1. Nurse #2 stated		resident representative		
	-	3:30 PM to 4:00 PM and she		orders/interventions wh		
	obtained the assistan	ice of NA #2 to hold up the		education of staff. The	audit was	
		ident #1 to perform wound		completed by 5/30/24.		
		ound. Nurse #2 stated she				
		ser on the bandage to soak		On 5/29/24, the Directo	•	
		ndage. Nurse #2 stated as		initiated an in-service w		
		dage a maggot dropped		regarding (1) Observat		
	-	Inderneath the heel. Nurse		Acute Changes with en	-	
	into the room while w	ember of Resident #1 walked		immediate notification		
	provided. Nurse #2 s	-		acute changes to inclue new or worsening would		
	-	ien the maggot dropped		larvae for further recom		
		A #2 so as not to alert the		assessment of the resid		
		room. Nurse #2 stated she		interventions when indi	-	
		than 20 maggots on the		of the resident represe		
		of Resident #1. Nurse #2		documentation in the e		
	-	ut all the maggots and		Treatments with empha		
		ell with the wound cleanser		responsibility of comple	eting treatments per	
		e wound care orders and		physician order in the a		
		ng. Nurse #2 stated after		treatment nurse, comp		
	-	e approached NA #2 and told		assessments when ind		
		in the wound of Resident		of the physician if resid		
	-	and find the DON to tell her.		treatment or treatment		
		f this occurred on 5/14/2024.		completed as ordered a		
		did notify the DON who told		of treatment on the eTA also included that when		
	including talking to th	ould take care of everything		of the facility for an app		

Facility ID: 923018

If continuation sheet Page 10 of 16

	S FUR MEDICARE &	MEDICAID SERVICES				10. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
		345164	B. WING		0	C 5/30/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	5/50/2024
				1341 PARADISE ROAD		
CHOWAN	RIVER NURSING AND F	REHABILITATION CENTER		EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETIC DATE
				DEFICIENCY)		
F 684	Continued From page	e 10	F 68	4		
		went back to her nursing		nurse should complete treatme	ntunon	
		and left the notification of the		return to the facility unless othe		
		nily to the DON. Nurse #2		ordered by the physician and (		
	stated the only error	•		that Require Notification of the		
		fication of the DON of the		Administrator and DON to inclu	ida but nat	
	-			limited to larvae in wounds. In-		
	stated she recalled th	d and dressing. Nurse #2				
				will be completed by 5/30/24. A		
		I the date on the bandage		5/30/24, any nurse who has no		
		lurse #2 indicated she spoke		this in-service will receive it price		
	-	on 5/16/2024 in the morning		beginning their next scheduled		
		he did perform the dressing		newly hired nurses will be in-se	ervice	
	-	and she did see maggots in		during orientation by the Staff	2)	
	stated she did not pe			Development Coordinator (SD0		
		2024 but, she knew the		On 05/29/4, the Assistant Direc		
		wound care orders were		Nursing (ADON), Staff Develop		
	completed after Resid	dent #1 took a shower.		Coordinator (SDC), and weeke supervisor initiated an in-service		
	Review of the nursing	g notes documentation on		nursing assistants regarding O	bservation	
	5/14/2024 and 5/16/2	2024 did not reveal any		and Reporting Acute Changes	to include	
	documentation of the	observance of maggots on		(1) Examples of acute changes	to include	
	or near the wounds for	or Resident #1.		but not limited to new skin cond	cerns or	
				pests noted on or around wour		
	NA #2 was interview	ed on 5/29/2024 at 2:50 PM.		dressings, or residents (2) imm	ediately	
	NA #2 confirmed on t	he 3:00 PM to 11:00 PM		reporting acute changes to the		
	shift on 5/14/2024 sh	e was assigned to care for		In-service will be completed by		
	Resident #1. NA #2 s	stated Nurse #2 requested		After 05/30/24, any nursing ass		
	her help in positioning	g Resident #1 for wound		has not worked or completed th	ne	
		when she was holding the		in-service will complete upon n	ext	
		1, a maggot dropped down		scheduled work shift. All newly		
		heel, but she did not know		nursing assistants will be in-se		
	· ·	e. NA #2 stated she did not		orientation regarding Observati		
		nd, nor did she see any other		Reporting Acute Changes.		
	maggots. NA #2 reite	-				
		the left leg and that was		The ADON, Unit Managers will	review	
		confirmed a family member		progress notes 5 x per week x		
	did enter the room du			then monthly x 1 month utilizing		
	treatment on that day	-		Change Audit Tool. This audit is	-	
		und care she removed the		acute changes in condition to in		

Facility ID: 923018

If continuation sheet Page 11 of 16

TATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
	CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING			C
		345164	B. WING		0	5/30/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER		1341 PARADISE ROAD EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	trash from room. NA a approached her in the she knew what it was below the heel. NA # and Nurse #2 told he then revealed Nurse a DON and tell her abo she looked for the DO left for the day so, she duties. NA #1 was interviewed PM. NA #1 stated on for her 7:00 AM to 3:0 assisting Resident #1 maggot in the bed ne #1 and one maggot of recall what day this of immediately reported (Nurse #1) in the half came into the room of maggots, and went to stripped the bed and garbage. NA #1 could occurred. Nurse #1 was interview PM. Nurse #1 stated for the day on 5/16/20	e 11 #2 revealed Nurse #2 e hallway and asked her if t that dropped onto the pad 2 told her she did not know, r it was a maggot. NA #2 #2 told her to go find the ut the maggot. NA #2 stated DN, but the DON had already e returned to her nurse aide ed on 5/29/2024 at 12:15 her initial morning rounds D0 PM shift, as she was with care, she observed a ar the left foot of Resident in the floor. NA #1 could not ccurred. NA #1 revealed she this to the Unit Manager way. NA #1 stated Nurse #1 f Resident #1, saw the o notify the DON while NA #1 threw the maggots in the a not recall what day this ewed on 5/29/2024 at 12:37 as soon as she clocked in D24 she was notified by NA room of Resident #1, and	F 68	<ul> <li>not limited to new/worsen wounds with larvae to ens was assessed by the nurs and resident representativa cute change, new orders initiated when indicated w documentation in the elect The ADON and Unit Mana address all concerns idem audit to include assessme resident, notification of the resident representative, ir interventions when indicated documentation in the elect and re-training of staff. The view the Acute Change per week x 4 weeks, then month to ensure all concerns addressed.</li> <li>The DON will forward the Audit Tools to the Quality Performance Improvemer Committee monthly x 2 m and to determine trends a that may need further interview interventions and to determine trends a that may need further interview interview</li></ul>	sure the resident se, the physician ve notified of s/interventions vith ctronic record. agers will titified during the ent of the e physician and nitiation of ted with ctronic record he DON will Audit Tools 5 x monthly x 1 erns were Acute Change Assurance nt (QAPI) nonths for review and / or issues erventions put ne the need for	
	she went to the room observed a maggot o confirmed she notifier accompanied NA #1 assess the wounds o administer wound car The DON was intervie	of Resident #1 and n the bed. Nurse #1 d the DON and to the shower room to f Resident #1 and				

If continuation sheet Page 12 of 16

				E CONOTRUCTION			
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         345164       345164			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		A. BUILDING		с			
		B. WING			05/30/2024		
		STREET ADDRESS, CITY, STATE, ZIP CODE			5/30/2024		
	OVIDER OR SUPPLIER				ODE		
HOWAN	RIVER NURSING AND R	REHABILITATION CENTER		1341 PARADISE ROAD EDENTON, NC 27932			
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		(XE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 684	Continued From page	e 12	F 684	4			
		ved on the bed and another	1 00	-			
		she herself never saw them.					
	•	on 5/16/2024 she was not in					
		notified Certified Nursing					
	Assistant (NA) #1 fou	ind the maggots in the room					
		DON revealed she came to					
	•	told by NA #1 she observed					
	one maggot on the floor and one on the blanket in						
	the bed on Resident #1 close to his left heel						
	wound. NA #1 reported to the DON she had already thrown the maggots away in the garbage						
	-	N stated she spoke with					
	Nurse #2, the nurse a	-					
	Resident #1 from 7:0	•					
	5/16/2024 and was to						
	completed wound car	re for Resident #1, and she					
		ggots. The DON stated she					
	•	ident #1 taken to the shower					
		re body cleaned, his wounds					
	assessed, and his wo						
		ated she had the room of					
		aned to include the floor,					
	any food or snacks th	and cabinets. The DON said					
		ditional food was put in a					
		iner. The DON stated that in					
		ded boot Resident #1 wore					
		ON stated when the RP					
	arrived at the facility,	she spoke with him in her					
	office and informed h						
		the bed and on the floor as					
	-	were being taken to prevent					
		gots. The DON stated she					
		cian (MD #1) for Resident #1 naggot observations by the					
	nursing staff.	aggor observations by the					
	-						
	An interview was con	ducted with the responsible					

Facility ID: 923018

If continuation sheet Page 13 of 16

CENTER STATEMENT (	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			PRINTED: 06/27/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
245464		345164	B. WING			С		
		545104				05/	30/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER		341 PARADISE ROAD EDENTON, NC 27932				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	RP came to visit Resi morning. When the R was notified by the Di maggot had been obs on the foot of Resider #1 asked the DON wh do about it and what s so that it does not hap the RP, Resident #1 w shower and the room be deep cleaned to fir or maggots. The RP r taken to the emergent the wound because h there might be more r not being done proper Documentation in the 5/16/2024 revealed R emergency room for a at the request of his F facility with no new or The DON was intervite AM. The DON stated and confirmed Nurse but less than 20 magg of Resident #1 on 5/11 The DON denied Nurse tell her about the mag Resident #1 on 5/14/2 occurrence of her bein morning of 5/16/2024 actions she took on th have the wound asset the deep cleaning of the	dent #1 revealed the A couple of weeks ago the dent #1 in the facility in the P arrived at the facility he rector of Nursing (DON), a served by the nursing staff int #1. The RP of Resident nat the facility was going to steps were going to be taken open again. The DON told was going to be taken to the of Resident #1 was going to nd the source of the maggot requested Resident #1 be cy room for assessment of e was greatly concerned maggots or wound care was rly at the facility. nursing notes dated tesident #1 was sent to the an evaluation of his wounds RP and returned to the ders. ewed on 6/30/2024 at 8:30 she spoke with Nurse #2 #2 had told her she saw 10 gots on the left heel wound 4/2024 during wound care. se #2 had contacted her to gots seen in the wound of 2024 and that the first	F 684					

Facility ID: 923018

If continuation sheet Page 14 of 16

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPU	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				A. BUILDING		
						С
		345164	B. WING	05/30/2024		
NAME OF P	ROVIDER OR SUPPLIER		\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHOWAN	RIVER NURSING AND	REHABILITATION CENTER		1341 PARADISE ROAD EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 684	Continued From pag	e 14	F 684			
		known of the maggots. The				
	DON stated when sh	ne spoke with Nurse #2 on				
		ned Nurse #2 was talking				
	about performing wound care for Resident #1on the morning of 5/16/2024.					
	Documentation in a	physician's follow up note				
	dated 5/16/2024 revealed in part, "Reviewed					
		care notes. Alerted this				
	morning, a few hours ago, of the patient					
	potentially having in his left heel some maggot formation. Since that time, the wound has been					
		ughly cleansed and dressed.				
		y inspection this afternoon,				
		of any maggot formation.				
		ptic or toxic. He appears at				
	baseline. He denies any pain. I do not think there is any significant decomposition in his sacral right					
	heel or left heel wou					
	MD #1, the physiciar	n for Resident #1, was				
		2024 at 9:30 AM. MD #1				
	stated he would have	e wanted to be notified on				
		s were found in the left heel				
		1. MD #1 stated if he had				
		/2024 he would have come alize the wound and to make				
	-	cleaned appropriately. MD				
		he had a picture or at least a				
		n 5/14/2024 so that he could				
		nd was cleaned appropriately				
		atment that was provided for				
		aggots in the left heel wound #1 confirmed he came to the				
		and observed the left heel				
	-	#1. MD #1 stated all the				
		e left heel wound, looked				
		pear to be infected. MD #1				
		prically maggots had been				

Facility ID: 923018

If continuation sheet Page 15 of 16

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 06/27/202 FORM APPROVE OMB NO. 0938-039	D
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345164		B. WING			C 05/30/2024		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER		1341 PARADISE ROAD EDENTON, NC 27932			
	SI IMMARY ST	ATEMENT OF DEFICIENCIES	ID		S PLAN OF CORRECTION	(75)	_
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		
F 684		45					
F 004	Continued From page	ids without causing harm, it	F 68	4			
		d practice. MD #1 stated					
		wounds of Resident #1 on					
		Resident #1 requested o the emergency room for					
	wound evaluation cor	nfirming no more maggots or					
	concerns were found						

Facility ID: 923018

If continuation sheet Page 16 of 16