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 _____ OCT 28 2011	C 10/11/2011

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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to produce a care plan with goals, and interventions to prevent pressure ulcers (Resident #1) for 1 of 3 sampled residents. The findings include: Resident #1 was admitted to the facility on 8/25/11 with multiple diagnoses including in part hip fracture, diabetes mellitus and diabetic neuropathy. The admission MDS (Minimum Data Set) assessment dated 8/28/11, indicated	F 279	**The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is October 27th, 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.** **F279 Develop Comprehensive Care plans** A care plan to address assessment and monitoring goals regarding prevention of pressure ulcers has been implemented for Resident #1.	10/27/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Garrell — TITLE: Administrator — (X6) DATE: 10/26/11

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.

K.M.

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F 279	Continued From page 1 Resident #1, had functional limitation in range of motion with one side of her lower extremities and required extensive assist with bed mobility with two person physical assistance. Section M indicated Resident #1 was at risk to develop pressure ulcers and had no pressure ulcers upon assessment. The assessment further indicated that the resident had memory and decision making problems. The CAA (Care Area Assessment) summary dated 9/9/11 indicated in part , risk for skin alteration due to generalized weakness, poor mobility, some urinary incontinence and a surgical incision to hip. Proceed to care plan. The care plans were reviewed; no care plan had been implemented to address assessment, monitoring or goals regarding prevention of pressure ulcers. During an interview on 10/11/11at 247 pm, Aide #1 indicated to prevent pressure ulcers residents who are bed ridden were turned every 2 hours, alternating using positioning of the pillows, behind the back and between the legs and the arm elevated slightly, the heels would also be kept off of the bed. She indicated she would make sure the pressure relief bed was working correctly and the resident was dry. She would report to the nurse if she were to find a skin change. During an interview on 10/1/11 at 3:11pm, MDS, coordinator indicated she had been in the positon for one month, and did not know why the care plan had not been completed. She indicated Resident #1 was at risk for pressure ulcers and she should have been careplanned. The nurses and aides get the careplan information from the chart and the information was also sent to the	F 279	A review of all MDS assessments was completed by the Director of Nurses and her unit managers at the time of the survey. No other care plan for prevention of pressure ulcers was found to be lacking. Care cards were audited as well and all were found to be in place in the care card book at the nurse's station and accurate. Re-education has been completed for both licensed and certified staff regarding residents' care card location. The MDS nurse has been educated regarding implementation of care plans for those who are determined to be at risk for pressure ulcers through the MDS assessment. The Director of Nurses will review MDS's completed and care plans associated with those that indicate potential for pressure ulcers weekly x 4 weeks, then monthly times 3 months. Variances will be corrected as identified.	

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F 279	Continued From page 2 computer for each disapline to know what they were expected to do. During an interview on 10/11/11at 3:42pm, Aide #2 indicated to prevent pressure sores a resident who was bed bound she would, turned the patient every two hours, specifying the boney parts should be kept off of the bed using pillows and if there were special boots in the room those were used and to keep the resident dry. She indicated the nurses told the aides what care the resident recieved, there should be a care card in the closet. During an interview on 10/11/11 at 5:30pm, Aide#3 indicated the nurses determine what care was to be done for the residents. The care card should be on the door of the closet. After looking in two closets a care card was found. She indicated she asked a lot of questions to the nurses because the care plans on the doors were not always right. The residents who are at risk for pressure ulcer may have special boots to wear, and turned every two hours. During an interview on 10/11/11 at 4:28 pm, the director of nursing indicated a skin care plan should have been generated for the resident when she was admitted due to her surgical wound and her risk of pressure sore that was indicated on the mds dated 8/28/11.	F 279	The QA committee will review findings during the monthly QA committee meeting x 3 months or until resolved to monitor for on-going compliance with additional education being provided if indicated. Continued compliance will be monitored through routine record reviews, review of new orders, the MDS assessment process and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. **F314 Treatment/SVCS to prevent/heal Pressure Sores**	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	Resident #1's care plan was updated to include preventative measures and treatment of the existing pressure ulcer. The resident received treatment as ordered and the pressure ulcer has healed.	10/27/11

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F 314	Continued From page 3 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record reviews, the facility failed to implement measures to prevent a pressure ulcer (Resident #1) in 1 of 3 sampled residents. Finding included: Resident #1 was admitted to the facility on 8/17/11 discharged to the hospital on 8/23/11 and readmitted to the facility on 8/25/11 with multiple diagnoses including in part hip fracture, anemia, diabetes mellitus and diabetic neuropathy. The admission MDS (Minimum Data Set) assessment dated 8/28/11, indicated Resident #1, had functional limitation in range of motion with one side of her lower extremities and required extensive assist with bed mobility with two person physical assistance. The assessment indicated Resident #1 was at risk to develop pressure ulcers and had no pressure ulcers upon assessment. The assessment further indicated that the resident had memory and decision making problems. The CAA (Care Area Assessment) summary dated 9/9/11 indicated in part, risk for skin alteration due to generalized weakness, poor mobility, some urinary incontinence and a surgical incision to hip. Proceed to care plan. Review of the hospital transfer form dated, 8/17/11 indicated the skin condition intact and identified the surgical incision to the left thigh.	F 314	A review of all MDS assessments was completed by the Director of Nurses and her unit managers at the time of the survey to determine if a timely skin assessment had been completed upon admission and if interventions had been put into place. Care cards were audited as well and all were found to be in place in the care card book at the nurse's station and accurate. A full in-house skin sweep will be conducted by the administrative nurses and designees on current residents to assure any pressure ulcers have been identified, interventions implemented and care plans and care cards reflect current treatment and preventions. A full 4 page assessment will be completed for readmissions that are out to the hospital greater than 24 hours. The resident will also have a skin audit completed by the treatment nurse and/or the unit manager. Re-education has been	

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F 314	Continued From page 4 A Nursing Admission Assessment dated 8/17/11, indicated skin was intact, and identified sixteen (16) staples to the left hip. The heels were described as normal and red. No other narrative was written regarding the red of the heels. The admission care plans dated 8/17/11 were reviewed; no care plan had been implemented to address assessment, monitoring or goals regarding prevention of pressure ulcers. Review of the discharge summary dated 8/25/11, made no reference to skin breakdown. Review of lab values on the discharge summary dated 8/25/11, revealed blood sugar values elevated 8/23/11, 272 and at discharge 276(normal values 70-100),) hemoglobin 8.1(normal values 12-16) Review of a prealbumin lab value dated 9/6/11, revealed a below normal value of 6.7 (normal values were 17-42), indicated a high risk ulcer development, based on the facilities nutritional care plan dated 8/23/11. Review of the Nutritional At Risk Monitoring documentation dated 8/26/11 and 9/9/11, indicated Resident #1 skin was intact, documentation 9/16/11 indicated a left heel pressure ulcer. Wound care notes dated 8/25/11, indicated resident was readmitted with left surgical hip wound was clean and had sixteen staples no further skin assessment was written. The next wound note was written on 9/2/11 indicated the surgical staples were removed. Review of the readmission nursing note dated 8/25/11 at 6:00pm, indicated Resident #1 was admitted alert and oriented skin was warm and	F 314	completed for both licensed and certified staff regarding residents' care card location. The MDS nurse has been educated regarding implementation of care plans for those who are determined to be at risk for pressure ulcers through the MDS assessment. Additional education relating to the prevention of pressure ulcers will be presented by CCME. The Unit Managers/designees will monitor intervention implementation (3) three times a week for the next (4) four weeks then randomly thereafter. The charge nurses observe for intervention implementation every shift. Variances will be corrected at the time of observation. Monitoring results will be reported to the Director of Nurses weekly for the next (4) four weeks and concerns will be reported to the quality assurance committee for further recommendations.	

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F 314	Continued From page 5 dry, the surgical incision with staples was intact to left thigh, and vital signs were recorded. Resident #1 voiced no complaints of pain. An antibiotic for a urinary tract infection was started. Review of nursing note dated 8/29/11, indicated skin assessment completed; indicated skin was warm and dry. Nursing note dated 9/5/11 at 10:00pm, indicated a stage 2 pressure ulcer was found on the left heel. It was dressed and treated per the wound protocol with treatment nurse to assess. Review of the wound care note written on 9/7/11, " 3x3 st (stage) 2 on left heel. 0 (no) open areas. Smushy purple skin. Betadine applied and covered pressure relieving boot (name brand) applied. Both heels floated. " Review of a bilateral arterial Doppler lower extremity ultra sound dated 9/20/11 revealed Resident #1 had a normal blood flow to her lower legs and feet. During an interview on 10/11/11at 11:50am, Nurse #2 indicated Resident #1 heel wound was found by a family member who brought it to the facilities attention. Her heels were not being floated the day it was found. She indicated she immediately assessed it and began treating it with betadine and a dry dressing. The wound was dark and unstable to the left heel. She indicated when Resident #1 was admitted she did not want to get out of bed , she did not want to eat, she recommended a body pillow to the family for positioning. Her family member was able to get her to do what she needed to do. She concluded, the facilities would have to take responsiblity for the pressure sore, but also felt Resident #1	F 314	New admissions are reviewed during the morning clinical meeting. The Director of Nurses/Unit Managers will review readmission nursing assessments and care plans associated with those that indicate potential for pressure ulcers to ensure care plans are initiated and interventions identified. Variances will be corrected as indicated. Continued compliance will be monitored through routine review of new admissions, readmissions and new orders during the morning clinical meeting, routine record reviews, through the MDS assessment process, routine review of weekly skin assessments and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 314	Continued From page 6 pressure sore was unavoidable because of her poor nutrition. During the wound observation on 10/11/11 on 1:51pm, Resident #1 revealed a 6cm circular heel wound, which was red, dry and healing. Nurse #3 cleaned the sore with normal saline and treated the wound with Betadine and a dressing. During the observation nurse #3 indicated she had assessed Resident #1upon admission and the heels did not have any indication of breakdown. She said there was a week the resident was in bed and did not participate in therapy.She indicted a family member came in to the room and found the heels not floated(elevated off the bed to prevenet pressure ulcers) and brought it to the adminstrators attention the family member then taped a laminated note was placed on the closet to float Resident #1 heels. Nurse #2 was on duty when the pressure ulcer was discovered. During an interview on 10/11/11at 2:47 pm, Aide #1 indicated to prevent pressure ulcers residents who are bedridden would be turned every 2 hours, alternating using positioning of the pillows, behind the back and between the legs and the arm elevated slightly, the heels would also be kept off of the bed and make sure the pressure relief bed was working correctly and the resident was dry. She also reported to the nurse if there was a skin change. The director of nursing indicated the aide assessments did not reflect a skin change. During an interview on 10/11/11at 3:42pm, Aide #2 indicated to prevent pressure sores on a resident who was bed bound she would, turned the patient every two hours, the " boney parts " should be kept off of the bed using pillows and if there were special boots in the room those were	F 314		

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F 314	Continued From page 7 used, to keep the resident dry. She indicated the nurses tell the aides what care for each resident, there should be a care plan in the closet. During an interview on 10/11/11, at 3:11pm, MDS, coordinator indicated Resident #1 should have had a careplan for the surgical wound upon admission and indicated a care plan to prevent pressure ulcers should have been generated .No care plan was done for resident skin since admission. MDS coordinator indicated when a care plan was generated the aides portion of the careplan showed up on the computer , which was how the aides knew what to do for each resident.All aides use the computer to document what was done for each resident. During an interview on 10/11/11 at 4:28pm, Director of nursing (DON) indicated an assessment of Resident#1 when she returned from the hospital should have been completed, by the nursing staff in a nursing note. Unless a resident has been out for three days a new admission form would not be completed. The staff should have done a better job completing the nursing assessment when the resident returned from the hospital. The wound care nurse and the mds nurses work closely together. A skin care plan should have been generated for the resident when she was admitted due to her surgical wound and her risk of pressure sore that was indicted on the MDS dated 8/28/11. The DON returned to the room and and indicated there was no skin assessment notation made by the aides which indicated any breakdown to Resident #1 heels. During an interview on 10/11/11 at 5:30pm, Aide#3 indicated the nurses determined what	F 314		

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F 314	Continued From page 8 care was to be done for the residents. During demonstrated of the computer on the wall used by the aides, Aide#3 indicated information how to turn a resident was on the care card in the closet. After looking in two closets a care card was found. Aide #3 indicated she asked a lot of questions to the nurses because the care cards on the doors were not always right. The residents who are at risk for pressure ulcer may have special boots to wear, the nurses get those and patient were to be turned every two hours. During an interview on 10/11/11 at 5:40pm, the DON indicated they needed to come up with a better system of assessment when residents return from the hospital, there was no way to know if the ulcer happened in the hospital due to the poor assessment when Resident #1 returned. A total assessment sheet would have been done after three days in the hospital. She conclued we need to do better.	F 314		