STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345421	A. BUILDING _____ B. WING _____ AUG 1 3 2011	C 07/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to follow a medication order in 1 of 4 sampled residents (Resident #1). The findings include: Resident #1was admitted 05/09/06 with diagnoses, in part, senile dementia, chronic renal failure and a history of urinary tract infections. The Minimum Data Set (MDS) dated 04/20/11 indicated the resident had short and long term memory loss and had moderately impaired cognition. The MDS indicated the resident triggered for a urinary tract infection (UTI) Care Plan. The Care Plan indicated the resident had a suprapubic catheter. The Care Plan indicated an approach was to administer medications per physician ' s orders. The Progress Note dated 07/13/11 at 5:00 PM by Nurse #3, indicated the Nurse Practitioner (NP) ordered a urine specimen obtained first then Levaquin 750 mg (milligrams) given now. The Progress Note dated 07/13/11 at 6:00 PM by the NP, indicated the NP ordered Levaquin 750 mg po (orally) immediately after obtaining a urine specimen. The Progress Note dated 07/13/11 at 7:00 PM by	F 281	The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is August 16, 2011. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. **F 281 Services Provided Meet Professional Standards** The nurse has been re-educated regarding the importance of writing and following physicians' and/or physician extender's orders timely.	8-16-11

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

John Farrell Administrator 8-8-11

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

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F 281	Continued From page 1 the NP, indicated Nurse #3 was unable to get a urine specimen because the urine was thick. The Note indicated Nurse #3 had not given the Levaquin. The Progress Note dated 07/13/11 at 7:00 PM by the NP, indicated the NP ordered the suprapubic catheter changed and a urine specimen obtained but if unable, the Levaquin was to be given right away and the urine specimen obtained later. The pharmacy Activity Report dated 07/13/11 indicated 3 tablets of Levaquin 250 mg were removed from the pharmacy back-up supply for Resident #1. The Report indicated the antibiotic was removed by Nurse #3 at 7:01 PM. The Progress Note dated 07/13/11 by the NP, indicated Resident #1 had an acute febrile illness most likely a UTI. The Note indicated the family requested transfer to the hospital. The Progress Note dated 07/13/11 at 9:45 PM by Nurse #3, indicated Resident #1 was transferred to the hospital. The Progress Note dated 07/13/11 at 10:00 PM by Nurse #3, indicated Levaquin was not started for Resident #1. The Hospital Record dated 07/13/11 indicated Resident #1 was admitted after " a sudden decline today " . The Record indicated " his family elected to make the patient comfort care and do not resuscitate " . The Record dated 07/14/11 indicated Resident #1 had a " UTI and eventually had bacteremia " . The Record indicated the preliminary causes of death were	F 281	An audit of charts going back one month from the date of this survey was completed by the Director of Nurses to determine if any other orders had not been carried out timely. No other variances were identified. Staff nurses have been re-educated by the Director of Nurses to write all verbal orders immediately and to carry those orders out timely. A QA Monitoring tool will be utilized by the Director of Nurses or her designee weekly x 4 weeks, then monthly times 2 months then randomly thereafter to ensure compliance with this regulation. Any variances identified will be dealt with on an individual basis with the licensed nurse. Concerns will be reported to the quality assurance committee for further recommendations. Continued compliance will be monitored through routine review of new orders during the morning	

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F 281	Continued From page 2 UTI, sepsis and acute respiratory failure. On 07/25/11 at 2:06 PM, the NP stated she felt Nurse #3 did not respond timely to the resident ' s needs. The NP stated the medical intervention of one dose of oral antibiotics would not have changed the outcome for Resident #1. On 07/25/11 at 2:21 PM, the Unit Coordinator stated her expectation was if a medication was ordered now, then the medication should be given now. On 07/25/11 at 3:10 PM, Nurse #3 showed she had written down on a scrap piece of paper to give Levaquin after the urine was obtained for Resident #1. Nurse #3 stated if a medication was ordered now then the medication should be given now. On 07/25/11 at 3:44 PM, the Director of Nurses (DON) stated usually antibiotics are given after the urine specimen is obtained. The DON stated it was reported the urine was thick and a specimen could not be drawn with a syringe from the suprapubic tube. The DON stated her expectation was Levaquin should have been administered after the 7:00 PM phone call with the NP. The DON stated Levaquin should have been given especially since the medication had been pulled from the pharmacy back-up supply. The DON stated Levaquin should have been administered before Resident #1 left the facility.	F 281	clinical meeting and review of the 24 hr nursing report, routine record reviews and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	