STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted a complaint investigation and follow-up to a Covid Focused Infection Control survey on-site February 3-4, 2021, with desk review on February 5, 2021, and February 8-12, 2021 with an exit conference via telephone on February 12, 2021. The complaint investigation was initiated by the Wake County Department of Social Services on January 5, 2021.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure the facility was free of hazards as evidenced by toilets and sinks that were clogged with feces and urine and others that were dysfunctional, a chair propped up against the bathroom door in a resident's room to prevent usage of the toilet and sink, feces and urine on bathroom floors and on the floor and wall of a resident's bedroom, and bathrooms without the resources for proper hand and toileting hygiene and a shower that was not operational resulting in residents having to take sink baths and a resident having to use a common shower on the	D 079		

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	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 079	Continued From page 1 COVID-19 positive hall. The findings are: Observations of resident rooms in the Special Care Unit (SCU) on 02/03/21 at 12:10pm through 12:53pm revealed: -In Room 401 there was rolled up toilet paper all over the bed, on the bedroom floor and the bathroom floor. -There was a strong smell of urine in the bedroom, and of urine and feces in the bathroom. -The toilet was filled to the rim of the porcelain seat with fecal matter, urine and toilet paper. -There was brown staining on the porcelain base of the toilet and on the floor around the toilet. -The bathroom sink was clogged and filled halfway with brown stained and urine soaked paper and other unidentified matter. -There were brown stained papers under the sink that smelled of urine. -There was brown staining under the sink and near the toilet on the floor. -In Room 409, the bathroom door was blocked with an upholstered chair in front of the entrance. -In Rooms 409, 410, 418, 421 and 423 there was black buildup around the base of the toilet and the linoleum on the floor around the toilet bowl had dried brown staining. -In Room 421 there was dried feces on the floor and the walls of the bedroom, near the head and side of the bed. -In Rooms 409 and 417 the sinks were dysfunctional and had clothing (409) and a bag of liquid soap (417) in the sink bowl. -In Rooms 409, 410, 417, 418, 421 and 423 there was no toilet paper to use when toileting, or paper towels or soap for handwashing. -Two briefs soiled with urine and feces were thrown on the resident's bedroom floor during	D 079		

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	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

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CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 079	Continued From page 2	D 079		

incontinence care, in addition to a soiled blanket with dried feces.
-The "Men's Shower room", located on the COVID-19 negative side of the hall, had yellow caution tape across the door and a sign "Do Not Enter".

Interview with a personal care aide (PCA) on 02/03/21 at 12:15pm revealed:
-Several of the toilets in the Special Care Unit (SCU) had issues that made them unable to function properly.
-The staff had to manually flush the toilets with buckets of water in an attempt to unclog them.
-The men's shower room had been out of service for awhile, 6 months or more.
-Before COVID-19 restricted access to the entire hall, she used the women's shower room for all the residents.
-There were 3 residents on the COVID-19 negative side of the hall and she had been bathing them at their sinks.
-The Special Care Coordinator (SCC) was aware of the issue with the toilets and men's shower room.

Interview with SCC on 02/03/21 at 1:45pm revealed:
-There had been problems with the toilets in the SCU for awhile.
-Several of the toilets and some sinks were dysfunctional.
-The staff had to pour buckets of water down some toilets in order to flush them.
-The resident in Room 401 was ambulatory, so he used the toilet without the staff's knowledge.
-There were a few toilets that shifted on their base and leaked around the base.
-Housekeeping was responsible for cleaning the bathrooms and the bedrooms.

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	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 079	Continued From page 3	D 079		

-The housekeeper for the SCU was on leave and the staff was assisting with cleaning the resident's rooms as needed.
-They were short staffed at times as a consequence of COVID-19 and the staff were not keeping up with housekeeping tasks due to providing personal care to the residents.
-She had made the Maintenance Director aware of their housekeeping concerns.

Interview with the Maintenance Director on 02/03/21 at 4:31pm revealed:
-He was responsible for the maintenance of the building and the supervision and scheduling of the housekeepers.
-Staff placed work orders for items that needed repair in his box or the Executive Director's (ED) box located in the office.
-Some of his staff had been out for the past 3 weeks due to COVID-19.
-He had been trying to keep up with the housekeeping responsibilities in the community.
-It was the responsibility of the housekeepers to clean the residents' bathrooms.
-He knew the toilet in Room 401 was not flushing, but he did not know there was a resident living in that room; he thought the room was empty.
-The men's shower room was not available to be used because the sink was not attached to the wall. The sink was on the floor in the middle of the room.
-It had been this way for several months.
-Currently he had obtained the supplies he needed to attempt the repair, but he had been busy with housekeeping tasks.
-Prior to the COVID-19 outbreak, the residents had been using the women's shower that was located on the COVID-19 positive side of the 400 hall.
-He did not know what the residents on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 079	Continued From page 4	D 079		

COVID-19 negative hall were using for showers.
-There were no showers in the resident's rooms.

Interview with the housekeeper on 02/03/21 at 1:04pm revealed:
-It was his responsibility to clean the bathrooms, tables and high touch areas with an Environmental Protection Agency (EPA) approved disinfectant daily.
-The SCU housekeeper was out on leave and he had left a housekeeping cart with fresh water and a spray disinfectant bottle in the SCU so the staff could assist with housekeeping chores in her absence.
-The staff had been assisting him with the cleaning of the bathrooms and bedrooms as needed.

Telephone interview with the SCC on 02/11/21 at 9:30am revealed:
-There were 3 residents on the COVID-19 negative hall.
-The men's shower room had not been usable for several months.
-The staff bathed all residents in the women's shower room down the hall until the COVID-19 outbreak.
-The resident in Room 417 was washed at the bedside using a bucket of water from the sink.
-The dirty water was then poured down the toilet in the bathroom.
-The resident in Room 401 washed himself at the sink independently.
-The resident in Room 405 had been washing herself at the bathroom sink, however, she requested that her hair be washed since it was "so greasy".
-Staff applied the personal protective equipment (PPE), gowns, a surgical mask and gloves, to the resident and themselves, and brought her to the

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	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

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CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 079	Continued From page 5	D 079		

women's shower room located on the COVID-19 positive hall, to be showered last week.
-The housekeeper for the SCU was out on leave and the care staff were trying to keep up with the housekeeping responsibilities in the SCU.
-The housekeeper on the assisted living side of the facility left a cart with clean water, a mop and a spray sanitizer to use on the floors and the toilets.
-Supplies for proper handwashing were supplied by the housekeeping staff.
-The supplies were in a locked closet on the 100 hall and the 300 hall.
-There were times the SCU staff purchased their own handwashing supplies.
-She did not know Room 401's toilet and sink were dysfunctional.

Interview with the ED on 02/03/21 at 2:35pm revealed:
-The housekeeper for the SCC had been on leave since 01/13/21.
-The current housekeeping staff included a full time housekeeper and one part time housekeeper.
-The Maintenance Director was expected to fill in for housekeeping staff when needed.
-The housekeepers were responsible for supplying items for proper handwashing in the residents' bathrooms.
-She did not know why items for hand and toileting hygiene were not in 7 out of 9 resident's bathrooms.
-There were housekeeping supply closets for these items on the 100 hall and the 300 hall.
-These closets were locked but the staff had access to the keypad with a code that was kept on the wall in the medication room.
-She expected the staff to clean soiled bathrooms, feces from the floor and provide

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	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

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CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 079	Continued From page 6 supplies to the residents bathrooms when housekeeping was not available. _____ The failure of the facility to maintain bathroom sinks and toilets free of an accumulation of feces and urine, bedroom and bathroom floors free of urine and feces, and exposing a COVID-19 negative resident to the COVID-19 positive hall as the only means to provide her with a shower, was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on March 4, 2021. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 29, 2021.	D 079		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all plumbing equipment, including multiple toilets, sinks and showers were maintained in a safe and operating condition, for 7 of 9 sampled bathrooms and 1 of 2 sampled shower rooms, in the Special Care Unit (SCU). The findings are: Observations of the Special Care Unit (SCU)	D 105		

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D 105	Continued From page 7	D 105		

bathrooms and bedrooms on 02/03/21 from 12:10pm through 1:20pm revealed:
-The Special Care Coordinator (SCC) accompanied the surveyor while touring the SCU residents's rooms in the 400 hall.
-In Room 401, the toilet in the bathroom was full of toilet paper, feces and urine to the level of the toilet seat.
-The bathroom sink was halfway filled with feces stained toilet paper.
-In Room 409 the toilet did not flush.
-In Rooms 401, 417, 421 and 423 the toilets were not able to be flushed and there was urine and feces in the toilets.
-In Rooms 401, 409 and 417 the bathroom sinks were clogged and did not drain properly.
-In Room 423 the toilet was not secured to the floor.
-In Room 418 the toilet base was not secure to the floor, and was wobbly.
-The Men's Shower Room, across from the medication room, had yellow caution tape across the door and a sign saying "Do Not Enter".

Interview with a personal care aide (PCA) on 02/03/21 at 12:15pm revealed:
-Several of the toilets in the SCU did not flush or have other issues that made them unable to function properly.
-The staff had to manually flush the toilets with buckets of water in an attempt to unclog them.
-The men's shower room had been out of service for awhile.
-Before COVID-19 restricted access to the entire hall, she used the women's shower room for all the residents.
-There were 3 residents on the COVID-19 negative side of the hall and she had been washing them at the sink.
-The Special Care Coordinator (SCC) was aware

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	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 105	Continued From page 8	D 105		

of the issue with the toilets and men's shower room.

Interview with SCC on 02/03/21 at 1:45pm revealed:
-There had been problems with the toilets in the SCU for awhile.
-Several of the toilets did not flush.
-The staff had to pour buckets of water down some toilets to flush.
-There were a few toilets that shifted on their base and leaked around the base.
-There were some toilets and sinks that clogged frequently and get stopped up.
-The process for reporting maintenance issues was to fill out a work order.
-The work orders could be submitted directly to the Maintenance Director or to the Executive Director (ED).
-She submitted her work orders to the ED.
-On 08/31/20 she submitted work orders for Rooms 421 and 423.
-On 10/17/20 she submitted a work order for the men's shower room
-On 12/31/20 she submitted a work order for Room 410.
-On 12/23/20 and 12/27/20 she submitted a work order for Room 401.
-She had submitted other work orders but did not make a copy of the order.
-Some repairs she verbalized to the Maintenance Director or the ED.

Review of the work order requests on 02/03/21 at 1:50pm revealed:
-There were copies of work orders for Rooms 421 and 423 on 08/31/20.
-There was a copy of a work order for the men's shower room on 10/17/20.
-There was a copy of a work order for Room 410

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 105	Continued From page 9	D 105		

dated 12/31/20.
-There were copies of work orders for Room 401 on 12/23/21 and 12/27/20.

Telephone interview with the SCC on 02/11/21 at 9:30am revealed:
-The men's shower room was not usable for several months.
- The staff had been using the women's shower room for all the residents until the COVID-19 outbreak.
-The women's shower room was on the COVID-19 positive hall.
-The resident's on the COVID-19 negative hall are washed at the sink in their bathrooms.
-The resident in Room 417 was washed at the bedside using a bucket of water from the sink and the dirty water was then poured down the toilet in the bathroom.
-She did not know the sink in Room 401 was clogged or how long it had been clogged.

Interview with Maintenance Director on 02/03/21 at 4:31pm revealed:
-He was responsible for the maintenance of the building.
-Staff placed work orders for items that needed repair in his box or the ED's box located in the office.
-He had a monthly budget and if the repair was within the budget for that month, he could purchase the item and repair.
-If the repair was greater than the budget, the ED had to authorize the expenditure.
-If it was necessary to contract with an outside vendor, the ED contacted the regional team and they would contract with a local company.
-He had ordered kit repairs throughout the building for toilets that were not secure at the base.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 105	Continued From page 10	D 105		

-Most of the toilet repairs required wax rings on the bottom of the toilet that secured them to the floor.
-He had been trying to keep up with the housekeeping responsibilities in the community since the COVID-19 outbreak.
-He knew the toilet in Room 401 was not flushing, but he did not know there was a resident living in that room; he thought the room was empty.
-The men's shower room was not available to be used because the sink was not attached to the wall. The sink was on the floor in the middle of the room.
-It had been this way for several months.
-He had obtained the supplies he needed to attempt the repair, but he had been busy with housekeeping tasks.

Interview with the ED on 2/3/21 at 2:35pm revealed:
-The maintenance director was responsible to obtain work orders for repairs that were needed throughout the facility.
-He was responsible to order supplies and obtain whatever was needed to complete the repair.
-She would hire a plumber if needed, and would have to get approvals for the repairs from the regional team.
-She was not sure if she had contacted the regional team regarding these repairs that were needed in the SCU.
-Her expectation was that the plumbing issues would be repaired in a timely manner.
-She expected to be able to get approvals for repairs within 48 hours.
-The plumbing issues should be repaired within one to two days.
-She did not know why the toileting and shower sink repairs were taking so long.
-She supervised the Maintenance Director, and

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	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 105	Continued From page 11 was not aware of the ongoing plumbing issues in the SCU that had not been resolved.	D 105		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews the facility failed to ensure that non-licensed personnel were competency validated by return demonstration for 3 of 3 sampled staff (Staff F, E, and A) who provided care for one resident who required routine colostomy care. The findings are: Review of Resident #2's current FL2 dated	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 161	Continued From page 12	D 161		

09/12/20 revealed:
-Diagnoses included Alzheimer's Disease, coronary artery disease, hypertension , history of a myocardial infarction, colostomy (a surgical formation of an artificial rectum by connecting the colon to an opening in the abdominal wall), and hypothyroidism.
-The resident was disoriented constantly.
-The resident was non-ambulatory, a wanderer, and verbally abusive.

Review of Resident #2's signed physician order report dated 09/18/20 revealed:
-There was an order for ostomy care / irrigation to be performed every shift.
-There was an order to check the skin around the stoma every shift, and report any signs of broken skin to special care coordinator (SCC).
-Colostomy care and skin checks were to be completed one time between 7am and 3pm, 3pm and 11pm, and 11pm and 7am.

Review of Resident #2's licensed health professional support (LHPS) review dated 08/22/20 revealed:
-Resident #2 received colostomy care each shift and PRN.
-There was a small amount of brown matter in the bag, and no discomfort was noted.
-Colostomy care, transfer with assistance, and ambulate with wheelchair were listed as LHPS personal care tasks provided.
-Staff competency validated on the LHPS review sheet was not checked off.

Review of pictures of Resident #2's abdomen dated 09/11/20 revealed:
-There was an area of pinkish-red excoriation that was surrounding the stoma and extended just beyond the edges of the wafer of the colostomy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 161	Continued From page 13	D 161		

bag.
-The surrounding skin was dry and scaly.
-The stoma was moist and beefy red in color.
-The stoma and peristomal skin junction was intact.

Review of pictures of Resident #2's abdomen dated 10/19/20 revealed:
-There was an area of pinkish-red excoriation that was surrounding the stoma and extended 1-2 inches beyond the edges of the wafer of the colostomy bag.
-The surrounding skin was dry and scaly.

Review of pictures of Resident #2's abdomen dated 12/15/20 revealed:
-There was an enlarged area of pinkish-red excoriation that was surrounding the stoma.
-The area extended beyond the edges of the wafer of the colostomy bag across the umbilicus and onto the right lower quadrant of the abdomen.
-The surrounding skin was dry and scaly.

Review of Resident #2's PCP's Consultation Notes dated 12/15/20 revealed:
-Resident #2 continued treatment for a yeast infection.
-The PCP ordered an antifungal powder, one application to where colostomy bag was attached to skin, externally twice a day until clear of infection.
-Although the Nystatin powder had been documented as administered, there was no powder present on Resident #2 and the yeast infection had worsened, particularly to the left groin area.
-The case was discussed with colleagues who had seen Resident #2 last week and reported the same findings during time of exam.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 161	Continued From page 14	D 161		

-It was evident the medication was not being administered because this was an easily treatable condition that was progressively getting worse.

1. Review of Staff F's, medication aide (MA), employee record revealed:
-Staff F was hired on 10/23/19.
-There was documentation of a Licensed Health Professional Support (LHPS) task competency validation dated 11/14/19, but task number 9, colostomy care was marked "N/A".

Telephone interview with Staff F, MA on 02/05/21 at 11:28am revealed:
-She worked in the special care unit (SCU) on 2nd shift.
-She was responsible for providing colostomy care and changing the bag for Resident #2.
-She was not trained on colostomy care at the facility.
-She was not trained or competency validated for colostomy care.

Refer to telephone interview with a MA on 02/08/21 at 10:17am.

Refer to telephone interview with the special care coordinator (SCC) on 2/09/21 at 1:36pm.

Refer to telephone interview on 02/10/21 at 11:08am with the business office manager (BOM).

Refer to telephone interview with the LHPS nurse on 2/10/21 at 1:09pm.

Refer to telephone interview with the Executive Director (ED) on 02/11/21 at 11:07am.

Refer to telephone interview with the home health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 161	Continued From page 15	D 161		

nurse on 2/11/21 at 4:43pm.

2. Review of Staff E's, medication aide (MA), employee record revealed:
-Staff E was hired on 08/15/17.
-There was documentation of a Licensed Health Professional Support (LHPS) task competency validation dated 08/12/17, but task number 9, colostomy care was marked "N/A".

Telephone interview with Staff E, MA on 2/08/21 at 11:18am revealed:
-She was responsible for providing colostomy care to Resident #2.
-She was not trained or competency validated for colostomy care.
-She was not sure of who reviewed steps of changing colostomy bag and care with the other MAs.
-She observed redness on/off around stoma on Resident #2, some days skin was healed and then there would be a sudden flare up.

Refer to telephone interview with a MA on 02/08/21 at 10:17am.

Refer to telephone interview with the special care coordinator (SCC) on 2/09/21 at 1:36pm.

Refer to telephone interview on 02/10/21 at 11:08am with the business office manager (BOM).

Refer to telephone interview with the LHPS nurse on 2/10/21 at 1:09pm.

Refer to telephone interview with the Executive Director (ED) on 02/11/21 at 11:07am.

Refer to telephone interview with the home health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 161	Continued From page 16 nurse on 2/11/21 at 4:43pm. 3. Review of Staff A's, medication aide (MA), employee record revealed: -Staff A was hired on 11/01/19. -There was no documentation of a Licensed Health Professional Support (LHPS) task competency validation. Interview with Staff A, MA on 02/09/21 at 3:06pm and 3:33pm revealed: -She had worked in the facility on 3rd shift as a MA for one year in the special care unit (SCU). -Resident #2 was admitted to the SCU with a colostomy. -The special care coordinator (SCC) informed the MAs of a resident that was admitted with a colostomy and the MAs would be responsible for providing care of the colostomy. -She was responsible to change the entire colostomy appliance for the resident. -She was not trained or competency validated for colostomy care. -She changed the colostomy bag only when the bag was full. -She removed the full colostomy bag, cleaned and dried the area, applied a new bag and powder around area. -She had observed some redness, and then it would look normal at times with no redness, only pinkish in color. Telephone interview on 02/10/21 at 11:08am with the business office manager (BOM) revealed Staff A did not have the LHPS competency validation checklist in her employee record and only had the MA skills checklist. Refer to telephone interview with a MA on 02/08/21 at 10:17am.	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 161	Continued From page 17 Refer to telephone interview with the special care coordinator (SCC) on 2/09/21 at 1:36pm. Refer to telephone interview on 02/10/21 at 11:08am with the BOM. Refer to telephone interview with the LHPS nurse on 2/10/21 at 1:09pm. Refer to telephone interview with the Executive Director (ED) on 02/11/21 at 11:07am. Refer to telephone interview with the home health nurse on 2/11/21 at 4:43pm. _____ Telephone interview with a MA on 02/08/21 at 10:17am revealed: -She was employed by facility a year ago. -She worked in the SCU. -Only the MAs were responsible for changing and providing colostomy care of Resident #2's colostomy. -She was not trained or competency validated for colostomy care. -She did not recall being checked off by the LHPS nurse for colostomy care. -She changed colostomy bag whenever it was full on her shift. -She was aware of the redness around stoma. -She applied Nystatin powder after she removed the colostomy bag, cleaned, dried, and adhered new bag. -She applied Nystatin powder with every change of the colostomy bag. Telephone interview with the SCC on 2/09/21 at 1:36pm revealed: -There was no training of staff on colostomy care.	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 161	Continued From page 18 -There was no one checked off on LHPS for colostomy care. -The ED was unable to locate the LHPS checklists for some staff. Telephone interview on 02/10/21 at 11:08am with the business office manager (BOM) revealed: -The LHPS nurse was responsible for the LHPS check-offs -The ED scheduled the training and competency validation with the LHPS nurse. -The LHPS nurse completed them and gave the competency checklists to her for filing. -The ED was responsible for ensuring all staff training was completed. -Colostomy care was required for one resident. Telephone interview with the LHPS nurse on 2/10/21 at 1:09pm revealed: -The 3 MAs had been compentency validated for other tasks. -The 3 MAs told the LHPS nurse that they had already been trained by home health, so she did not address the colostomy care task on the checklist. -She worked as the LHPS nurse full time until October 26, 2020. -She agreed to work part time until they could find a replacement. -She was usually in the facility 2-3 times per week for assessments and check-offs, but now they just called when they needed her. -When Resident #2 was admitted to the facility she was aware of the need for colostomy training for staff. -When she attempted to provide the training she was told by staff that they had already been trained by the home health nurse. -Resident #2 was the only resident in the facility with a colostomy.	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 161	Continued From page 19 -She usually provided colsotomy care training to the MAs only, but had not trained anyone at this facility. Telephone interview with the home health nurse on 2/11/21 at 4:43pm revealed: -She had assessed and provided care for Resident #2's colostomy in September 2020 . -She only saw the resident once and did not provide any education on colostomy care to the staff at the facility. -The resident had been discharged from services a few months ago. -She did not have the exact date. _____ The facility's failure to ensure that non-licensed personnel were competency validated by return demonstration for personal care tasks related to colostomy care, prior to staff performing the task resulted in irritation and continued infection around the stoma. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on February 09, 2021 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 29, 2021	D 161		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 20	D 269		

care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews and record reviews, the facility failed to provide personal care to 3 of 5 sampled residents, related to a resident who was found wearing 2 briefs and had been incontinent of bowel and bladder, with feces on his hands, under his nails and on his bed and a pressure wound on his butttocks (Residents #3); a resident who developed unstageable pressure wounds on his sacrum and feet (Resident #5); and a resident who required assistance with the care of a colostomy bag who experienced irritation and continued fungal infection around the stoma site (Resident #2).

The findings are:

1. Review of Resident #3's current FL2 dated 10/30/20 revealed:
-Diagnoses included vascular dementia, hypoxia and a dysphagia III diet, (moist foods in bite size pieces).
-He was semi-ambulatory with a wheelchair.
-He was continent of bowel and occasionally incontinent of bladder.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 06/05/20.

Review of the primary care provider's (PCP) consultation notes from December 1, 2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 21	D 269		

through January 31, 2021 revealed:
-The PCP conducted virtual visits with Resident #3 due to the COVID-19 outbreak status at the facility.
-There was no documentation in the consultation notes that the PCP was made aware of any skin breakdown or personal care issues for Resident #3.

Review of Resident #3's progress notes from December 1, 2020 through February 4, 2021 revealed there was no documentation Resident #3 had any skin breakdown or personal care issues.

Review of Resident #3's Body Evaluation and Observation Forms provided from January 5, 2021 to February 4, 2021 did not reveal documentation of any redness or skin breakdown.

Review of Resident #3's Special Care Unit (SCU) Profile Reassessment Form dated 12/10/20 revealed:
-Staff will assist Resident #3 with toileting every 2 hours, and as needed, to ensure cleanliness.
-Staff will assist Resident #3 with bathing, per facility schedule of twice weekly, and as needed, to ensure safety and cleanliness.
-Staff will assist Resident #3 with grooming and hygiene to ensure cleanliness and safety.
-Staff will monitor Resident #3 and report any changes or concerns.
-Staff will assist Resident #3 with ambulation and report any changes or concerns.

Review of Resident #3's Care Plan dated 12/29/20 revealed:
-Resident #3 was ambulatory with a wheelchair.
-He had limited strength and limited range of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 22	D 269		

motion in his upper extremities.
-He had occasional incontinence of bowel and bladder, less than daily.
-He was forgetful and needed reminders.
-He was limited in toileting, ambulation, transfers, grooming, personal hygiene, and dressing.

Observation of Resident #3 on 02/04/21 at 12:07pm revealed:
-Resident #3 was lying in his bed with the same hospital gown he had on yesterday during the tour of the facility.
-There was dried feces on the floor
-Resident #3 was lying on the vinyl mattress covering with no bed linens.
-He was wrapped in a blanket that had dried feces staining.
-The personal care aide (PCA) changed Resident #3's brief.
-Resident #3 was double briefed.
-Both of the briefs were soaked with urine and feces.
-The left buttock had a deeply reddened area approximately 4 inches by 3 inches.
-There was a dime size open area at the base of the spine in between the buttocks.
-There was dried feces in the brief and on the buttocks and surrounding the genital area.
-The PCA was unaware of the skin breakdown.
-The PCA threw the soiled briefs and the soiled blanket on the floor next to the bed.
-Resident #3 had dried feces on his fingers and under his nails on both hands.
-His toenails were overgrown and thick on both feet.
-The PCA attempted to leave Resident #3's room after changing his brief, without cleaning his hands and nails.

Interview with a first shift PCA on the SCU on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 23 02/03/21 at 1:10pm revealed: -Her responsibilities included assisting residents with showers, toileting, making beds, changing linens twice a week on the resident's shower day or as needed. -She also passed out food trays at meal time, and assisted residents with their meals. -In conjunction with housekeeping, she was responsible to keep the resident's rooms tidy and free of hazards. -She documented the completion of her tasks on the computer. -On shower days, she observed the resident's skin and completed the Body Evaluation and Observation Form. -She would also fill out the form in between showers if she observed any skin breakdown or open areas on the residents when toileting or dressing. -Resident #3 was incontinent of bowel and bladder. -She checked his brief when she made her rounds every 2 hours and changed him when needed. -She had not showered Resident #3 because his scheduled shower was on second shift. -She had not observed any changes in his skin in the past few weeks. Interview with another first shift PCA on 02/04/21 at 3:40pm revealed: -Resident #3 was occasionally incontinent, so he wore a brief. -She had assisted him with showers in the past month. -She had changed his brief at least once during the shifts she worked in the past month. -She had not noticed any skin breakdown during those instances of personal care. -She had not observed Resident #3 with 2 briefs	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 24 when she provided incontinence care. Observation of Resident #3 during personal care on 02/04/21 at 3:55pm revealed: -Resident #3 was able to reposition himself in the bed. -His left buttock was deep red, approximately 4 inches by 3 inches, and 2 dime size openings on his sacrum. -The second shift PCA positioned the resident to be standing by the side of his bed, holding onto his walker, and attempted to clean him from the front. -The hospital gown covered the skin breakdown on the buttocks and sacral areas. -Resident #3 had to sit on the side of the bed several times during the personal care due to fatigue. -In wiping the buttocks and the sacral area, the PCA observed blood on the wipe. -All three areas of skin breakdown were open and bleeding slightly. -Resident #3 winced and grimaced during the personal care. -The PCA did not observe the areas of skin breakdown until she noticed the blood on the wipe. Interview with a second shift PCA on 02/04/21 at 3:55pm revealed: -When she entered Resident #3's room there was a strong smell of urine. -Resident 3's brief was soaked with urine and feces. -She said she had changed the resident and showered him several times over the past few weeks and not noticed either areas. -If she had observed the skin breakdown she would have reported it to her medication aide (MA).	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 25 Telephone interview with Resident #3's occupational therapist (OT) on 02/04/21 at 1:41pm revealed: -Resident #3 was on her client list and working on active range of motion and standing using his walker. -During one of their sessions, 01/11/21, she observed a small open wound on Resident #3's lower back. -When she reported the wound to the staff, they did not know of the wound. -The therapist educated the caregiver and MA on the importance of position changes, keeping the resident upright in his wheelchair and not supine in bed to allow for wound healing and decreased risk of pressure sores. Telephone interview with a third shift PCA on 02/09/21 at 8:11am revealed: -Resident #3 frequently had feces all over him, his room and the floor, from the contents of his brief. -Since he had been sick in early January he did not attempt to toilet himself anymore. -He wanted to stay in bed all day. -The staff had to change his brief, usually twice every shift, or as needed. -Resident #3 was able to reposition himself. -She did not double brief:"I do not believe it is good for the resident." -She had seen residents double briefed sometimes when she went to change them. -She did not remember a specific policy regarding double briefing, or management instructing her not to double brief. Telephone interview with a first shift MA on 02/10/21 at 9:59am revealed: -Her responsibilities were to administer	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 26	D 269		

medications, assist with showers and in passing meals to the residents, and anything PCAs needed assistance with.
-Resident #3 used to keep himself clean but recently started removing his brief and "digging" in his genital area.
-Staff showered Resident #3 on Friday, 02/05/21, and she reported skin breakdown on his lower back to the Special Care Coordinator (SCC).
-She cut his nails and cleaned his room
-There had been no report prior to 02/05/21 of Resident #3 having any skin breakdown.
-She documented the area of skin breakdown on the Body Evaluation and Observation Form and placed the form in the SCC box.
-She observed some of the residents double briefed at times, but she always told the PCAs not to place 2 briefs on a resident at the same time.

Telephone interview with another PCA on 02/12/21 at 10:52am revealed:
-Resident #3 was independent with his personal care until he became sick.
-The staff kept him in a hospital gown so he could be changed with less difficulty.
-He was total care at this time with all activities of daily living (ADLs).
-She had changed his brief in the past 2 weeks "a few times" and had not noticed any skin breakdown.

Telephone interview with a second PCA on 02/09/21 at 8:53am revealed:
-Resident #3 used to get in his wheelchair and "do for himself".
-Now the staff have to provide personal care to Resident #3.
-He was a "heavy wetter".
-She checked on the heavy wetters every hour and the remainder of the residents every 2 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 27 -The PCAs changed residents' linens twice a week on their shower day. -Resident #3 did not like sheets on his bed. -He preferred to sleep on the vinyl mattress without a sheet. -When there was only one aide it was hard to keep up with personal care. Interview with the SCC on 02/04/21 at 1:20pm revealed: -Resident #3 was able to ambulate independently with his wheelchair, and toilet independently with occasional incontinence until last month. -Since his decline in health on 01/13/21, Resident #3 had been in the bed all day and incontinent of bowel and bladder. -She had not changed his care plan to indicate the increase in care. -She had been short staffed since the outbreak and had been assisting with the administration of medications on several shifts. -She communicated the needs of the residents to the staff verbally during shift change or staff meetings. -The staff completed a Body Evaluation and Observation Form each time a resident was showered or bathed, documenting any skin discoloration or breakdown, and the condition of their fingernails and toenails. -Those forms should be completed if any skin irregularity was observed during personal care, including incontinence care. -The completed form should be placed in her box in the medication room. -The PCAs should also inform the MAs if there was skin breakdown observed during personal care, if she was not in the building. -She reviewed these evaluation forms on a regular basis and was responsible for following up with the provider to inform them of any	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 28	D 269		

changes with their residents.
-There was no Body Evaluation and Observation Form for Resident #3 in January 2021 or February 2021 that documented any skin breakdown in Resident #3's sacral area or buttocks, or any changes in his hygiene.
-She did not know Resident #3 had skin breakdown on his left buttock and sacral area, or that he was being double briefed.
-She did not know how the staff could have been providing personal care to Resident #3 and not observe his wounds.
-The staff have been trained per our policy not to double brief residents.
-She did not know he was without bed linens and was using a soiled blanket.
-PCAs were responsible to place clean linens on resident's beds twice a week or as needed.
-She did not know the staff were throwing dirty briefs and laundry on the floor of resident's room.

Telephone interview with Resident #3's primary care provider (PCP) on 02/05/21 at 9:14am revealed:
-Their team of providers were conducting virtual visits with the residents in this facility due to COVID-19 outbreak status.
-Personal care and hygiene had been an issue at this facility with all her residents.
-On a previous visit, she observed a resident who was soaked with urine from shoulders to knees and had a rash on his back.
-When she brought it to the attention of the care staff she was informed, "He is going to get a shower soon".
-Resident #3 had been in his bed since early January.
-He required total care with activities of daily living (ADLs).
-She had not been informed Resident #3 had skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 269	Continued From page 29	D 269		

breakdown on his left buttocks and sacral area.
-She had not been informed he was "digging" in his brief and spreading the contents over himself and his room.
-If Resident #3's brief was not changed frequently, and he was in the bed most of the day, this would contribute to skin breakdown.
-During the virtual visits, he looked disheveled.

Interview with the Executive Director (ED) on 02/04/21 at 3:15pm revealed
-The PCAs were to check on incontinent residents every 2 hours and change them as needed.
-Double briefing of residents was not allowed per facility policy. It was uncomfortable for the resident and can lead to health issues.
-She did not know Resident #3 had skin breakdown on his left buttocks and an open area that was bleeding during incontinence care in his sacral area.
-She did not know how the staff missed those areas on Resident #3's skin when he was showered twice a week.
-If he refused showers, skin observations could be completed during incontinence changes.
-There was no reason the staff should have missed Resident #3's skin breakdown.
-Resident 3's fingernail and toenail care should also be observed during shower days, or during incontinence checks.
-These areas should be cleaned and maintained by the SCC and the staff.
-Dirty briefs and soiled blankets should never be thrown on a resident's bedroom floor.

Based on observations and interviews it was determined Resident #3 was not interviewable.

2. Review of Resident #5's current FL2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 30	D 269		

11/20/20 revealed:
-Diagnoses included dementia, hypertension, Type II diabetes mellitus with neuropathy.
-He was non-ambulatory.
-He was incontinent of bowel and bladder.
-The recommended level of care was the Special Care Unit (SCU).

Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 11/03/21.

Review of Resident #5's Care Plan dated 11/30/20 revealed:
-Resident #5 was ambulatory with assistance and the aide of a wheelchair and walker.
-He was incontinent of bowel and bladder, and required extensive assistance with continent care.
-He required limited assistance in bathing, grooming and transfers.

Review of Resident #5's Body Evaluation and Observation Forms provided from December 15, 2020 to January 13, 2021 did not reveal documentation of any redness or skin breakdown.

Review of Resident #5's progress notes from December 15, 2020 through January 13, 2021 revealed there was no documentation Resident #5 had any skin breakdown or personal care issues.

Telephone interview with Resident #5's power of attorney (POA) on 02/01/21 at 9:17am revealed:
-On 11/03/21, Resident #5 was admitted to the facility.
-She noticed a cut on his toe and she made an appointment with his primary care provider (PCP) to examine him on 11/17/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 269	Continued From page 31 -On 01/05/21, she received a call from the special care coordinator (SCC) that he had fallen down and "busted his head". -On 01/11/21, Resident #5 pulled out some of the stitches from his head wound of 01/05/21 and returned to the Emergency Department for additional stitches to stop the bleeding from the wound. -On 01/13/21, Resident #5 returned to the Emergency Department due to lethargy, stomach distention, diarrhea and pain in the lower abdominal quadrant. -He was admitted to the hospital for further assessment. -The hospital sent the POA pictures of an unstageable pressure sore on Resident #5's sacrum and pressure wounds on both feet. -She had provided care to him for 10 years and he never had a pressure ulcer or any other health issue from poor hygiene or care. Review of hospital documentation and pictures dated 01/14/21 revealed: -There was an unstageable pressure injury to the sacrum midline. -It was unstageable due to yellow slough and black/brown eschar. -The wound length was 1 centimeter (cm), the width 1 cm and depth unstageable. -There was stable eschar to toes on bilateral feet. -The wound length was 3cm and width 4cm. Telephone interview with Resident #5's PCP's Registered Nurse (RN) on 02/01/21 at 9:54am revealed: -He had been a patient since 2010 and had always presented as well cared for. -Resident was last seen by the PCP on 11/17/20 for skin breakdown on his right and left foot - the tips of his great toes.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 32 -The PCP ordered the areas to keep covered until healed, to prevent possible infection. -Based on his general appearance and condition at this visit, she observed a general decline in his appearance. -His nails were overgrown and his affect was flat and non engaging. Interview with first shift personal care aide (PCA) on 02/04/21 at 12:00pm revealed: -Resident #5 was very aggressive with the staff when providing personal care. -We often needed 2 or 3 staff to provide personal care. -His shower was scheduled on a different shift. -She changed Resident #5's briefs on first shift up until the day he went to the hospital for the last time. -He was incontinent of bowel and bladder. -She never observed any skin breakdown or changes in his skin when she provided incontinence care. -Resident #5 stayed in the bed for most of the shift. -He was able to reposition himself in the bed, but was too weak to get up. Interview with the physical therapist on 02/04/21 at 12:50pm revealed: -Resident #5 was on her client list for therapy to increase his strength and endurance, and increase his participation with grooming and personal hygiene. -She was in the facility twice a week, on Tuesday and Thursdays. -She assisted the staff as a translator outside of Resident #5's therapy sessions since there was a language barrier that caused him to be very anxious around personal care. -He was a little aggressive and defensive with	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 269	Continued From page 33	D 269		

staff, especially if more than 1 person approached him.
-She worked closely with Resident #5's family member who provided advice on motivational tools.
-He responded well to a lot of encouragement and a gentle approach.
-She would observe him at meals when she was in the facility.
-She applied his dentures, if they were not in his mouth, and cut his food at the meals she observed.
-Up until early January, she was cutting his meat for him when she was at the facility.
-As part of Resident #5's therapy, she assisted in one shower in December 2020, with the PCA.
-His sacral area was reddened and the knuckles on his toes were reddened, but there were no open areas.
-On therapy visits, she found him in the bed most of the time.
-If he was not in the bed he was in a transfer wheelchair.

Telephone interview with the first shift medication aide (MA) on 02/12/21 at 9:25am revealed:
-There were no staff reports of Resident #5's skin breakdown.
-She assisted with incontinence care at times and did not observe any wounds or reddening of the skin.
-Resident #5 was incontinent of bowel and bladder and was dependent on staff for personal care.
-The staff assisted Resident #5 with his shower or bed bath.
-There were no additional tasks required for Resident #5.

Interview with the second shift PCA on 02/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 34 at 3:40pm revealed: -Resident #3 was very combative with personal care. -He was more willing to let us assist him with personal care if we used the Spanish translation flash cards. -He liked to sleep in and they had to strongly encourage him out of bed before lunch. -He was usually in his wheelchair by second shift. -She noticed skin breakdown when she showered him (around Christmas time). -His sacral area was a little pink. -She thought she reported it to the MA. -She did not document the area on the Body Evaluation and Observation Form. -She thought reporting to the MA was the procedure. Telephone interview with the third shift MA on 02/09/21 at 8:11am revealed: -Resident #5 was difficult to provide care for and it took 2 or 3 people to change his brief. -There was a communication barrier. -There were Spanish flashcards with simple commands that she used and that helped at times. -He was a full assist with all activities of daily living (ADLs). -She worked the past weekend and she did not observe any skin breakdown on his sacral area or feet. Telephone interview with another first shift MA on 02/09/21 at 8:53am revealed: -At times there was only 1 PCA in the Special Care Unit. -When there was only one PCA, it was hard to keep up with the personal care of the residents. Telephone interview with Resident #5's PCP on	D 269		

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	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 269	Continued From page 35 02/11/21 at 3:44pm revealed she had not received any information from the staff at the facility regarding wounds on his sacral area or his feet. Telephone interview with the facility's contracted PCP on 02/11/21 at 2:53pm revealed pressure on the bony prominences, without positioning changes every few hours, increased the risk for pressure ulcers. Interview with the SCC on 02/04/21 at 1:20pm revealed: -There was a Body Evaluation and Observation Form that staff fill out when the resident was showered that provided an opportunity for them to diagram any skin abrasions and condition of nails and foot care. -The staff could also use this form when providing incontinence care or dressing a resident if they see any skin breakdown or redness. -The staff should report skin breakdown or redness to the MA if she was not in the building and leave the Body Evaluation and Observation Form in her box. -She assessed the resident when she returned to the facility if there was a report of skin breakdown. -She communicated with the PCP regarding the needs of the residents -Staff were required to complete 2 hour checks on every resident and during those checks to observe if the resident needed to be changed or toileted. -The folder for the in house PCP was full since they stopped coming in to the facility. -Recently, she started faxing the physician orders and requests to their main office. Telephone interview with the SCC on 02/11/21 at	D 269		

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	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 36 9:30am revealed: -She did not know Resident #5 had an unstageable pressure wound on his sacral area or wounds on both feet when he arrived at the hospital on 01/13/21. -She did not know how the staff could provide personal care to Resident #5 and not be aware of those wounds. Interview with the Executive Director (ED) on 02/04/21 at 3:15pm revealed: -The SCC had trained the staff to fill out the Body Evaluation and Observation Form with all observances of skin breakdown and discoloration and return to her. -If staff observed skin breakdown or wounds, an order should be obtained from the PCP and home health was to be contacted to assess and evaluate. -She was not aware Residents #5 had an unstageable pressure wound on his sacral area and wounds on both feet when he arrived at the hospital on 01/13/21. 3. Review of Resident #2's current FL2 dated 09/12/20 revealed: -Diagnoses included Alzheimer's Disease, coronary artery disease, hypertension , history of a myocardial infarction, colostomy, and hypothyroidism. -The resident was disoriented constantly. -The resident was non-ambulatory, a wanderer, and verbally abusive. Review of Resident #2's signed physician order report dated 09/18/20 revealed: -There was an order for ostomy care / irrigation to be performed every shift. -There was an order to check the skin around the stoma every shift, and report any signs of broken skin to special care coordinator (SCC).	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 37	D 269		

-Colostomy care and skin checks were to be completed one time between 7am and 3pm, 3pm and 11pm, and 11pm and 7am.

Review of Resident #2's physician orders dated 10/02/20 revealed:
-There was an order to clean skin around the stoma, pat dry, apply Nystatin powder (a powder used to treat fungal infections), reapply a clean colostomy bag until home health applies wafer around the stoma.
-There was no documented frequency on the order.

Review of Resident #2's physician orders dated 10/20/20 revealed there was an order for zinc oxide cream (a topical medication used to treat dermatitis) apply topically to skin breakdown on abdomen once daily.

Review of Resident #2's primary care provider's (PCP) Consultation Notes dated 11/06/20 revealed the resident was treated for infection around the colostomy site, it had improved, continue with Nystatin powder.

Review of Resident #2's care plan dated 11/19/20 revealed:
-Resident #2 had a colostomy.
-Resident #2 did not perform self-care of the colostomy.
-There was redness around the stoma.
-Skin care needs included to apply Nystatin powder to red area around the stoma and desitin for skin breakdown around abdomen.

Review of Resident #2's PCP's Consultation Notes dated 12/04/20 revealed:
-There was a rash around the colostomy site.
-She was given an order for Diflucan (an oral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 38	D 269		

medication used to treat fungal infections), and to continue the Nystatin powder.
-"Will emphasize to the facility again about staff ensuring that they use it regularly."

Review of Resident #2's physician orders dated 12/08/20 revealed:
-There was an order to change zinc oxide cream 13% from once daily to as needed (PRN) to skin breakdown on abdomen.
-There was documentation "resident's skin is intact looks good and staff use Nystatin BID."

Review of Resident #2's PCP's Consultation Notes dated 12/08/2020 revealed:
-Resident #2 was initially treated for scabies with Permethrin 5% (a topical medication used to treat scabies), until she received a consult with dermatology.
-The PCP had consulted with dermatology and started Ivermectin (an oral medication used to treat scabies) 3 mg once as directed.
-There was no documentation of the location of the scabies rash.

Review of Resident #2's shower skin assessment form dated 12/13/20 revealed:
-There was redness noted around the stoma.
-There were red spots near the breast area.

Review of Resident #2's PCP's Consultation Notes dated 12/15/20 revealed:
-Colostomy was in place and secure, surrounded candida (yeast) infection present.
-Resident #2 continued treatment for a yeast infection.
-The PCP ordered Nystatin powder, 100,000 unit/gram, one application to affected area(s) where colostomy bag is attached to skin, externally twice a day until clear of infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 39 -Although the Nystatin powder had been documented as administered, there was no powder present on Resident #2 and the yeast infection had worsened, particularly to the left groin area. -The case was discussed with colleagues who had seen Resident #2 last week and reported the same findings during time of exam. -It was evident the medication was not being administered because this was an easily treatable condition that was progressively getting worse. -She had discussed with the special care coordinator (SCC) on this date, 12/15/20, and an order was left to apply medication as already ordered on eMAR and monitor closely for further infection or complications. -Resident #2 was to continue treatment of scabies and skin was relatively improved from last evaluation with evidence of disease was remaining. -Resident #2 had tolerated the scabies treatment and was to repeat the dose one time in 14 days. -Benadryl 25 mg (an antihistamine medication used to ease itching), 2 tablets, orally, every 4 hours as needed for itching changed to every 6 hours scheduled dosing for 3 days, then resume as needed. Review of Resident #2's PCP's Consultation Notes dated 12/22/20 revealed: -Colostomy was in place and secure, surrounded candida infection present. -Staff was to provide meticulous colostomy and skin care as infection and skin breakdown continued to present as persistent problem. -Resident #2 was treated for a yeast infection. -The Nystatin powder (an antifungal powder) 100,000 unit/gram order was continued. -The yeast infection was relatively unchanged from last assessment, evidence of Nystatin	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 40	D 269		

powder was observed during this exam, no skin breakdown this time.
-Resident #2 was treated for scabies and rash was relatively unchanged from last assessment.
-Resident #2 continued to itch intensely.
-The Benadryl was apparently not being given appropriately.
-She had discussed with staff during this visit to use Benadryl for complaint or signs and symptoms of itching.
-Resident #2 was to receive second dose of two medications used to treat scabies a few days later.

Review of Resident #2's licensed health professional support (LHPS) review dated 08/22/20 revealed:
-Resident #2 received colostomy care each shift and PRN.
-There was a small amount of brown matter in the bag, and no discomfort was noted.
-Colostomy care, transfer with assistance, and ambulate with wheelchair were listed as LHPS personal care tasks provided.
-Staff competency validated on the LHPS review sheet was not checked off.

Review of pictures of Resident #2's abdomen dated 09/11/20 revealed:
-There was an area of pinkish-red excoriation that was surrounding the stoma and extended just beyond the edges of the wafer of the colostomy bag.
-The surrounding skin was dry and scaly.
-The stoma was moist and beefy red in color.
-The stoma and peristomal skin junction was intact.

Review of pictures of Resident #2's abdomen dated 10/19/20 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 41	D 269		

-There was an area of pinkish-red excoriation that was surrounding the stoma and extended 1-2 inches beyond the edges of the wafer of the colostomy bag.
-The surrounding skin was dry and scaly.

Review of pictures of Resident #2's abdomen dated 12/15/20 revealed:
-There was an enlarged area of pinkish-red excoriation that was surrounding the stoma.
-The area extended beyond the edges of the wafer of the colostomy bag across the umbilicus and onto the right lower quadrant.
-The surrounding skin was dry and scaly.

Telephone interview with a medication aide (MA) on 02/05/21 at 11:28am revealed:
-She worked in the special care unit (SCU) on 2nd shift.
-She was responsible for providing colostomy care and changing the bag for Resident #2.
-She was not trained on colostomy care at the facility.
-She was not trained or competency validated for colostomy care.
-She was aware of the redness around the stoma of Resident #2.
-She applied the Nystatin Powder 100,000 units/gram topically as was prescribed by PCP to red area around stoma after the colostomy bag was removed, the area was cleaned and dried, and reattached new bag with adhesive.
-She reported Resident #2 was anxious about her colostomy.

Telephone interview with a second MA on 02/08/21 at 10:17am revealed:
-She was employed by facility a year ago.
-She worked in the SCU.
-Only the MAs were responsible for changing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 42	D 269		

providing colostomy care of Resident #2's colostomy.
-She was not trained or competency validated for colostomy care.
-She did not recall being checked off by the LHPS nurse for colostomy care.
-She changed colostomy bag whenever it was full on her shift.
-She was aware of the redness around stoma.
-She applied Nystatin powder after she removed the colostomy bag, cleaned, dried, and adhered new bag.
-She applied Nystatin powder with every change of the colostomy bag.

Telephone interview with third MA on 2/08/21 at 11:18am revealed:
-She had worked in the facility for three years.
-She worked in the SCU.
-She was responsible for providing colostomy care to Resident #2.
-She was not trained or competency validated for colostomy care.
-She was not sure of who reviewed steps of changing colostomy bag and care with other MAs.
-She observed redness on/off around stoma on Resident #2, some days skin was healed and then there would be a sudden flare up.
-She applied Nystatin powder around the stoma on the affected area and zinc oxide ointment on affected area on abdomen.

Telephone interview with fourth MA on 2/09/21 at 3:33pm revealed:
-When she started working at facility there was no one with a colostomy.
-Resident #2 was admitted to facility in SCU with a colostomy.
-She was not trained or competency validated for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 43	D 269		

colostomy care.
-The SCC informed the MAs of a resident that was admitted with a colostomy and the MAswould be responsible for providing care of the colostomy.
-She changed colostomy bag when the bag was full.
-She removed the full colostomy bag, cleaned, dried area, applied new bag and powder around area.
-She observed some redness at times, and then the area would look normal at times with no redness only pinkish in color.
-She was not sure if there was any cream for redness though was aware of the powder.
-She was aware of cream used to treat scabies with Resident #2 and did not recall Resident #2 having a pill prescribed to treat the scabies because she only worked 3rd shift.

Review of Resident #2's December 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for ostomy care, clean area around stoma after each bag change, dry skin and apply nystatin powder as directed, apply a clean bag every shift.
-Ostomy care was documented as performed three times daily from 12/01/20 to 12/22/20.
-There was an entry dated 12/05/20 for Nystatin powder, 100,000 units/gram clean area around stoma with soap and water/pat dry, apply topically twice daily to affected areas until clear of infection, apply where the colostomy bag is attached to the skin.
-The Nystatin powder was documented as administered from 12/05/20 to 12/22/20 at 8am and 8pm.

Telephone interview with the PCP on 02/08/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 44 1:12pm revealed: -Resident #2 developed an infection at one time around stoma and had some skin breakdown on the abdomen. -Staff was not consistently providing colostomy care each shift. -Staff was checking off on medication administration record (MAR) that Nystatin Powder had been applied to treat redness around stoma, but a few times the PCP observed no powder on the area during examination. -The area around stoma was better and appeared healing when staff was consistently applying the Nystatin powder. -She also treated Resident #2 for scabies that was contracted from another resident in the SCU. -She addressed with the ED the concerns of staff not administering treatments and medications as prescribed, and not enough staff to care for residents. Interview with a medication aide (MA) on 02/09/21 at 3:06pm revealed: -She was responsible to change the entire colostomy appliance for the resident. -The resident's skin had become red in color. -At one point, she used alcohol wipes to clean around the stoma and placed the bag directly around the stoma. The wafer would stick without any adhesive. Telephone interview with the LHPS nurse on 02/10/21 at 1:09pm revealed: -When Resident #2 was admitted to the facility she was aware of the need for colostomy training for staff. -Resident #2 was the only resident in the facility with a colostomy. -She had assessed Resident #2 and was sure that colostomy care was documented on the resident's LHPS form.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 45 -Resident #2 had the disposable type bags, with the clamp that could be emptied over the toilet that did not have to be changed daily. Telephone interview with the ED on 02/11/21 at 11:07am revealed: -She was aware Resident #2 had irritation around the stoma. -Due to the resident's request for more frequent appliance changes, it was certain to cause skin irritation. -Once the new colostomy bags were used, the wafer stayed intact better, and the resident became more compliant. -Once home health discharged the resident, she switched back to her old type of appliance. -She had not observed the area since home health was involved, and did not see it prior to going to the hospital in December 2020. -When Resident #2 was first admitted to the facility they were notified by the RP that the resident would ask for frequent chages of the entire unit or just the bag. -The ED was not aware of any skin issues when she was first admitted. _____ The facility failed to provide personal care for 3 of 5 sampled residents, Resident #3 who was bedridden and was a "heavy wetter", was wearing 2 briefs in between incontinence changes, and personal care was not being provided to his hands and fingernails as needed, nor was he encouraged by the staff to reposition himself in the bed, which led to a pressure wound on his left buttock that was not reported by the staff to the provider; and Resident #5 with a history of dementia, who was left in the bed and not repositioned by the staff and developed an unstageable pressure ulcer on his sacrum and pressure wounds on both his feet; and Resident	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 269	Continued From page 46 #2 with an irritation of skin around a colostomy site and groin area, who did not receive consistent and proper colostomy care by staff. These injuries resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on February 4, 2021 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 14, 2021.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure staff on the special care unit (SCU) were available to supervise and meet the needs of the residents during mealtime, for 1 of 5 sampled residents, related to a resident who was a choking risk (Resident #3). The findings are: Review of Resident #3's current FL2 dated	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 270	Continued From page 47 10/30/20 revealed: -Diagnoses included vascular dementia, hypoxia and a dysphagia III diet, (moist foods in bite size pieces). -His diet was mechanical soft with thin liquids. -He was semi-ambulatory with a wheelchair. Review of Resident 3's Profile and Care Plan Form dated 12/10/20 revealed: -Resident #3 was a choking risk. -Staff will supervise Resident #3 during all meals. -Signs placed (outside Resident #3's door) to inform staff that Resident #3 was a choking risk. -Diet orders for mechanical soft meals with nectar thickened liquids. Review of Resident #3's December, 2020 electronic medication administration record (eMAR) revealed: -There was an entry, listed as "Special Instructions" : Supervise Resident While Eating and Document if Resident Has Trouble with Meals, to be observed at 8:00am, 12:00pm and 5:00pm. -There was documentation by the medication aides (MAs) at 8:00am, 12:00pm and 5:00pm from 12/01/20 through 12/31/20. Review of Resident #3's January, 2021 eMAR revealed: -There was an entry, listed as "Special Instructions" : Supervise Resident While Eating and Document if Resident Has Trouble with Meals, to be observed at 8:00am, 12:00pm and 5:00pm. -There was documentation by the medication aides (MAs) at 8:00am, 12:00pm and 5:00pm from 01/01/21 through 01/31/21. Review of Resident #3's February, 2021 eMAR	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 270	Continued From page 48	D 270		

revealed:
-There was an entry, listed as "Special Instructions" : Supervise Resident While Eating and Document if Resident Has Trouble with Meals, to be observed at 8:00am, 12:00pm and 5:00pm.
-There was documentation by the medication aides (MAs) at 8:00am, 12:00pm and 5:00pm from 02/01/21 through 02/03/21.

Interview with the first shift MA on 02/04/21 at 9:15 am revealed:
-There were no residents that needed any special assistance or observation during meals.
-Resident #3 was at the end of the COVID-19 positive hall.
-Resident #3 had a choking incident a few months ago, but he had been fine since and did not need any monitoring during meals.

Observation of COVID-19 positive hall in the Special Care Unit (SCU) during the initial tour on 02/03/21 at 12:12pm revealed:
-The food trays had been delivered to the residents on the 400 hall.
-The fire doors were closed separating the COVID-19 positive residents from the COVID-19 negative residents.
-There was no staff in the COVID-19 positive hall.
-There were no staff sitting in the chair near the fire doors in the COVID-19 negative hall.
-There was a sign posted on the wall outside Resident #3's room which read: CHOKING RISK-Resident eats in dining room only. Monitor all meals for choking risk.

Observation of the COVID-19 positive hall in the SCU on 02/04/21 at 12:17pm through 12:40pm revealed:
-The MA and the PCA pushed the lunch cart into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 270	Continued From page 49	D 270		

COVID-19 positive hall and passed out lunch trays to each resident in their rooms..
-Resident #3 was the last tray delivered.
-The MA and PCA then rolled the lunch cart out of the COVID-19 positive hall and parked it outside the medication room on the COVID-19 negative hall.
-The lunch meal was ham, pinto beans and cornbread with beverages
-On entering Resident #3's room, he was attempting to drink his beverage lying down.
-His meal plate and second drink was propped on the seat of his wheelchair next to his bed.
-His meal was mechanical soft, and he had finished most of the entree.
-He did not respond to questions regarding his position when eating his meals.
-There were no staff in the COVID-19 positive hall during this time.

Interview with second shift PCA on 02/04/21 at 3:40pm revealed:
-Resident #3 had a choking incident in December 2020.
-He was on a regular diet when he choked.
-He returned from the hospital on a mechanical soft diet.
-The "CHOKING HAZARD" sign was posted before the hospital changed his diet.
-Staff did not have to supervise him any longer during meals since he had been on a mechanical soft diet.
-He has not had a choking incident since his diet change that she is aware of.

Interview with the speech therapist on 02/04/21 at 3:50pm revealed:
-It was reported to her by the staff in October 2020, Resident #3 was coughing during his meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 270	Continued From page 50	D 270		

-She observed he had trouble chewing his food and breaking it down to smaller pieces.
-After a choking incident in the dining room during his meal, Resident #3 had a swallow study done around October 2020.
-The study showed Resident #3 was at a higher risk for aspiration with a regular diet.
-His diet was changed to a mechanical soft diet.
-She directed staff to monitor Resident #3 during meals to ensure he was not having any difficulty.

Telephone interview with the first shift MA on 02/10/21 at 9:59am revealed:
-The staff observed the residents every 15 minutes during meals.
-Staff had to monitor Resident #3 at meal time and when administering his medications.
-When his meal tray was delivered, staff were to assist him to a sitting position before he ate.
-Staff checked on him again when the plates were picked up and returned to the kitchen.
-When she administered medications to Resident #3 she directed him to stand by the side of the bed until he had swallowed the medications.
-These directives were given to her verbally from the occupational therapist and the Special Care Coordinator (SCC).

Telephone interview with the SCC on 02/11/21 at 9:30am revealed:
-Resident #3 had a choking incident a few months back.
-A swallow test was performed in the hospital and he was put on a mechanical soft diet with thin liquids.
-When he returned from the hospital, the "CHOKING HAZARD" sign was placed outside his room.
-Staff were instructed to remind Resident #3 to eat slowly and chew his food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 270	Continued From page 51	D 270		

-Her expectation was that staff walk the halls during meal time and check on all the residents, as well as Resident #3, to make sure they were not having difficulty with their meals, and to encourage them to eat.
-Staff should go into Resident #3's room and monitor him while eating to report any coughing episodes.
-The staff were not required to stay with Resident #3 during the entire meal.
-The MAs document on the eMAR after each meal that they have supervised Resident #3 while eating.
-Since the MAs were documenting completion of the task, she assumed they were supervising Resident #3 during meals.
-She has trained the staff to read the entire eMAR, not only the medications, and perform each task.
-She did not know the staff were delivering trays to the COVID-19 positive hall and leaving the hall until the time trays were picked up.
-Resident #3 has not had any recent coughing or choking incidents that have been reported to her.

Interview with the Executive Director (ED) on 02/04/21 at 3:15pm revealed:
-The staff monitored the dining room during mealtimes before the COVID-19 outbreak.
-She expected the staff to monitor the residents eating in their rooms during mealtime.
-She would expect the staff to monitor more closely residents who have had choking incidents or swallowing difficulties.
-She expected the staff to monitor Resident #3 during meals by going into his room and observing that he was sitting up while he ate and was not coughing when eating or drinking.

Based on observations and interviews it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 270	Continued From page 52 determined Resident #3 was not interviewable. _____ The facility failed to the ensure supervision of one resident (#3) with a diagnosis of dysphagia, a history of choking and identified as a choking risk by a speech therapist, which resulted in the resident attempting to drink while lying down with a meal next to him on the seat of a wheelchair, at the end of a COVID-19 positive hall, behind a closed fire door, with no supervision by the staff in the facility. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on March 5, 2021. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 29, 2021.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up with the physician for 2 of 5 sampled residents related to not providing timely notification to the physician regarding wounds on the buttocks and sacral area (Resident #3) and an unstageable wound to the sacral area, wounds on both feet, and a significant weight loss	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 53 (Resident #5). The findings are: 1. Review of Resident #5's current FL2 dated 11/20/20 revealed: -Diagnoses included dementia, hypertension, Type II diabetes mellitus with neuropathy. -He was non-ambulatory. -He was incontinent of bowel and bladder. -He had a healed sore on his left foot. -There was no documentation of Resident #5 having dentures or oral care assistance. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 11/03/20. Review of Resident #5's Care Plan dated 11/30/20 revealed: -Resident #5 was ambulatory with assistance and the aide of a wheelchair and walker. -He was incontinent of bowel and bladder, and required extensive assistance with continent care. -He required limited assistance in bathing, grooming and transfers. a. Telephone interview with power of attorney (POA) on 02/01/21 at 9:17am revealed: -The POA had cared for Resident #5 in her home until admission to the facility on 11/03/21. -She noticed an opening on his toe shortly after admittance and made an appointment with his primary care provider (PCP) on 11/17/21 to assess. -The PCP placed a dressing on the area and instructed staff to keep Resident #5's toe clean and covered to prevent infection. -On 01/13/21 Resident #3 was admitted to the hospital testing positive for COVID-19 and	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 54	D 273		

metabolic encephalopathy.
-Pictures from the hospital on 01/14/21 sent to the POA from a wound assessment, showed an unstageable wound with eschar on Resident #3's sacral area and wounds on both his feet.
-She was never contacted by the staff at the facility regarding these open areas and wounds.

Review of hospital documentation dated 01/14/21 revealed:
-There was an unstageable pressure injury to the sacrum midline.
-It was unstageable due to yellow slough (dead tissue that needs to be removed for wound healing) and black/brown eschar (dead tissue that has hardened).
-The wound length was 1 centimeter (cm), the width 1 cm and depth unstageable.
-There was stable eschar to toes on bilateral feet.
-The wound length was 3cm and width 4cm.

Interview with a personal care aide (PCA) on 02/04/21 at 12:00pm revealed:
-Resident #5 was very aggressive with staff when they attempted to provide personal care.
-He was incontinent and she changed his briefs during her shift up until the day he went to the hospital on 01/13/21.
-She did not see any skin breakdown or changes in his skin when she changed his brief.

Interview with the physical therapist (PT) on 02/04/21 at 12:50pm revealed:
-Resident #5 had a language barrier-he spoke Spanish.
-She acted as a translator for Resident #5 and the staff when she was in the building.
-She was in the facility twice weekly and worked with Resident #5 from admission to discharge.
-On treatment days she found him in the bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 55	D 273		

most of the time.
-As part of his therapy, she assisted in one shower in December of 2020.
-She noticed his sacral area was reddened as well as the knuckles on his toes.
-There were no open areas that she observed at that time.
-The staff providing the shower was made aware.

Interview with a second shift PCA on 02/04/21 at 3:40pm revealed:
-She noticed Resident #5's sacral area was a little pink when she showered him "around Christmas time".
-The area stayed pink over the next few weeks.
-She did not document this on the Body Evaluation and Observation Form.
-She thought she told the MA at the time.
-She had been taught by the staff who trained her to report skin changes to the MA.

Telephone interview with another MA on 02/10/21 at 9:59am revealed:
-She had assisted the PCAs in changing Resident #5's brief because he was combative with care.
-She did not observe any skin breakdown when changing his brief.
-It was not reported to her by the staff that Resident #5 had any skin breakdown.

Telephone interview with Resident #5's PCP on 02/11/21 at 3:44pm revealed:
-She had not received any information from the staff at the facility regarding wounds on his sacral area or his feet.
-Malnutrition was a risk factor for skin breakdown.

Telephone interview with the facility's contracted PCP on 02/11/21 at 2:53pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 56	D 273		

-Protein deficiency placed a resident at a higher risk for pressure ulcers.
-Pressure on the bony prominences, without positioning changes every few hours, also increased the risk for pressure ulcers.

Telephone interview with a Registered Nurse (RN) in wound care on 02/11/21 revealed:
-The development of eschar on a wound takes some time.
-If a resident was diabetic, it may take less time.
-Other factors, such as nutrition and comorbidities can influence the rate at which a wound develops.
-With all those factors in mind, it definitely would take a week or more for a wound to develop eschar.

Interview with the Special Care Coordinator (SCC) on 02/04/21 at 1:20pm revealed:
-She did not know Resident #5 had an unstageable wound on his sacrum and wounds on both his feet.
-There was no documentation of skin breakdown on his Body Evaluation and Observation Form from 01/01/21 through 01/13/21.

Interview with the Executive Director (ED) on 02/04/21 at 3:15pm revealed she did not know Resident #5 had an unstageable wound on his sacrum and wounds on both his feet.

b. Telephone interview with Resident #5's PCP on 02/11/21 at 3:44pm revealed:
-Resident #5 was seen at her office on 11/17/20.
-His weight at that time was 159 pounds (lbs).

Review of documentation from Resident #5's hospital records on 01/22/21 revealed Resident #5 weighed 122 lbs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 57 Interview with a PCA on 02/04/21 at 12:00pm revealed: -The PCAs or MAs weighed the residents monthly. -She weighed Resident #5 and other residents in the Special Care Unit (SCU) monthly. -The weights were reported to the SCC and she documented them. -The weight scale that was used was inaccurate. -Management was aware the scale was not accurately measuring the weights of the residents. -The scale had been inaccurate for a "long time". Telephone interview with the facility's contracted provider on 02/10/21 at 9:14am revealed: -She did not review the weights that were documented by the facility for her residents any longer. -The weights documented were "wildly variable" and as such were not accurate. -The Special Care Coordinator (SCC) had mentioned the weight scale that was used for resident's weights needed to be calibrated. -She did not want to change any treatment plans, including medications, based on inaccurate weight fluctuations. Telephone interview with the facility's contracted PCP on 02/11/21 at 2:53pm revealed a weight loss of 37 pounds in 2 months indicates Resident #5's nutritional status was not good, and could put the resident's skin integrity at risk. Telephone interview with Resident #5's PCP on 02/11/21 at 3:44pm revealed: -She had not received any information from the staff at the facility regarding Resident #5's 30lb weight loss.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 58 -It was her expectation the facility would notify her of a significant weight loss. Interview with SCC on 02/04/21 at 11:19am revealed: -It was the facility's policy to weigh the residents monthly. -The policy was not documented. -The wheelchair scale was not properly calibrated. -The weights that were reported were probably not accurate. -She had informed the ED, and then she purchased a small bathroom scale for those residents who could ambulate and stand on the scale. -Resident #5 was weighed in his wheelchair on the faulty scale. -Due to the demands of the facility during an outbreak of scabies infestation, she did not review the resident's weights in December 2020. -The last recorded weight for Resident #5 was on 12/05/20 at 129.5 lbs. -She did not inform the physician of Resident #5's significant weight decrease since admission. -It was her responsibility to inform the resident's PCP when there was a significant weight loss. Interview with the Executive Director on 02/04/21 at 3:15pm revealed: -It had been reported to her the weight scales were inaccurate and needed to be calibrated. -She knew the SCC had purchased a smaller scale to get a more accurate reading of the resident's monthly weights. -She had not contacted anyone at that time to evaluate and repair the wheelchair scale. -She did not know Resident #5 had a 30 pound decrease in weight from 11/17/21 to 01/22/21.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 59	D 273		

2. Review of Resident #3's current FL2 dated 10/30/20 revealed:
-Diagnoses included vascular dementia, hypoxia and dysphagia III diet, (moist foods in bite size pieces).
-He was semi-ambulatory with a wheelchair.
-He was continent of bowel and occasionally incontinent of bladder.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 06/05/20.

Review of the primary care provider's (PCP) consultation notes from December 1, 2020 through January 31, 2021 revealed:
-The PCP conducted virtual visits with Resident #3 due to the COVID-19 outbreak status at the facility.
-There was no documentation in the consultation notes that the PCP was made aware of any skin breakdown for Resident #3.

Review of Resident #3's progress notes from December 1, 2020 through February 4, 2021 revealed there was no documentation Resident #3 had any skin breakdown.

Observation of Resident #3 on 02/04/21 at 12:07pm revealed:
-The personal care aide (PCA) changed Resident #3's brief.
-There were 2 briefs on Resident #3 and both were soaked with urine and soiled with feces.
-The left buttock had a deeply reddened area approximately 4 inches by 3 inches.
-There was a dime size open area at the base of the spine in between the buttocks.

Telephone interview with Resident #3's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 60	D 273		

occupational therapist (OT) on 02/04/21 at 1:41pm revealed:
-Resident #3 was on her client list and working on active range of motion and standing using his walker.
-During one of their sessions, 01/11/21, she observed a small open wound on Resident #3's lower back.
-Staff reported to the therapist they had not seen this wound before.
-She left a note in the provider's folder notifying her that Resident #3 had a reddened area on his lower back.
-She did not know Resident #3's provider was not coming in to the facility.
-She did not know if the provider received her note since it did not require follow up on her part.
-She did not know if the staff notified the provider of Resident #3's open area on his back.

Interview with a first shift PCA on 02/04/21 at 3:40pm revealed:
-Resident #3 was occasionally incontinent, so he wore a brief.
-She had assisted him with showers in the past month.
-She had changed his brief at least once during the shifts she worked in the past month.
-She had not noticed any skin breakdown during those instances of personal care.

Observation during personal care of Resident #3 on 02/04/21 at 3:50pm revealed:
-Resident #3's brief was soaked for a second time that day with urine and feces.
-There was a deep red area on the left buttock and an open area at the tip of the sacrum.
-In wiping the buttocks and sacral area, the PCA observed blood on the wipe.
-She had not observed the open areas until she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 61 noticed the blood on the wipe. Interview with a second shift PCA on 02/04/21 at 3:50pm revealed: -She had changed Resident #3 and showered him several time over the past few weeks and not noticed either area. -If she had noticed the skin breakdown, she would have reported it to her MA. -That was the process for reporting skin breakdown. Telephone interview with another PCA on 02/09/21 at 8:11am revealed: -She had worked this past weekend and noticed a "spot" on Resident #3's buttocks while changing his brief. -She reported the spot to the MA. -She did not fill out a Body Evaluation and Observation Form, which was used during showers to observe the skin integrity of residents. -She did not know she had to do anything else but inform the MA. Telephone interview with a MA on 02/10/21 at 9:59am revealed: -She assisted the PCAs with resident's showers and personal care. -Resident #3 used to keep himself clean, but now required incontinence care. -She did not observe any skin breakdown on Resident #3 prior to 02/05/21, when she assisted with his shower. -She was not informed by staff there was any skin breakdown prior to this date. -She completed the Body Evaluation and Observation Form and left it in the Special Care Coordinator's (SCC) box in the medication room. Telephone interview with another PCA on	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 62	D 273		

02/12/21 at 9:45am revealed:
-She worked in the Special Care Unit (SCU) on 02/02/21 .
-She changed Resident #3's brief and noticed a reddened area on his buttocks.
-She reported the skin breakdown to the SCC.
-She had not worked on the SCU since then.

Interview with the SCC on 02/04/21 at 1:20pm revealed:
-Since Resident #3's COVID-19 diagnosis on 01/13/21, he had been in the bed all day and incontinent of bowel and bladder.
-The staff completed a Body Evaluation and Observation Form each time a resident was showered or bathed, documenting any skin discoloration or breakdown, and the condition of their fingernails and toenails.
-The forms should be completed if any skin irregularity was observed during personal care, including incontinence care.
-The completed form should be placed in her box in the medication room.
-The PCAs should also inform the MAs if she was not in the building.
-She was responsible for following up with the provider to inform them of any changes with their residents.
-There was no Body Evaluation and Observation Form for Resident #3 in January 2021 or February 2021 that documented any skin breakdown in Resident #3's sacral area or buttocks.
-She did not know Resident #3 had skin breakdown on his left buttock and sacral area.

Review of Resident #3's Body Evaluation and Observation Forms provided from January 5, 2021 to February 4, 2021 did not reveal documentation of any redness or skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 63	D 273		

breakdown.

Telephone interview with Resident #3's PCP on 02/05/21 at 9:14am revealed:
-She had not been notified of any skin breakdown on Resident #3's buttocks or sacral area.
-The medical doctor (MD) would be conducting a virtual visit with Resident #3 today and she would make her aware.
-One of them would send an order to the facility for home health to assess and evaluate Resident #3's wounds.

Telephone interview with the home health agency on 02/12/21 at 9:09am revealed they had not received a referral for a wound assessment and evaluation for Resident #3 from the facility.

Telephone interview with the SCC on 02/11/21 at 9:30am revealed:
-The physician's order for home health to evaluate and treat Resident #3's pressure wound was received at the facility on 02/06/21.
-The first shift MA had been instructed to forward the order to home health on 02/06/21.
-The SCC returned to work on 02/09/21 and found the order had not been sent to the home health agency.
-She sent Resident #3's home health order on 02/09/21 and did not know why they had not received the order.
-She did not keep Fax confirmations and did not call the agency and follow up.

Interview with the Executive Director (ED) on 02/04/21 at 3:15pm revealed
-The PCAs were to observe the condition of the resident's skin during personal care, and document on the Body Evaluation and Observation Form located in the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 64 room. -The completed sheets should be turned in to the SCC or ED. -If wounds or skin breakdown were documented, the SCC contacted the physician and requested an order for home health to evaluate and treat. -The SCC had trained her staff regarding this process of documenting and reporting. -She did not know Resident #3 had skin breakdown on his left buttocks and an open area that was bleeding during incontinence care in his sacral area. -She did not know how the staff missed those areas on Resident #3's skin when he was showered twice a week. -If he refused showers, skin observations could be completed during incontinence changes. -There was no reason the staff should have missed Resident #3's skin breakdown. Based on observations and interviews it was determined Resident #3 was not interviewable. _____ The facility failed to notify the residents' physicians of skin breakdown which resulted in a delay of care and progression of pressure ulcers in the sacral area for Resident #3 and #5 and failed to notify the physician of a 30 lb weight loss resulting a nutritional deficit malnutrition and decreased skin integrity which aided the formation and progression of pressure ulcers on his sacral area and bilateral feet. The failure of the facility resulted in risk for serious physical harm and neglect of the residents and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on February 11, 2021.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 273	Continued From page 65 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 14, 2021.	D 273		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to ensure the recommendations and guidance established by the Centers for Disease Control (CDC), The North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 related to the screening of staff in the facility and staff not wearing appropriate personal protective equipment (PPE) when caring for COVID-19 positive and negative residents.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 612	Continued From page 66 The findings are: Review of the CDC guidelines to prevent the spread of COVID-19 in Assisted Living facilities (ALFs) revealed: -Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms consistent with COVID-19 before starting each shift/when they enter the building. -Send visitors and personnel home if they have a fever (temperature of 100.0 degrees Fahrenheit or greater) or symptoms consistent with COVID-19. -For situations where close contact with any resident cannot be avoided, personnel should at a minimum, wear eye protection (goggles or face shield) and an N95 mask or higher-level respirator (or a facemask if respirators are not available). -Cloth face coverings are not PPE and should not be used when a respirator or facemask is indicated. -If personnel have direct contact with a resident, they should also wear gloves. -If available, gowns are also recommended but should be prioritized for activities where splashes or sprays are anticipated, or high-contact resident-care activities that provide opportunities for transfer to pathogens to hands and clothing of personnel. -Personnel who do not interact with residents and do not clean resident environments or equipment do not need to wear PPE. However, they should wear a cloth face covering or, if PPE supplies are sufficient, a facemask for source control. Review of North Carolina Department of Health	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 612	Continued From page 67	D 612		

and Human Services (NC DHHS) "What to Expect: Response to New COVID-19 Cases or Outbreaks in Long Term Care Settings" dated 09/04/20 revealed:
-Facility staff should wear appropriate PPE when caring for patients with undiagnosed respiratory infection or confirmed COVID-19.
-Implement universal use of face masks for all staff while in the facility if supplies are available.
-Consider routine use of gloves for all patient interactions.
-Use of eye protection is recommended in areas with moderate to substantial community transmission.
-Staff should be screened for fever and respiratory symptoms prior to starting their shift.

Review of COVID-19 guidance received by the facility from the LHD revealed the LHD nurse had emailed links to guidance and had printed out guidance from the CDC, NC DHHS, and the LHD.

Interview with the Executive Director (ED) on 02/03/21 at 12:00pm revealed:
-She reported daily to the local health department (LHD) communicable disease (CD) nurse the number of positive COVID-19 residents and staff.
-She also reported who was in the hospital, any related deaths, and of any residents that had returned to the facility.

A second interview with the ED on 02/03/21 at 12:49 PM revealed:
-On 01/06/21 they performed facility wide testing for all residents and staff because one employee had tested positive for COVID-19.
-She was symptomatic and went to the emergency room for testing.
-The week of 01/06/21 the facility had 21 residents and 8 staff that tested positive for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 612	Continued From page 68	D 612		

COVID-19.
-The week of 01/11/21 there were 11 additional positive residents and 1 positive staff, plus 2 additional staff that tested positive outside of the facility.
-The week of 01/18/21 there were 5 additional positive residents.
-On 01/27/21 they had 2 additional residents test positive for COVID-19, then 1 resident went to the hospital and was tested positive while at the hospital .
-The 300 hall COVID-19 unit residents had completed the 14 day quarantine, but were all going to stay on that hall for now.
-There was only one special care unit resident that was still within the 14 day window for quarantine.

A third interview with ED on 02/03/21 at 2:35pm revealed:
-There was one resident on the special care unit (SCU) that was still on the 14 day quarantine.
-The residents on the 300 hall COVID-19 unit were finished with their 14 day quarantine, but were remaining in those rooms for now.

1. Observation of the facility's COVID-19 screening station on 02/03/21 at 2:07pm revealed:
-There was a sign with screening directions for staff and visitors which stated: You cannot screen yourself. Another employee must be listed as your screener."
-There was one tablet, one infrared thermometer, and a container of hand sanitizer at the screening table.

Observation of a medication aide (MA) reporting to work on 02/03/21 at 2:18 pm revealed:
-The MA was coming into work on second shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 612	Continued From page 69 -The MA stopped at the COVID-19 screening station and took her own temperature and logged into the tablet, located at the front entrance. -There was not a staff member there to confirm her temperature and screening questions were answered appropriately. Observation of a second MA reporting to work on 02/03/21 at 2:23 pm revealed: -The MA was coming into work on second shift. -The MA stopped at the COVID-19 screening station and took her own temperature and logged into the tablet, located at the front entrance. -There was not a staff member there to confirm her temperature and screening questions were answered appropriately. Review of the time punch detail from 01/20/21 to 01/25/21 and COVID-19 staff screening logs revealed: -On 01/20/21, there were two staff out of twenty who worked that were not screened for COVID-19 prior to working. -On 01/21/21, there were two staff out of twenty-two who worked that were not screened for COVID-19 prior to working. -On 01/22/21, there were two staff out of twenty-three who worked that were not screened for COVID-19 prior to working. -On 01/23/21, there were three staff out of sixteen who worked that were not screened for COVID-19 prior to working. -On 01/24/21, there were three staff out of seventeen who worked that were not screened for COVID-19 prior to working. Interview with a MA on 02/03/21 at 3:00pm revealed: -At the start of each shift, staff screened themselves at the front entrance and results were	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 612	Continued From page 70	D 612		

logged onto the tablet.
-Visitors were screened at the front entrance.
-If a staff had a high temperature, then they reported it to management.
-She had not received any training regarding COVID-19 infection control.

Interview with ED on 02/03/21 at 2:35pm and 3:45pm revealed:
-Staff screening was expected to be performed before the beginning of every shift.
-Staff were expected to answer the questions on the tablet and then be checked off by a supervisor or management.
-Staff and essential visitors were screened on the tablet by the front door.
-The software on the tablet asked COVID-19 specific screening questions.
-They asked if the visitor had any symptoms and what residents they were visiting that day.
-The facility staff generally did not self-screen.
-They could put their own information into the tablet and the ED, business office manager (BOM) or supervisor should take their temperature.
-The tablet software was developed to give a message to the employee if they answer in the positive to any of the screening questions and it would send a message to them that they were not qualified to work.
-If staff received that message, they were to notify a supervisor or management and on call staff were requested to come in to cover the shift.
-Management had told staff not to come in if they had any symptoms of illness.
-She had the ability to review the screening report and compare the results with the time punch detail on any given shift.
-The 2nd shift supervisor screened the oncoming third shift staff and 3rd shift screened oncoming

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 612	Continued From page 71	D 612		

1st shift staff.
-Management screened staff during normal business hours, which included 2nd shift staff.

Telephone interview with the Special Care Coordinator (SCC) on 02/11/21 at 9:49am revealed:
-Staff were to be screened using the tablet and thermometer.
-They were supposed to be checked off by another employee, who was to type their name into the tablet.
-At one point the screener name dropped off the tablet software, she was unsure why this happened.
-Sometimes the screening was performed on pre-printed forms.
-Staff should always be signed off by another staff member or management.

Review of the facility's Infection Control 21 - Coronavirus policy dated 10/21/20 revealed:
-Staff will be trained on recognizing signs and symptoms of coronavirus, how to report suspected coronavirus complications, risk factors for complications.
-There was no information regarding screening of staff.

Telephone interview with the ED on 02/11/21 at 11:07am revealed:
-The staff that did not screen prior to working were focused on coming in for work.
-They had inservices and talked about importance of doing screenings.

2. Observation of the SCU on 02/03/21 at 12:25pm revealed:
-There were 2 PCAs, 1 MA and the Special Care Coordinator (SCC) on the unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

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CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 612	Continued From page 72 -The fire doors on the SCU unit were closed to serve as a barrier for the SCU's COVID-19 positive hall. -There was PPE in the medication room which had a padlock with a code. -The PCAs only wore surgical masks and walked from the COVID-19 positive hall and the non-COVID hall freely without gowns, gloves, face shields and did not sanitize hands or change masks. Observation of the housekeeper on 02/03/21 at 12:40pm and 1:28pm revealed: -The housekeeper had on a white disposable coverall and a surgical mask. -He moved from COVID-19 positive hall to non-COVID hall, into the dining area and to the kitchen of the SCU, and through the Assisted Living halls (non-COVID) to the employee lounge wearing the same jumpsuit he had on while working in the COVID hall in SCU. Further observation of the housekeeper in the Assisted Living unit on 02/03/21 at 2:05pm revealed: -He was wearing a disposable white coverall over his clothing while working in the AL non-COVID-19 hall. -He was going from one room to the next room emptying the trash. -He then entered the 3 resident rooms on the COVID-19 unit on the 100 hall without stopping at the barrier to don PPE or sanitize his hands. -He was not wearing gloves, gown, or face shield throughout the entire process. -He then exited the COVID-19 unit on the 100 hall without performing hand hygiene. -He was only wearing a surgical mask and the coverall. At no point did he wash his hands or use hand sanitizer.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 612	Continued From page 73 -He entered resident's rooms on the 100 and 200 hall non COVID-19 units without gloves, collected the trash and placed it into the rolling trash can. -He then pushed the trash can from room to room and repeated the same process. -He then entered the 300 hall COVID-19 unit without performing hand hygiene, he did not put on an isolation gown, gloves, or face shield. -He remained in the same white coverall and had the same surgical mask on. Interview with the same housekeeper on 02/02/21 at 12:50pm revealed: -He wore a white coverall over his street clothes when he arrived for work in the am. -He wore the same coverall throughout the shift between the COVID positive and non-COVID halls on the SCU and AL side as he cleaned. -He wore the same mask unless it became soiled. Observation of the Assisted Living hallways during tour on 02/03/21 at 12:30pm revealed: -There was a large trash receptacle at the exit of the 100 hall COVID-19 unit. -There was not a trash receptacle at the exit of the 300 hall COVID-19 unit. Interview with a medication aide (MA) on 02/03/21 at 3:00pm revealed: -Staff received the following PPE supplies: face shields, surgical masks, disposable gowns and gloves. -There were two isolated sections on the AL side for residents who tested positive for COVID-19 on the 300 hall and a portion of 100 hall. -Staff were required to use face shields, surgical masks, disposable gowns and gloves, when they entered the isolated sections. -Upon staff exiting the isolated area, they were	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 612	Continued From page 74	D 612		

instructed to remove all PPE items and dispose of them in the trash can outside of the isolated area.
-The MA notified the ED when the PPE supplies were low in the medication room.
-To her knowledge, there had not been a shortage of PPE supplies.
-The MA had not received any training regarding COVID-19 infection control.

Interview with the ED on 02/03/21 at 12:49 PM revealed:
-Staff should wear surgical masks and face shields at all times and gloves for direct patient care.
-Gloves, gowns, face shields and surgical masks should be worn at all times while working with COVID-19 positive residents on COVID-19 halls.
-Upon exiting the COVID-19 halls, staff should remove their contaminated PPE in the trash receptacle and perform hand hygiene.

Telephone interview with the facility's contracted PCP on 02/08/21 at 1:12pm revealed she observed the facility staff often working without the appropriate PPE.

Observation of the laundry staff on 02/03/21 at 1:32pm revealed:
-She left the COVID positive hall of the SCU wearing full PPE.
-She went into room 408 (non-COVID) for laundry, and left the SCU continuing to the AL side with the same PPE on.

Interview with a MA on 02/04/21 at 9:15am revealed:
-He was an MA in the SCU.
-He took care of residents in the COVID-19 positive hall first.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 612	Continued From page 75	D 612		

-He wore PPE which was stored in the medication room in the SCU.
-He would remove his gown when he left the COVID-19 positive hall and dispose of it in the trash receptacle located in the dining room or medication room of the non-COVID area of the SCU.
-He sanitized the medication cart with purple top wipes after the medication pass and at the end of his shift.

Interview with the ED on 2/3/21 at 3:45pm revealed:
-When staff exited a COVID-19 positive hall, they should take off the PPE and dispose in a trash receptacle that should be placed at the exit door.
-They just realized there were not trash receptacles outside the COVID-19 positive 300 and 400 halls.

Telephone interview with the facility's contracted PCP on 02/10/21 at 12:54pm revealed:
-She did virtual visits in January 2021 because of COVID-19.
-The ED carried her cell phone around to all the residents on the PCP's list to be seen.
-The ED traveled from COVID positive hall to non-COVID halls wearing only a surgical mask.
-One of the PCP's colleagues also noticed the ED only wore a mask when going between COVID positive and non-COVID halls during facetime visits with residents.
-The facility did not always observe infection control protocols which led to the PCP's office decision to only perform virtual visits.
-The PCP visited other facilities in person and did not want to contaminate those facilities after visiting this facility.

Telephone interview with the SCC on 2/11/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 612	Continued From page 76 9:49am revealed: -Staff should wear face mask, face shield, gowns and gloves when caring for residents who tested positive for COVID-19.. -The should remove contaminated PPE just outside of the COVID positive halls in a large trash receptacle. -They should clean the faceshields for reuse and then perform hand hygiene, prior to entering the non-COVID halls. -Face masks should be changed out if supply on hand was adequate. -Housekeeping staff, laundry and maintenance staff were required to wear the same PPE as direct patient care staff. -She had reminded the housekeeper about wearing proper PPE in the past, but he was not used to wearing it. -Training on PPE was provided to all staff. -She did not know why staff were not wearing isolation gowns on the SCU. -Staff knew it was required and she had been "preaching to them to wear gowns." Review of the facility's Infection Control 21 - Coronavirus policy dated 10/21/20 revealed: -Staff should wear a surgical or procedure mask, gowns, and gloves when caring for residents with COVID-19. -Staff should remove contaminated PPE when leaving the COVID-19 halls and resident rooms and discard of the PPE in the biohazard linen hampers. -They should handle used gear as infectious. -Staff should change gloves and gowns after each encounter with an ill resident and perform hand hygiene. -After removing gloves, staff should immediately without touching surfaces or objects, wash their hands with soap and water.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D 612	Continued From page 77 -Laundry staff should wear gloves, a face mask, and a disposable gown when physical contact with soiled linens is necessary. _____ The facility's failure to ensure the recommendations and guidance established by the Centers for Disease Control (CDC), The North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 related to the screening of staff in the facility and staff not wearing appropriate PPE when caring for COVID-19 positive and negative residents was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on February 04, 2021 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 29, 2021	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D912	Continued From page 78	D912		

federal and state laws and rules and regulations related to competancy validation for Licensed Health Professional Support (LHPS) tasks, Housekeeping and Furnishings, Infection Control and Prevention Program, and Personal Care and Supervision.

The findings are:

1. Based on interviews and record reviews the facility failed to ensure that non-licensed personnel were competency validated by return demonstration for 3 of 3 sampled staff (Staff F, E, and A) who provided care for one resident who required routine colostomy care. [Refer to Tag 161 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Tasks (Type B Violation)].

2. Based on observations and interviews, the facility failed to ensure the facility was free of hazards as evidenced by toilets and sinks that were clogged with feces and urine and others that were dysfunctional, a chair propped up against the bathroom door in a resident's room to prevent usage of the toilet and sink, feces and urine on bathroom floors and on the floor and wall of a resident's bedroom, and bathrooms without the resources for proper hand and toileting hygiene and a shower that was not operational resulting in residents having to take sink baths and a resident having to use a common shower on the COVID-19 positive hall. [Refer to Tag 079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].

3. Based on observations, interviews and record reviews the facility failed to ensure the recommendations and guidance established by the Centers for Disease Control (CDC), The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D912	Continued From page 79 North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 related to the screening of staff in the facility and staff not wearing appropriate PPE when caring for COVID-19 positive and negative residents. [Refer to Tag 612 10A NCAC 13F .1801(c) Infection Control and Prevention Program (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to ensure staff on the special care unit (SCU) were available to supervise and meet the needs of the residents during mealtime, for 1 of 5 sampled residents, related to a resident who was a choking risk (Resident #3). [Refer to Tag 270 10A NCAC 13F .0901(b), Personal Care and Supervision (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free from neglect as related to personal care and supervision and health care. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide personal care	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R-C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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) COMPLETE DATE
D914	Continued From page 80 to 3 of 5 sampled residents, related to a resident who was found wearing 2 briefs and had been incontinent of bowel and bladder, with feces on his hands, under his nails and on his bed and a pressure wound on his butttocks (Residents #3); a resident who developed unstageable pressure wounds on his sacrum and feet (Resident #5); and a resident who required assistance with the care of a colostomy bag who experienced irritation and continued fungal infection around the stoma site (Resident #2). [Refer to Tag 269 10A NCAC 13F .0901(a), Personal Care and Supervision (Type A1 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up with the physician for 2 of 5 sampled residents related to not providing timely notification to the physician regarding wounds on the buttocks and sacral area (Resident #3) and an unstageable wound to the sacral area, wounds on both feet, and a significant weight loss (Resident #5). [Refer to Tag 273 10A NCAC 13F .0902(b), Health Care (Type A2 Violation)].	D914		