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 _____	C 12/14/2017

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 000	INITIAL COMMENTS The Statement of Deficiencies was admended on 1/9/18 at tags F741 and F744.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interview, the facility failed to protect a cognitively impaired resident (Resident #105) from physical abuse of a cognitively intact resident (Resident #85) for 1 of 2 sampled residents reviewed for abuse. Findings included: Resident #105 was admitted to the facility on 11/12/16 with multiple diagnoses including dementia with behaviors and psychosis. The annual Minimum Data Set (MDS) assessment dated 11/17/17 indicated that Resident #105 had severe cognitive impairment, needed extensive assist with transfer and had received antipsychotic medication during the assessment	F 600	The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is January 11, 2018. 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.	1/11/18

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

Electronically Signed | 01/08/2018

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F 600	Continued From page 1 period. The assessment also indicated that Resident #105 had no behavioral symptom during the assessment period. Resident #105 nurse's notes dated 11/25/17 at 1:16 AM was reviewed. The notes revealed that approximately at 7:05 PM of 11/24/17, a NA (nurse aide) #5 informed Nurse #6 that Resident #105 had a tape on his chin and in his hands. Nurse #6 assessed Resident #105 and he was alert, smiling and was not in distress. A piece of paper tape was found in his chin measuring 8 inches in length and he was holding other pieces in his hand. Nurse #6 informed Nurse #2 (Nurse Supervisor)and the Director of Nursing (DON). Resident #105 was separated from Resident #85 (perpetrator). The notes further indicated that Resident #85 admitted that he put a tape on Resident's face. Resident #85 was admitted to the facility on 8/19/17 with multiple diagnoses including end stage renal disease. The quarterly MDS assessment dated 11/15/17 indicated that Resident #85's cognition was intact, had no behavioral symptoms and needed supervision with transfer. Resident #85's nurse's notes were reviewed. The notes dated 11/25/17 at 1:24 AM revealed that at 7:05 PM, the resident was in his room and was asked if he had put tape on Resident #105's mouth. Resident #85 stated "yes, so he would shut his mouth and I can get some sleep". Resident #85 was informed that he could not do this and he would need to leave the room. Nurse #2 notified the DON and RP of Resident #85. Resident #85 was moved to another room and was attended by a NA.	F 600	F600 Free from Abuse and Neglect Corrective Action At the time of the alleged incident, prior to the survey, resident #85, the perpetrator, was moved to another room on 11-24-2017, in the facility, and was provided constant one on one supervision until he discharged to an Assisted Living Facility on 12-14-2017. Resident #85 was interviewed by the geriatric psych Nurse Practitioner. Documentation in the medical record reveals that resident 85 stated he never asked for a room change or had an incident prior to this alleged incident. Corrective Action for those having the potential to be affected At the time of the alleged incident on 11-24-2017, all residents that were able to be interviewed were asked if they were having any issues with their room-mate assignment. No other issues were identified. Systemic Changes All staff, licensed and certified, full time, part time, PRN, has been inserviced by the Staff Development Coordinator (SDC), by 1-9-2018, to notify the Director of Nurses (DON), and/or Administrator immediately, if there are any instance brought to their attention, by a resident, that a request has been made for a room change, or if they notice that resident	

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F 600	Continued From page 2 The facility investigation was reviewed. The timeline of the incident provided by the facility included: On 11/24/17 at approximately 8 PM, the DON was notified of a situation regarding Resident #105 having a tape inappropriately hanging off his chin. The tape was immediately removed and Resident #105 was assessed with no areas of altered skin integrity or redness noted. Nurse #2 notified the DON that the roommate of Resident #105 who was Resident #85 had admitted "placing the tape over his (Resident #105) mouth so he would shut up". Nurse #2 has educated Resident #85 that he could not put tape on another's mouth and he verbalized understanding. Resident #85 was escorted out of his room to be assigned to another room. One on one was initiated for Resident #85. Emotional support was provided to Resident #105. Nurse #6 notified the responsible party (RP) of Resident #85 of the incident. The DON directed Nurse #2 and Nurse #6 to initiate the investigation and to notify the Police department. The DON notified the Administrator, Regional Vice President, Clinical Nurse Consultant and the Social Worker (SW) of the incident. DON notified the RP of Resident #105 of the incident. The Police came and interviewed Resident #85 and a citation was issued for assaulting Resident #105. The SW had interviewed the interviewable residents who agreed that care was good and they have been treated with dignity and respect on all shift. Re-education was provided to staff on all types of abuse and reporting with verbalization of material/education provided. The Ombudsman was notified of findings and plan for Resident #85 and was in agreement with steps/actions taken.	F 600	room-mates are not getting along. Responsible Party's (RP) are told at the time of admission if there is a request for a room change to see the Admissions Coordinator or Administrator or DON. In addition, during family care plan meetings, the Social Worker (SW) will ask if there are any issues that may necessitate a room change. This has also been made part of the orientation program for new staff. Monitoring The Director of Nurses (DON), and/or her nurse manager, will perform audits bi-weekly for one month and then monthly for one quarter, of all interviewable residents and interviews with families to determine if there are any issues that need to be resolved between room-mates or if a room change has been requested. Results of the audits will be taken to the Quality Assurance (QA) committee by the DON and will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 600	Continued From page 3	F 600		

In conclusion, the above incident could have caused harm to Resident #105. Resident #85 was issued a 30 day notice for deliberately trying to harm Resident #105.

The 24 hours report dated 11/25/17 and the 5 day report dated 11/29/17 were reviewed. The 5 day report revealed the allegations for reasonable suspicion of a crime and abuse were substantiated.

The Police report dated 11/24/17 was reviewed. The report revealed that Resident #85 was charged with assault to Resident #105 by using a tape on his mouth.

The written statements from NA #5 and NA #6 were reviewed.

NA #5's written statement indicated that she was passing the trays on 800 hall and when she served the tray to Resident #85, he informed her that he put a tape on Resident #105's mouth. He stated that he had done this to keep him quite because he could not sleep. She observed Resident #105 with a tape attached to him. Resident #85 stated that he thought he would be able to get some sleep but it didn't seem that way because the tape didn't help shut him up. NA #5 informed Nurse #6 and observed her removing the tape from Resident #105's mouth.

NA #6's written statement revealed that at 6:15 PM (11/24/17), she was feeding Resident #105 in his room. While feeding Resident #105, Resident #85 stated "I hope he stays quite tonight so I can get some sleep". NA #6 told him that after dinner she would get Resident #105 comfortable and that he would be asleep. NA #6 had finished

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F 600	Continued From page 4	F 600		

feeding Resident #105 and left the room at 6:30 PM. At around 7:00 PM, she overheard NA #5 telling Nurse #6 that Resident #85 had stuck a tape on Resident #105's mouth. She also overheard Nurse #6 asking Resident #85 and he replied "I put it to keep him quite so I can get some sleep".

On 12/11/17 at 4:35 PM, Resident #105 was observed in his room and attempted to interview him but he was not able to answer to questions. He was quite during the observation.

On 12/11/17 at 4:43 PM, Resident #85 was observed in his room. A sitter was observed beside him. When interviewed, Resident #85 stated that he told Resident #105 to be quite but he kept talking so he had to put a tape on his mouth but that didn't stop him from talking. Resident #85 further stated that Resident #105 bothered him at night, he could not sleep. Resident #85 further stated that he had told the nurse to bring him out but the nurse told him that she could not do that because he would bother other residents.

On 12/12/17 at 9:50 AM, the DON was interviewed. She stated that she was informed around 8 PM on 11/24/17 that Resident #85 had put a tape on Resident #105's mouth. Resident #85 was moved to another room and was placed on 1:1 supervision. She added that the Police was informed and charged Resident #85 with assault. The DON also stated that nobody had informed her that Resident #85 had requested to be moved because of Resident#105's constant talking.

On 12/12/17 at 10:10 AM, attempted to interview

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F 600	Continued From page 5	F 600		

the Police but did not return the call.

On 12/12/17 at 3:30 PM, NA #5 was interviewed. She stated that she was serving the tray when Resident #85 told her that he put a tape on Resident #105's mouth to shut him up but it didn't work. She had observed the tape on the chin of Resident #105 and reported it to Nurse #6.

On 12/12/17 at 3:35 PM, Nurse #2 was interviewed. She stated that she was informed by Nurse #6 that Resident #105 had a tape on his mouth and that Resident #85 admitted that he did it to shut him up. She indicated that it was a paper tape and she had informed the DON and the Police. Resident #85 and Resident #105 were separated and Resident #85 was placed on 1:1 supervision. The Police cited Resident #85 with assault. Nurse #2 stated that she was not informed that Resident $#85 had requested to be moved due to Resident #105 constant talking.

On 12/12/17 at 3:40 PM, NA #6 was interviewed. She stated that she just finished feeding Resident #105 when NA #5 served the tray to Resident #85. She overheard NA #5 that Resident #85 had put a tape on Resident #105's mouth to shut him up. NA #6 revealed that Resident #85 had been requesting several times to be moved because he could not sleep at night with Resident #105 constant talking. She added that the nurses knew about his request but she didn't know why he was not moved. She further stated that while she was feeding Resident #105, Resident #85 said that he would find a way to keep him quite so he could sleep tonight. NA #6 indicated that she told Nurse #6 about it.

On 12/12/17 at 3:45 PM, Nurse #6 was

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F 600	Continued From page 6 interviewed. She stated that she was called to the room of Resident #85 and Resident #105. She observed a paper tape on Resident #105's chin and hand and when she asked Resident #85 he replied that he put a tape on his mouth to shut him up. She removed the tape and assessed Resident #105 with no injury noted. She removed Resident #805 from the room and the DON and the Police were notified. When Resident #85 was moved to another room, he stated "I would have done that earlier if I have known I will get a private room". Nurse #6 also stated that Resident #85 had been complaining about Resident #105 and wanted to be moved. She indicated that Nurse #2 was aware about his request but she didn't know why he was not moved.	F 600		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the required Significant Change in Status Assessment (SCSA) following	F 637	F637 Comprehensive Assessment After a Significant Change.	1/11/18

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F 637	Continued From page 7 his admission to hospice care for 1 of 1 residents reviewed for hospice. The findings included: Resident #56 was admitted to the facility on 6/3/16 with diagnoses that included dementia with behavioral disturbance and bipolar disorder. A physician ' s order dated 9/12/17 indicated a hospice evaluation was requested for Resident #56. A review of hospice documentation indicated Resident #56 was admitted to hospice care on 9/15/17. A review of the facility ' s payor source for Resident #56 indicated hospice Medicaid was active as of 9/15/17. A review of Resident #56 ' s Minimum Data Set (MDS) assessments indicated a SCSA had not been completed within 14 days of his admission to hospice care (9/15/17). An SCSA dated 12/11/17 indicated Resident #56 was rarely/never understood and he was unable to complete the brief interview for mental status. He had short term memory problems, long term memory problems, and severely impaired daily decision-making skills. Resident #56 had a prognosis of 6 months or less and was receiving hospice care. An interview was conducted with the MDS Coordinator on 12/14/17 at 1:29 PM. She confirmed Resident #56 was admitted to hospice services on 9/15/17 and the services were ongoing. A review of the MDS assessments that indicated an SCSA had not been completed	F 637	Corrective Action The resident has had a Significant Change in Status Assessment (SCSA) completed as required on December 15th, when determined by the Minimum Data Set (MDS) nurse that it was not completed. Corrective Action for those having the potential to be affected On December 15th, all residents that had been admitted to hospice were reviewed by the MDS/Care Plan Coordinator to determine if there were any residents that required a significant change MDS completed because they had been admitted to hospice. No other resident was found to need a SCSA performed. Systemic Changes The MDS nurse has been re-educated on January 3rd, 2018 by the regional nurse consultant regarding performing a SCSA when a resident is admitted to a hospice service in the facility. Monitoring The Regional Nurse Consultant/and/or the DON, will perform audits bi-weekly for one month and then monthly for one quarter, to determine if there are any residents that have been admitted to hospice and have not had a SCSA performed. Results of the audits will taken to QA by the DON and will be reviewed at the monthly	

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F 637	Continued From page 8 within 14 days of his admission to hospice (9/15/17) was reviewed with the MDS Coordinator. She verified this information and revealed she had not been made aware Resident #56 was admitted to hospice at the time of his admission so she had not completed an SCSA until this week (12/11/17) when she reviewed all of the hospice residents and realized an SCSA had not been done. She indicated an SCSA should have been completed within 14 days of Resident #56 ' s admission to hospice. An interview was conducted with the Director of Nursing on 12/14/17 at 3:12 PM. She indicated she expected the MDS to be completed accurately and as required.	F 637	Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the Minimum Data Set accurately in the areas of hospice and life expectancy (Resident #56) and diagnoses (Resident #48) for 2 of 27 sampled residents. The findings included: 1. Resident #56 was admitted to the facility on 6/3/16 with diagnoses that included dementia with behavioral disturbance and bipolar disorder. A physician ' s order dated 9/12/17 indicated a hospice evaluation was requested for Resident #56.	F 641	F641 Accuracy of Assessments Corrective Action The assessment for resident #56 and #48 has been redone and transmitted by the MDS Coordinator on December 14th, 2017, to include the hospice diagnosis and life expectancy for resident #56, and the diagnoses of depression and hyperlipidemia for resident #48. Corrective Action for those having the potential to be affected	1/11/18

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F 641	Continued From page 9 A review of hospice documentation indicated Resident #56 was admitted to hospice care on 9/15/17. A review of the facility ' s payor source for Resident #56 indicated hospice Medicaid was active as of 9/15/17. The Annual Minimum Data Set (MDS) assessment dated 10/18/17 indicated Resident #56 was rarely/never understood and he was unable to complete the brief interview for mental status. He had short term memory problems, long term memory problems, and severely impaired daily decision-making skills. Resident #56 was coded as not receiving hospice care and not having a prognosis of six months or less. The Care Area Assessment (CAA) for the 10/18/17 MDS related to cognitive loss/dementia indicated Resident #56 received hospice care. An interview was conducted with the MDS Coordinator on 12/14/17 at 1:29 PM. She confirmed Resident #56 was admitted to hospice care on 9/15/17 and the services were ongoing. A review of the annual MDS assessment dated 10/18/17 that indicated Resident #56 was not on hospice care and had no prognosis of six months or less was reviewed with the MDS Coordinator. The CAA for the 10/18/17 MDS that indicated he was receiving hospice care was reviewed with the MDS Coordinator. The MDS Coordinator revealed the 10/18/17 MDS for Resident #56 was incorrectly coded for hospice and prognosis. She revealed she had not been made aware of Resident #56 ' s admission to hospice on 9/15/17 and she had completed those portions of the	F 641	On December 15th, all resident□s assessments that were performed in the past 3 months were reviewed by the MDS/Care Plan Nurse to determine if there were any residents that required an additional diagnosis added to the MDS. No other resident was found to need a diagnosis added to the MDS. Systemic Changes The MDS nurse has been re-educated by the regional nurse consultant by 1-9-18, to ensure that all the diagnoses are captured in the new Point Click Care medical record system, to include life expectancy for hospice patients, and not to rely that they all migrated to the new system. The Business Office Manager and the MDS Coordinator have been instructed by the Administrator to review the census every day to ensure capture of anyone admitted to hospice without the MDS Coordinator knowing. Monitoring The Director of Nurses, and/or her nurse manager, will perform audits bi-weekly for one month and then monthly for one quarter, to determine if all diagnoses are captured on the MDS and if the hospice patients assessment also includes life expectancy. Results of the audits will be taken to QA by the DON and reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to	

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F 641	Continued From page 10 MDS incorrectly. She explained that the Social Worker had completed the CAA that correctly indicated he was on hospice. An interview was conducted with the Director of Nursing on 12/14/17 at 3:12 PM. She indicated she expected the MDS to be completely accurately. 2. Resident #48 was admitted to the facility on 7/23/15 and was re-admitted on 11/9/17 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 10/16/17 indicated that Resident #48's cognition was intact and he had received an antidepressant medication during the assessment period. The assessment did not indicate that Resident #48 had diagnoses of depression and hyperlipidemia. Resident #48 physician's orders were reviewed. On 9/26/17, there was an order for atorvastatin (used to treat hyperlipidemia) 40 milligrams (mgs.) 1 tablet via gastrostomy (G) - tube in the evening for hyperlipidemia and on 9/27/19 for Fluoxetine (used to treat depression) 20 mgs 1 tablet via G-tube daily for depression. On 12/14/17 at 1:29 PM, the MDS Nurse was interviewed. She acknowledged that Resident #48 was on Fluoxetine for depression and atorvastatin for hyperlipidemia and the diagnoses of depression and hyperlipidemia should have been checked but they were not. She added that she missed to check both diagnoses on the quarterly MDS assessment dated 10/16/17 because she was still learning the new system.	F 641	ensure any further recommendations are carried out.	

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(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 641	Continued From page 11 On 12/14/17 at 3:15 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		1/11/18

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F 656	Continued From page 12 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop comprehensive plans of care in the areas of hospice (Resident #56) and behaviors (Resident #12) for 2 of 27 sampled residents. The findings included: 1. Resident #56 was admitted to the facility on 6/3/16 with diagnoses that included dementia with behavioral disturbance and bipolar disorder. A physician ' s order dated 9/12/17 indicated a hospice evaluation was requested for Resident #56. A review of hospice documentation indicated Resident #56 was admitted to hospice care on 9/15/17. A review of the facility ' s payor source for Resident #56 indicated hospice Medicaid was active as of 9/15/17. The Annual Minimum Data Set (MDS) assessment dated 10/18/17 indicated Resident #56 was rarely/never understood and he was unable to complete the brief interview for mental status. He had short term memory problems,	F 656	F656 Develop Comprehensive Care Plans Corrective Action The MDS nurse, on 12-12-2017, has re-done the assessment for resident #56 has been redone to include the hospice diagnosis and care plans for the diagnosis, and an assessment has been redone for resident #12 by the MDS nurse on 12-12-2017, to include updated care plans for resisting care. Corrective Action for those having the potential to be affected On 12-21-2017, all residents that had an assessment in the past three months were reviewed by the Director of Nurses and/or her nurse managers to determine if comprehensive care plans have been developed for all diagnoses, to include resisting care or any behaviors. No other resident was found to not have comprehensive care plans developed, to include behaviors or resisting care.	

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F 656	Continued From page 13 long term memory problems, and severely impaired daily decision-making skills. Resident #56 was coded as not receiving hospice care and not having a prognosis of six months or less. The Care Area Assessment (CAA) for the 10/18/17 MDS related to cognitive loss/dementia indicated Resident #56 received hospice care. A review of Resident #56 ' s comprehensive plan of care indicated a care plan related to hospice services was not initiated until 12/11/17. An interview was conducted with the MDS Coordinator on 12/14/17 at 1:29 PM. She confirmed Resident #56 was admitted to hospice care on 9/15/17 and the services were ongoing. A review of Resident #56 ' s annual MDS dated 10/18/17 that had him coded as not receiving hospice care, but had indicated conflicting information in the CAA that he received hospice care was reviewed with the MDS Coordinator. She revealed the annual assessment dated 10/18/17 had inaccurately coded Resident #56 as not receiving hospice care, but had correctly indicated in the CAAs that he was receiving hospice care. She revealed she had not been made aware of Resident #56 ' s admission to hospice on 9/15/17 and she had completed those portions of the MDS incorrectly. She explained that the Social Worker had correctly completed the CAA that indicated he was on hospice. The MDS Coordinator indicated she was reviewing all hospice residents this week and realized Resident #56 had been admitted to hospice (9/15/17) and a care plan related to hospice had not been developed. She revealed she had initiated the care plan related to hospice for Resident #56 on 12/11/17. She reported a care	F 656	Systemic Changes The MDS nurse has been re-educated by the regional nurse consultant on 1-9-2018, to ensure that all the diagnoses are captured and that person-centered care plans are developed for them. Education included to ensure care plans are developed by the MDS nurse for behaviors and resisting care. Monitoring The Director of Nurses, and/or her nurse manager, will perform audits bi-weekly for one month and then monthly for one quarter, to determine if all diagnoses are captured on the MDS and that person-centered care plans, to include behaviors and resisting care have been developed. Results of the audits will be taken by the DON to the QA meeting be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 656	Continued From page 14	F 656		

plan related to hospice should have been initiated promptly following his admission to hospice.

An interview was conducted with the Director of Nursing on 12/14/17 at 3:12 PM. She indicated she expected the care plans to person centered, comprehensive, and updated timely.

2. Resident #12 was admitted to the facility 11/7/16 with diagnoses that included dementia.

An Annual Minimum Data Set (MDS) dated 9/15/17 indicated Resident #12 was severely impaired in cognition. He required extensive assistance with dressing and eating and total assistance with personal hygiene.

On 12/11/17 at 11:45 AM, Resident #12 was observed sitting in his room in his wheelchair. An observation of Resident #12 ' s hands revealed all fingernails on his left hand were approximately 1-1 ½ inches long from the base of the finger. Resident #12 stated he did not know when asked if he let staff cut his fingernails.

On 12/13/17 at 10:20 AM, an interview was conducted with NA #3 who stated Resident #12 resisted care at times. She said he would hit at staff and sometimes refused to have his fingernails cut.

On 12/14/17 at 7:35 AM, an interview was conducted with the Director of Nursing who stated Resident #12 resisted care at times and stated she knew it took 2 staff members to cut Resident #12's fingernails.

On 12/14/17at 1:38 PM, an interview was conducted with the MDS Coordinator. She said

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F 656	Continued From page 15 she or the social worker implemented the care plan for behaviors and she was unaware that Resident #12 refused/ resisted care. A review of Resident #12's comprehensive plan of care revealed there was not a care plan related to resisting care/ combativeness. On 12/14/17 at 3:24 PM, an interview was conducted with the Director of Nursing. She indicated she expected the care plans to be person centered, comprehensive and the care plan for Resident #12 should have included a care plan for behaviors/ resisting care.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		1/11/18

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F 657	Continued From page 16 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the facility failed to review and revise the care plan for falls for one of four residents reviewed for accidents (Resident #12). The findings included: Resident #12 was admitted to the facility 11/7/16 with diagnoses that included dementia, balance disorder and falls. An Annual Minimum Data Set (MDS) dated 9/15/17 indicated Resident #12 was severely impaired in cognition. He required extensive assistance with bed mobility, transfers and locomotion on and off the unit. Ambulation did not occur during the observation period. There were no falls during the observation period. On 12/13/17at 7:50 AM, NA#3 was observed providing morning care for Resident #12. On completion of morning care, NA#3 transferred Resident #12 from his bed to his wheelchair by standing and pivoting Resident #12 to the wheelchair. She stated staff did not use a mechanical lift during transfers. A care plan dated 9/19/17 stated Resident #12 was at risk for fall related injuries related to Parkinson's, unsteady gait, psychotropic drug use, history of falls and recent episodes of dizziness. Approaches included, in part,	F 657	F657 Care Plan Timing and Revision Corrective Action As the residents transfer ability improved under our care, the care plan has been updated by the MDS nurse on 12-14-2017, to reflect the change from a mechanical lift to a stand and pivot. Although the transfer status was not accurate at the time of the survey, the care plan would have been updated 90 days from the 9-15-2017 assessment on our about 12-15-2017. Corrective Action for those having the potential to be affected On 12-15-2017, all residents that had an improvement or decline in transfer in the last 3 months, were reviewed by the MDS/Care Plan Coordinator by interview of staff to determine if there were any residents that required a revised care plan. No other resident was found to need a revised care plan. Systemic Changes The MDS nurse and Nurse Managers have been re-educated by the regional	

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F 657	Continued From page 17 mechanical lift for transfers. On 12/14/17 at 9:14 AM, a telephone interview was conducted with NA#4. She stated Resident #12 was a stand and pivot transfer and they did not use a mechanical lift for transfers. On 12/14/17 at 1:38 PM, an interview was conducted with the MDS Coordinator. She stated she knew Resident #12 used to use a mechanical lift and that he was now stand and pivot transfers. She said she should have revised the care plan ad discontinued the approach of the use of a mechanical lift for transfers. An interview was conducted with the Director of Nursing on 12/14/17 at 3:12 PM. She indicated she expected the care plans to be person centered, comprehensive and updated timely.	F 657	nurse consultant on 1-9-2018, to ensure that all improvements or decline in transfers are captured and that person-centered care plans are developed for them. The nurse managers will update care plan changes at the morning clinical meeting. Monitoring The Director of Nurses, and/or her nurse manager, will perform audits by asking licensed and certified staff if there has been a change in transferability, bi-weekly for one month and then monthly for one quarter, to determine if there are any residents who have had a decline or improvement in transfers have had a revised care plan developed. Results of the audits will be taken to the QA meeting by the DON and reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide nail care to 3 of 8 residents reviewed for Activities of Daily Living	F 677	F677 ADL Care for Dependent Residents Corrective Action	1/11/18

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F 677	Continued From page 18 (ADLs) (Resident #11, Resident #68, and Resident #12). The findings included: 1. Resident #11 was originally admitted to the facility on 9/10/12 and most recently readmitted to the facility on 9/3/17 with diagnoses which included: Dementia, generalized weakness, and arthritis. Review of Resident #11's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 12/12/17 revealed the resident's cognition was moderately impaired. The resident required extensive staff assistance for all activities of daily living except eating which required limited staff assistance and locomotion off of his unit which required total assistance. Review of Resident #11's care plan which was most recently updated on 12/11/17 revealed the resident was care planned as having required extensive assistance with ADLs related to stiffness and discomfort of bilateral hands. The goal listed for the resident was for the resident to be dressed and well groomed daily through the next assessment. The approaches/interventions listed included shower twice weekly and anticipate and meet the needs of the resident for ADL care on routine rounds and as needed. An observation and interview conducted on 12/11/17 at 10:03 AM revealed Resident #11's fingernails extended beyond his fingertips on all five fingers on each hand. All five fingernails on each hand were observed with dark debris under the free edge of each nail. The resident stated he	F 677	Residents #11, #68, and #12 has had their fingernails trimmed on 12-14-17, and they continue to be reviewed as scheduled on the shower day, and they are being trimmed as necessary. Corrective Action for those having the potential to be affected On 12-15-2017, all residents were reviewed by the nurse managers to determine if there were any residents that required nail care be done at the time. No other resident was found to require nail care. Systemic Changes The Certified Nursing Assistants, full time, part time, and PRN, have been re-educated by 1-9-2018 by the Staff Development Coordinator to provide nail care on shower day. In addition, the nursing assistants are to have the resident inspected by the charge nurse, and the shower sheet signed off on by the charge nurse, to ensure nail care has been completed. Staff that do not perform proper nail care will be subject to the progressive disciplinary process, up to and including termination. Monitoring The Director of Nurses, and/or her nurse manager, will perform observation of nails and documentation of shower sheet audits bi-weekly for one month and then	

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F 677	Continued From page 19 would like to have his fingernails trimmed. An interview with Nursing Assistant (NA) #7 while conducting an observation of Resident #11 was conducted on 12/13/17 at 5:20 PM. Resident #11's fingernails remained extended beyond his fingertips on all ten fingers and the dark debris remained under the free edge of the nail on each of the resident's ten fingernails. NA #7 stated the resident's nails needed to be trimmed and cleaned. The NA further stated residents' nails are to be trimmed on shower days and as needed. The NA further stated Resident #7's assigned shower time was on day shift and she usually worked second shift. The NA was unable to recall what days were the resident's assigned shower days. The resident communicated to the NA of his desire to have his finger nails trimmed. An interview with the Director Of Nursing (DON) while conducting an observation of Resident #11 was conducted on 12/13/17 at 5:48 PM. Resident #11's fingernails were observed to have been trimmed to a length which did not extend beyond the resident's fingertips and there was no dark debris under the free edge of the nail. The DON stated it was her expectation for the residents' nails to be kept clean and trimmed so the fingernails would not extend beyond the residents' fingertips. 2. Resident #68 was originally admitted to the facility on 4/14/16 and most recently readmitted to the facility on 8/6/17 with diagnoses which included: stroke, left sided weakness/paralysis, and dementia. Review of Resident #68's most recent Minimum Data Set (MDS) revealed a quarterly assessment	F 677	monthly for one quarter, to determine if nail care has been completed as necessary. Results of the audits will be taken to QA by the DON and reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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with an Assessment Reference Date (ARD) of 11/9/17 revealed the resident's cognition was severely impaired. The resident required extensive or total staff assistance for all activities of daily living.

Review of Resident #68's care plan which was most recently updated on 11/8/17 revealed the resident was care planned as having required total assistance with ADLs related to: stroke, left sided weakness/paralysis, contractures, and cognitive impairment. The goal listed for the resident was for the resident to be clean and dressed daily. The approaches/interventions listed included: the staff were to provide all ADL care that the resident could not complete, keep finger nails trimmed and clean, and to provide total assistance with shower twice weekly and as needed.

An observation conducted on 12/11/17 at 12:14 PM revealed Resident #68's fingernails extended beyond his fingertips on all five fingers on each hand. All five fingernails on each hand were observed with dark debris under the free edge of each nail.

An observation conducted on 12/13/17 at 4:25 PM revealed Resident #68's fingernails extended beyond his fingertips on all five fingers on each hand. All five fingernails on each hand were observed with dark debris under the free edge of each nail.

An interview with Nursing Assistant (NA) #8 while conducting an observation of Resident #68 was conducted on 12/13/17 at 4:34 PM. Resident #68's fingernails remained extended beyond his fingertips on all ten fingers and the dark debris

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remained under the free edge of the nail on each of the resident's ten fingernails. NA #8 stated Resident #68 was one of the residents she was assigned to take care of. The NA stated residents' nail care was to be completed as part of a resident's shower, along with shaving, and shampooing the resident's hair. The NA stated she did not know what day the resident's assigned shower day was but she did know Resident #68's assigned shower was to be completed on first shift. The NA further stated if she did have a resident and the resident's nails had not been trimmed she would trim them. The NA did clarify, if the resident was a diabetic, she would not trim that resident's nails. Resident #68 did not have diabetes listed as one of his diagnoses. In regards to Resident #68's cognition she stated the resident was able to communicate basic needs and wants. In response to if the resident would like to have his nails trimmed, the resident was observed to look at his nails, and answered yes.

An interview conducted on 12/13/17 at 5:30 PM with NA #7 revealed she had cared for Resident #68 on 12/3/17. The NA stated when providing nail care for Resident #68 he needed to be told about the care to be provided before providing the care. The NA further stated the resident had a history of jerking his hand away when nail care was attempted. NA #7 stated Resident #68's assigned shower time was during day shift and nail care was to be completed as part of a resident's shower unless it was seen the nails needed to be trimmed and cleaned.

An interview with the Director Of Nursing (DON) while conducting an observation of Resident #68 was conducted on 12/13/17 at 5:50 PM.

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Resident #68's fingernails were observed to extend beyond his fingertips on all ten fingers and had dark debris under the free edge of the nail on each of the resident's ten fingernails. The DON stated Resident #68's fingernails needed to be trimmed and the free edge of the fingernail needed to be cleaned. The DON further stated it was her expectation for the residents' nails to be kept clean and trimmed so the fingernails would not extend beyond the residents' fingertips.
3. Resident #12 was admitted to the facility 11/7/16 with diagnoses that included dementia.

An Annual Minimum Data Set (MDS) dated 9/15/17 indicated Resident #12 was severely impaired in cognition. He required extensive assistance with dressing and eating and total assistance with personal hygiene.

On 12/11/17 at 11:45 AM, Resident #12 was observed sitting in his room in his wheelchair. An observation of Resident #12 ' s hands revealed all fingernails on his left hand were approximately 1-1 ½ inches long from the base of the finger. Resident #12 stated he did not know when asked if he let staff cut his fingernails.

On 12/13/17at 7:50 AM, NA#3 was observed providing morning care for Resident #12. NA#3 washed Resident #12 ' s hands but did not provide any nail care during the observation. Resident #12 ' s fingernails on the left hand were observed to be 1-1 ½ inches in length from the tip of the fingers. When asked about nail care, NA#3 stated nails were usually cut/trimmed on shower days and Resident #12 received his showers on Monday and Thursday evenings. NA#3 observed Resident #12 ' s fingernails and stated they were too long and she should have

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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 677	Continued From page 23 cut them during morning care. On 12/13/17 at 10:20 AM, an interview was conducted with NA #3 who stated Resident #12 resisted care at times. She said he would hit at staff and sometimes refused to have his fingernails cut. On 12/14/17 at 7:35 AM, an interview was conducted with the Director of Nursing who stated Resident #12 resisted care at times and stated she knew it took 2 staff members to cut Resident #12's fingernails. On 12/14/17 09:14 AM, a telephone interview was conducted with NA#4. She stated Resident #12 refused to take a shower Monday evening so she gave him a bed bath and changed the bed. NA#4 stated nail care should be done on shower days but it was very difficult to trim Resident #12 ' s nails and she was unable to do nail care Monday evening. She did not remember if she informed the charge nurse of his refusal for nail care. On 12/14/17 at 3:21 PM, an interview was conducted with the Director of Nursing who stated she expected nail care to be done and, if refused by the resident, the nursing assistant should notify the charge nurse.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		1/11/18

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F 686	Continued From page 24 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide pressure ulcer care per physician orders for one of six residents reviewed for pressure ulcers (Resident #106). The findings included: Resident #106 was admitted to the facility 6/16/17. Cumulative diagnoses included a stage 4 pressure ulcer to the left ischium. A stage 4 pressure ulcer is full thickness tissue loss with exposed bone, tendon or muscle. Resident #106's physician orders were reviewed. On 11/17/17, there was a physician's order to cleanse the area to left ischium with normal saline. Apply zinc cream around the wound opening and pack with iodoform gauze. Cover with foam dressing. A Significant Change Minimum Data Set (MDS) dated 11/17/17 indicated Resident #106 was moderately impaired in cognition. Extensive assistance was needed with bed mobility, transfers and personal hygiene. Total assistance was needed with toilet use and bathing. Skin conditions included a stage 4 pressure ulcer that was present on admission. A Care Area Assessment dated 11/30/17 stated	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Corrective Action Resident #106 is receiving the treatment as ordered as observed by the DON on 12-15-2017 Corrective Action for those having the potential to be affected On 12-15-2017, all residents that required treatment orders for a pressure ulcer were reviewed by interview of the treatment nurse and observation by the DON and/or the Unit Managers with the treatment nurse to ensure each residents order was being followed correctly for wound care. No other resident was found to not receive the correct treatment performed. Systemic Changes The treatment nurse was re-educated by the DON on 12-15-2017, regarding the importance of following the exact treatment order. All licensed staff, both full time and PRN have been inserviced by	

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F 686	Continued From page 25 Resident #106 was admitted with a chronic non-healing stage 4 pressure ulcer to the left ischium and had developed a stage 3 (full thickness tissue loss with bone, tendon and muscle not exposed) to the right hip. Resident #106 was being followed by the Wound physician. A care plan dated 12/6/17 and revised on 12/12/17 stated Resident #106 had actual impaired skin integrity related to a stage 4 pressure ulcer to the left ischium. Interventions included treatment as ordered. On 12/13/17 at 11:25 AM, a dressing change observation was conducted with the Treatment Nurse. The Treatment Nurse cleansed the left ischium pressure ulcer with normal saline, packed the pressure ulcer with iodoform gauze and covered the area with a foam dressing. The Treatment Nurse did not apply zinc oxide around the wound opening. On 12/13/17 at 2:22 PM, the Treatment Nurse was interviewed. She stated she forgot to put the zinc oxide around the perimeter of the wound and should have applied the zinc oxide ointment as per physician orders. On 12/14/17 at 3:25 PM, the Director of Nursing was interviewed and stated she expected staff to follow physician orders for pressure ulcer care.	F 686	the DON and or ADON 1-10-2018 regarding the importance of following treatment orders as well. PRN staff will not be allowed to work till inserviced. Following treatment orders is now part of the orientation process and reviewed with the skills checklist. Monitoring The Director of Nurses, and/or her nurse manager, will perform wound care audits by direct observation of wound care treatment bi-weekly for one month and then monthly for one quarter, to determine if wound care orders are carried out as ordered. Results of the audits will be taken by the DON to QA and reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	
F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure	F 741		1/11/18

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F 741	Continued From page 26 resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on record review, observation, family interview, and staff interview, the facility failed to provide competent staffing with the knowledge and skillsets required to effectively interact with cognitively impaired residents. This had the potential to affect 13 of 13 residents who resided on the memory care unit. The findings included: This tag is cross referred to: F744: Based on record review, observation, family interview, and staff interview, the facility failed to implement person centered care planned	F 741	F741 Sufficient/Competent Staff Corrective Action Resident #56 continues to be living in the memory care unit and is being re-directed according to facility provided dementia training. NA2 has been re-educated regarding use of cell phone. The staff member that did not use proper technique to re-direct a resident had been suspended prior to survey and had been reported to the Health Care Registry for	

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F 741	Continued From page 27 interventions to address the needs of a resident with dementia for 1 of 2 sampled residents (Resident #56) who resided on the memory care unit. A review was conducted of the 12/3/17 census record for the memory care unit. There were 13 residents who resided on the memory care unit on 12/3/17. During an interview with Nursing Assistant (NA) #2 on 12/12/17 at 10:45 AM she stated she was working on the memory care unit with NA #1 on 12/3/17 during the second shift (3:00 PM to 11:00 PM). She indicated she and NA #1 were both sitting at the nurse ' s station on their cellular phones completing inservices during their shift. During a phone interview with NA #1 on 12/12/17 at 11:40 AM she stated she was working the second shift on the memory care unit on 12/3/17. NA #1 reported she and NA #2 were both sitting at the nurse ' s station on their cellular phones completing inservices for about a 20-minute time period. She indicated during this shift she tried to redirect Resident #56 verbally from across the room while she was seated at the nurse ' s station, but it was ineffective. NA #1 stated she got up from the nurse ' s station and walked over to Resident #56, she approached him from behind, placed her hands on his wrists, and physically directed him back into the hallway. An observation was conducted on 12/13/17 at 8:20 AM of the distance from the nurse ' s station on the memory care unit to the area of the dining room where Resident #56 was reportedly located on 12/3/17 when NA #1 attempted to verbally redirect him. The distance was approximately 31	F 741	investigation. The staff member terminated on December 15, 2017. As stated by the DON, it is our expectation that the staff on the memory care unit use the knowledge and skillsets they are taught, and to engage with the residents throughout the shift. Corrective Action for those having the potential to be affected All residents with the diagnosis of dementia have the potential to be affected by this alleged deficient practice and are identified through the MDS Care Planning process. Dementia training continues for those that work in the special care unit. The DON and the Nurse Manager for the special care unit have reviewed by direct observation, the caregivers for the unit. amd have not found anyone redirecting residents inappropriately or using cell phones. As stated earlier, the facility had already identified and put corrective measures in place. Systemic Changes All staff, both licensed and certified, full time and PRN, that are scheduled to work in the memory care unit are required to have dementia training by the Staff Development Coordinator (SDC), prior to being scheduled to work there. Continued periodic training will occur as well on a yearly basis. Monitoring	

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F 741	Continued From page 28 feet. An interview was conducted with the Staff Development Coordinator (SDC) on 12/13/17 at 2:10 PM. She indicated all staff received dementia management training as well training on managing problem/difficult behaviors. She reported some strategies that were taught to the staff included, in part, remain calm, utilize a quiet voice, speak slowly, give time to respond, be specific, make eye contact, and approach from the front. The SDC spoke specifically about the staff on the memory care unit and emphasized they were taught to engage with the residents throughout their shift. This interview with the SDC continued. The incident that occurred on 12/3/17 during the second shift (3:00 PM to 11:00 PM) involving Resident #56 was reviewed with the SDC. NA #1 and NA #2 were assigned to the unit and they each confirmed they were on their cellular phones during their shift. NA #1 confirmed she attempted to verbally redirect Resident #56 while she was seated across the room at the nurse ' s station. NA #1 also confirmed when the verbal redirection was ineffective she approached Resident #56 from behind and held his wrists to physically turn him around. The SDC stated staff on the memory care unit were not to be on their cellular phones while they were working on the floor. The SDC revealed it was not appropriate for NA #1 to attempt to verbally redirect Resident #56 from across the room while she sat the nurse ' s station. She additionally revealed NA #1 should not have approached Resident #56 from behind, held his wrists, and physically turned him around. She indicated the staff had not implemented the knowledge and skillsets they	F 741	The Director of Nurses, and/or her nurse manager, will perform random audits an all shifts, to include weekend observations, weekly for one month and then monthly for one quarter, to determine if staff are using facility taught procedures for redirecting residents. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 741	Continued From page 29 were taught. An interview was conducted with the Director of Nursing (DON) on 12/14/17 at 3:12 PM. She stated it was her expectation that the staff on the memory care unit implemented the knowledge and skillsets they were taught in order to effectively interact with cognitively impaired residents. The DON additionally stated she expected the NAs on the memory care unit to engage with the residents throughout their working shift.	F 741		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review, observation, family interview, and staff interview, the facility failed to implement person centered care planned interventions to address the needs of a resident with dementia for 1 of 2 sampled residents (Resident #56) who resided on the memory care unit . The findings included: Resident #56 was admitted to the facility on 6/3/16 with diagnoses that included dementia with behavioral disturbance, restlessness and agitation, psychosis, and bipolar disorders. The Annual Minimum Data Set (MDS) assessment dated 10/18/17 indicated Resident #56 was rarely/never understood and he was	F 744	F744 Treatment/Service for Dementia Corrective Action Resident #56 continues to be living in the memory care unit and is being re-directed according to facility provided dementia training. NA2 has been re-educated regarding use of cell phone. The staff member that did not use proper technique to re-direct a resident had been suspended prior to survey and had been reported to the Health Care Registry for investigation. The staff member terminated on December 15, 2017. As stated by the DON, it is our expectation	1/11/18

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unable to complete the Brief Interview for Mental Status (BIMS). He had short term memory problems, long term memory problems, and severely impaired daily decision-making skills. Resident #56 was assessed as inattentive and had disorganized thinking continuously. He had physical behaviors 1-3 days, verbal behaviors 1-3 days, and wandering behaviors daily during the 7 day MDS look back period. Resident #56 had no rejection of care. He was independent with walking in the room and required supervision of 2 or more staff when walking in the corridor on the unit and with locomotion on the unit.

The Care Area Assessment related to behavioral symptoms for the 10/18/17 MDS indicated Resident #56 had been verbally aggressive and physically aggressive at times when staff was trying to perform Activities of Daily (ADL) care. Staff were to try to redirect and/or leave Resident #56 alone and try again at a later time in a calm manner.

The plan of care for Resident #56 included, in part, the following areas:
- Resident #56 had thought process problems related to diagnoses of dementia and bipolar disorder, inaccurate interpretation of internal/external stimuli, and cognitive deficits. He had confusion/disorientation, he was rarely able to be understood and was rarely able to understand. This area was initiated on 10/17/17 and included the following the interventions: gain attention and eye contact before speaking, give simple 1-2 step commands when providing direction, and give simple choices and allow ample time to respond.
- Resident #56 had the potential for behavior problems due to end stage dementia with a

that the staff on the memory care unit use the knowledge and skillsets they are taught, and to engage with the residents throughout the shift.

Corrective Action for those having the potential to be affected

All residents with the diagnosis of dementia have the potential to be affected by this alleged deficient practice and are identified through the MDS Care Planning process. Dementia training continues for those that work in the special care unit. The DON and the Nurse Manager for the special care unit have reviewed by direct observation, the caregivers for the unit. amd have not found anyone redirecting residents inappropriately or using cell phones. As stated earlier, the facility had already identified and put corrective measures in place.

Systemic Changes

All staff, both licensed and certified, full time and PRN, that are scheduled to work in the memory care unit are required to have dementia training by the SDC, prior to being scheduled to work there. Continued periodic training will occur as well on a yearly basis.

Monitoring

The Director of Nurses, and/or her nurse manager, will perform random audits an all shifts, to include weekend observations, weekly for one month and

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F 744	Continued From page 31 history of hitting and yelling/cursing during ADL care and he wandered. This area was created on 10/17/17 and included the intervention of acknowledging Resident #56 had a right to choose not to follow the prescribed or recommended regimen. - Resident #56 wandered as he was in the memory care unit and walked about the unit aimlessly due to dementia. This area was created on 10/31/17 and included the following interventions: approach in a slow, calming manner when redirecting away from doors and observe whereabouts frequently - Resident #56 was at risk for increased anxiety, decline in cognition, and advancing dementia. This area was created on 10/31/17 and included the following interventions: maintain a calm manner when interacting with Resident #56, reassure he was safe and stay with him if this was necessary, and use simple language and brief statements when instructing him. A review of the record revealed a hard copy print out of an email to the Director of Nursing (DON) from Resident #38 ' s family member (Resident #38 also resided on the memory care unit) dated 12/3/17 at 7:29 PM. The email reported on that afternoon, 12/3/17, she was visiting Resident #38 on the memory care unit of the facility. She indicated she had arrived around 3:30 PM and there were 2 Nursing Assistants (NAs), NA #1 and NA #2, on the unit and both were sitting behind the desk at the nurse ' s station on their cellular phones. Resident #38 ' s family member described Resident #56 as "somewhat agitated" and not responsive to verbal redirection. She reported NA #1 had attempted to verbally redirected Resident #56 numerous times from across the room while seated at the nurse ' s	F 744	then monthly for one quarter, to determine if staff are using facility taught procedures for redirecting residents. Results of the audits will be taken by the DON to QA and will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 744	Continued From page 32	F 744		

station. The verbal redirection from across the room was ineffective for Resident #56. She indicated Resident #56 was in the dining area moving chairs around/through other residents. Resident #38 ' s family member explained that NA #1 got up from the nurse ' s station and went to get Resident #56 out of the tangle of chairs he was in and he was not cooperating. She reported NA #1 then physically redirected Resident #56 out of the area.

A written statement was completed by NA #1 on 12/3/17 at approximately 10:00 PM. The statement indicated NA #1 confirmed she was on her cellular phone working on an inservice while the family member of Resident #38 was visiting the memory care unit. NA #1 indicated, "I had [Resident #56] by his arms to get him out of the dining area towards the hallway so he wouldn ' t swing at anyone cause he has the tendency to strike at people".

An interview was conducted with Resident #38 ' s family member by phone on 12/11/17 at 2:45 PM. She confirmed she emailed the DON on the evening of 12/3/17 to report her observations from that afternoon. She stated she was visiting the memory care unit in the mid-afternoon on 12/3/17. She reported the 2 NAs (NA #1 and NA #2) who were working on the memory care unit were observed sitting behind the desk at the nurse ' s station on their cellular phones. She stated Resident #56 was in the dining area of the memory care unit and was getting behind one of the tables. One of the NAs (NA #1) tried to verbally redirect Resident #56 from across the room while she continued to sit in her chair at the nurse ' s station. The family member of Resident #38 reported Resident #56 was not responsive to

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the verbal redirection from across the room. She reported NA #1 then got up from her chair and she approached Resident #56 and physically redirected him out of the area.

An interview was conducted with NA #2 on 12/12/17 at 10:45 AM. She reported Resident #56 ambulated independently throughout the memory care unit during most of the day. She indicated he had physical behaviors that included swinging and hitting at anyone around him when he became agitated. She reported if Resident #56 was agitated and was around other residents she attempted to redirect him verbally. She indicated that if verbal redirection was not effective she held her hands on the outsides of Resident #56 ' s shoulders to prevent him from swinging at any other residents and she then directed him away from other residents by walking with him while her hands were still positioned outside of his shoulder area. NA #2 was asked what type of interventions were effective with managing Resident #56 ' s behaviors. She stated he was usually responsive if he you provided him with food and she also reported it was helpful to walk with him if he was agitated as this tended to calm him down.

This interview with NA #2 continued. NA #2 stated she was working on the memory care unit with NA #1 on 12/3/17 during the second shift (3:00 PM to 11:00 PM) when Resident #38 ' s family member was visiting the unit. She indicated she and NA #1 were both sitting at the nurse ' s station on their cellular phones completing inservices while Resident #38 ' s family member was visiting. NA #2 reported Resident #56 was observed in the corner of the dining room area near two other residents. She

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stated one of the other residents was getting close to Resident #56 and she and NA #1 were concerned Resident #56 would become physically aggressive with the other resident. She reported NA #1 got up from her chair at the nurse ' s station and moved toward Resident #56. She stated NA #1 approached Resident #56 from behind. NA #2 explained that the front of Resident #56 was blocked by one of the tables. She indicated NA #1 held Resident #56 by the arms and walked him out of the area and directed him down the hallway. NA #2 reported the DON came to the facility that evening (12/3/17) around 10:00 PM. She stated she and NA #1 were instructed not to be on their cellular phones for any reason while they were working on the floor.

An interview was conducted with NA #1 by phone on 12/12/17 at 11:40 AM. She stated she had worked at the facility for close to three years. She stated her normal assignment was not the memory care unit, but she had filled in on that unit numerous times in the past. She reported Resident #56 was ambulatory and he wandered about the memory care unit most of the day. She stated she was working the second shift on the memory care unit on 12/3/17 during the timeframe that Resident #38 ' s family member was visiting the unit. NA #1 reported she and NA #2 were both sitting at the nurse ' s station on their cellular phones completing inservices for about a 20-minute time period. She indicated Resident #56 was in the dining area of the memory care unit and he was visible from where she was sitting. She stated she saw that Resident #56 was getting close to other residents and she heard one of the other residents say something like, ' get away from me ' . NA #1 reported she was concerned Resident #56 was

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going to become physically aggressive with one of the other residents. She indicated she tried to redirect him verbally from across the room while she was sitting at the nurse ' s station by saying something like, ' come here [Resident #56] ' , but he had not complied. NA #1 stated she got up and walked over to Resident #56, she approached him from behind, placed her hands on his wrists, and directed him away from the other residents and back into the hallway. She indicated Resident #56 ' s hands were already down at his sides so she had held his wrists so he would not swing out at her or at any other resident. NA #1 reported the DON came into the facility around 10:00 PM or 10:15 PM that same evening (12/3/17). NA #1 reported she had confirmed to the DON that she and NA #2 were both on their cellular phones during their shift.

An observation was conducted on 12/13/17 at 8:20 AM of the distance from the nurse ' s station on the memory care unit to the corner area of the dining room where Resident #56 was reportedly located on 12/3/17 when NA #1 attempted to verbally redirect him. The distance was approximately 31 feet.

An interview was conducted with the DON on 12/14/17 at 3:12 PM. She stated it was her expectation that person centered care planned interventions were consistently implemented for residents with dementia. The incident that occurred on 12/3/17 involving Resident #56 and NA ' s #1 and #2 as referred to above was reviewed with the DON. She revealed it was not appropriate for NA #1 to attempt to verbally redirect Resident #56 from across the room (approximately a 31-foot distance) while she sat at the nurse ' s station. She additionally revealed

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F 744	Continued From page 36 it was not appropriate for NA #1 to approach Resident #56 from behind, hold both of his wrists, and physically turn him to face a different direction.	F 744		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		1/11/18

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F 756	Continued From page 37 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and Pharmacy Consultant and staff interview, the Attending Physician failed to document the rationale in the resident's medical records if not in agreement with the Pharmacy Consultant's recommendation or if there was no change in the medication for 2 of 6 sampled residents reviewed for unnecessary medications (Residents #7 & #78). Findings included: 1. Resident #7 was admitted to the facility on 6/5/17 with multiple diagnoses including anxiety and insomnia. The quarterly Minimum Data Set (MDS) assessment dated 12/4/17 indicated that Resident #7's cognition was intact and she did not have a pressure ulcer. Resident #7's physician's orders were reviewed. On 9/27/17, she had a physician's order for Vitamin C 500 milligrams (mgs.) 1 tablet by mouth twice a day. On 10/6/17, the Pharmacy Consultant had recommended to "discontinue the Vitamin C, resident was not on iron or zinc supplement". On 10/19/17, the Physician had responded "no change". There was no rationale documented in the medical records of Resident #7 or in the Consultant Pharmacist Communication to Physician form.	F 756	F756 Drug Regimen Review Corrective Action The physician, on 12-27-2017, has reviewed the pharmacy recommendations for residents #7 and #78, and has documented his rational for not agreeing with the recommendation on the pharmacy recommendation sheet. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. The physician has reviewed the recommendations for December on 12-27-2017, that were generated by the pharmacist. Any recommendation that was disagreed with by the physician has had a rationale entered by the physician. Systemic Changes The pharmacist has added a regulatory statement to each recommendation to alert the physician to provide rationale for not agreeing with a recommendation. The physician has been re-educated on 12-15-2017 by the Administrator and	

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F 756	Continued From page 38 On 12/14/17 at 11:32 AM, the Pharmacy Consultant was interviewed. He stated that he expected the Physician to respond to his recommendations and if he didn't agree or didn't want to change the medication to document the rationale in the resident's medical record or on the communication form. On 12/14/17 at 3:15 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the Physician to respond to the Pharmacist recommendations and he if didn't want to change or didn't agree, to document the rationale in the medical records or in the communication form. 2. Resident #78 was admitted to the facility on 4/26/13 with diagnoses that included vascular dementia with behavioral disturbance and psychosis. A physician ' s order dated 11/22/16 indicated Abilify (antipsychotic medication) 2.5 milligrams (mg) twice daily for Resident #78. A Consultant Pharmacist Communication to Physician form dated 8/7/17 indicated a recommendation for a GDR of Resident #78 ' s Abilify 2.5mg twice daily. The bottom portion of the form required the physician to indicate their agreement or disagreement with the recommendation. If the physician disagreed with the recommendation they were to write a brief statement on the form concerning the rationale for their response to the recommendation. The form indicated no agreement or disagreement and there was no rationale documented on the form.	F 756	Pharmacist regarding the regulation. Monitoring The Director of Nurses, and/or her nurse manager, will perform audits monthly for 6 months then quarterly for 2 quarters to determine if the physician is providing rationale as required for recommendations that he disagrees with. Results of the audits will be taken to QA by the DON and reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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A psychoactive medication quarterly review dated 10/31/17 indicated Resident #78 continued on Abilify 2.5 mg twice daily.

A significant change Minimum Data Set (MDS) dated 11/6/17 indicated Resident #78 ' s cognition was severely impaired. He had no behaviors and no rejection of care. Resident #78 received antipsychotic medication on 7 of 7 days during the MDS review period. He was noted to receive antipsychotic medications on a routine basis and has had no recent Gradual Dose Reductions (GDRs).

A review of Resident #78 ' s December 2017 Medication Administration Record through 12/13/17 indicated he continued to receive Abilify 2.5 mg twice daily.

An interview was conducted with the Pharmacy Consultant on 12/14/17 at 11:20 AM. He indicated the physician was to document on the pharmacy communication form their agreement or disagreement with the recommendation. He additionally indicated if the physician disagreed with the recommendation they were to write a brief statement on the form concerning the rationale for their response to the recommendation. The Pharmacy Consultant reported it was challenging to ensure a rationale was consistently documented on the form by the physician if they had disagreed with the recommendation. He stated he was going to remind the physician that a rationale was to be documented on the form if they disagreed with the recommendation.

The Director of Nursing (DON) attempted to reach the physician for interview by phone on

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F 756	Continued From page 40 12/14/17, but she was unable to reach him. An interview was conducted with the DON on 12/14/17 at 3:12 PM. She stated she expected the physician to write a rationale on the pharmacy communication form if the they had not agreed with the recommendation.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		1/11/18

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F 758	Continued From page 41 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and Pharmacy Consultant interview, the facility failed to ensure physician ' s orders for as needed (PRN) psychotropic medications were time limited in duration for 5 of 6 residents (Residents #7, #23, #28, #38, and #56) reviewed for unnecessary medications. The findings included: 1. Resident #56 was admitted to the facility on 6/3/16 with diagnoses that included dementia with behavioral disturbance, restlessness and agitation, psychosis, and bipolar disorder. A physician ' s order for Resident #56 dated 9/26/17 indicated Haldol (antipsychotic) 0.5 milligrams (mg) every 12 hours as needed (PRN). There was no stop date for this PRN Haldol order for Resident #56.	F 758	F758 Free from Unnecessary Psychotropic Meds Corrective Action Orders for residents #□7 has been discontinued (DC'd), #23 has been DC'd, #28 has been DC'd, #38 has been given a stop date of Feb 9th with rationale from MD to support use, and #56 has been DC'd. Corrective Action for those having the potential to be affected All residents that receive psychotropic medications have been reviewed by the pharmacist on 12-14-2017 for time limited orders. If any were determined to not be	

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F 758	Continued From page 42 The Annual Minimum Data Set (MDS) assessment dated 10/18/17 indicated Resident #56 was rarely/never understood and he was unable to complete the Brief Interview for Mental Status (BIMS). He received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period. An interview was conducted with the Pharmacy Consultant on 12/13/17 at 3:10 PM. He indicated he was aware of the regulation regarding a maximum 14-day duration for all PRN antipsychotic medications. He reported this was his first visit to the facility since the regulation was enacted and he was in process of implementing recommendations. An interview was conducted with the Director of Nursing (DON) on 12/14/17 at 3:12 PM. She stated her expectation was for all PRN orders for antipsychotic medications to have a maximum duration of 14 days as per the regulations. 2. Resident #38 was admitted to the facility on 10/1/17 with diagnoses that included anxiety. A physician ' s order for Resident #38 dated 9/29/17 indicated Clonazepam (antianxiety medication) 0.25 milligrams (mg) at bed time as needed (PRN). There was no stop date for this PRN Clonazepam order for Resident #38. The admission Minimum Data Set (MDS) dated 10/9/17 indicated Resident #38 ' s cognition was severely impaired. She received antipsychotic medication on 7 of 7 days and antidepressant medication on 6 of 7 days during the MDS review period.	F 758	limited in duration, a recommendation by the pharmacist has been made and carried out by the MD. Systemic Changes The Administrator and the Pharmacist has met with the Medical Director on 12-14-2017 to go over the regulation for stop orders for psychotropic medications. Monitoring The Director of Nurses, and/or her nurse manager, will perform audits monthly for all psychotropic medications for 6 months, then quarterly for 2 quarters, to determine if the physician is providing automatic stop orders as required for antipsychotic medications. Results of the audits will be take to QA by the DON and reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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An interview was conducted with the Pharmacy Consultant on 12/13/17 at 3:10 PM. He indicated he was aware of the regulation regarding a maximum 14-day duration for all PRN antipsychotic medications. He revealed he was unaware the regulation also indicated a time limited duration was required for all PRN psychotropic medications.

An interview was conducted with the Director of Nursing (DON) on 12/14/17 at 3:12 PM. She stated her expectation was for all PRN orders for psychotropic medications to be time limited in duration as per the regulations.

3. Resident #28 was admitted to the facility on 12/5/12 with diagnoses that included anxiety.

A physician ' s order for Resident #28 dated 9/26/17 indicated Klonopin 0.5 milligrams (mg) every 8 hours as needed (PRN). There was no stop date for this PRN Klonopin order for Resident #28.

The annual Minimum Data Set (MDS) dated 9/29/17 indicated Resident #28 ' s cognition was severely impaired. He received antianxiety medication and antidepressant medication on 7 of 7 days during the MDS review period.

An interview was conducted with the Pharmacy Consultant on 12/13/17 at 3:10 PM. He indicated he was aware of the regulation regarding a maximum 14-day duration for all PRN antipsychotic medications. He revealed he was unaware the regulation also indicated a time limited duration was required for all PRN psychotropic medications.

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F 758	Continued From page 44	F 758		

An interview was conducted with the Director of Nursing (DON) on 12/14/17 at 3:12 PM. She stated her expectation was for all PRN orders for psychotropic medications to be time limited in duration as per the regulations.

4. Resident #23 was admitted to the facility on 7/8/2010 with multiple diagnoses including Alzheimer's disease, dementia and psychosis. The quarterly Minimum Data Set (MDS) dated 9/19/17 indicated Resident #23 was severely impaired in cognition. Resident #23 had received antianxiety and antidepressant medication during the assessment period.

A review of Resident #23's physician orders revealed a physician order for Clonazepam 0.25 milligrams by mouth every eight (8) hours prn (as needed) for anxiety.

On 12/13/17 at 3:12 PM, the facility's pharmacist was interviewed. He stated that he didn't know that the new regulation for PRN use stop date covered all psychotropic medications. He thought it was only for antipsychotic medications.

On 12/14/17 at 11:40 AM, an attempt was made to interview the attending physician of Resident #23 but he was not available.

On 12/14/17 at 3:15 PM, the Director of Nursing was interviewed. She stated that she expected all psychotropic medications ordered to be given PRN to have a stop date of 14 days and, if ordered more than 14 days, to have a rationale documented in the resident's medical record.

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F 758	Continued From page 45 5. Resident # 7 was admitted to the facility on 6/5/17 with multiple diagnoses including anxiety and insomnia. The quarterly Minimum Data Set (MDS) assessment dated 12/4/17 indicated that Resident #7's cognition was intact and she had received an antianxiety and antidepressant medication during the assessment period. Resident #7 physician's orders were reviewed. On 9/27/17, there was a physician order for Trazodone 100 milligrams (mgs.) by mouth at bedtime as needed (PRN) for insomnia. On 9/30/17, there was a physician order for clonazepam 0.5 mgs. by mouth every 4 hours PRN for anxiety. On 12/13/17 at 3:12 PM, the facility's pharmacist was interviewed. He stated that he didn't know that the new regulation for PRN use stop date covered all psychotropic medications, he thought it was only for antipsychotic medications. On 12/14/17 at 11:40 AM, attempted to interview the attending physician of Resident #7 but he was not available to interview. On 12/14/17 at 3:15 PM, the Director of Nursing (DON) was interviewed. She stated that she expected all psychotropic medications ordered to be given PRN to have a stop date of 14 days and if ordered more than 14 days to have a rationale documented in the resident's medical records.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		1/11/18

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F 759	Continued From page 46 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to maintain a medication error rate of less than 5%, when an incorrect medication was administered to a resident (Resident #15) and by failing to flush the Percutaneous Endoscopic Gastrostomy (PEG) tube with water between each medication (Resident #48), 2 errors of 27 opportunities. The result of the medication errors could have resulted in negative side effects for two of four residents observed for medication administration. The medication error rate was 7.4%. Findings included: 1. Resident #15 was originally admitted to the facility on 8/1/13 and was re-admitted on 12/4/16 with multiple diagnoses including: Dementia and high blood pressure. Review of Resident #15's Minimum Data Set (MDS) assessment revealed a quarterly assessment with an Assessment Reference Date (ARD) of 9/23/17. The resident was coded as having had severe cognitive impairment. The resident was coded as requiring extensive assistance with bed mobility, transfer (such as from the bed to a chair), dressing, and limited assistance with eating. An observation was conducted of Nurse #7 during her medication pass preparing and administering medications to Resident #15. Nurse #7 was observed preparing the following medications at the medication cart for Resident	F 759	F759 Free of Medication Error Rates of 5 Percent or More. Corrective Action Resident#15 is receiving the correct medications, and resident #48 is receiving flushes in-between medications being delivered via his G-Tube as observed on 12-11-2017 by the nurse manager for the unit. Corrective Action for those having the potential to be affected All residents that receive medications have the potential to be affected by this alleged deficient practice. All medication carts were checked by the pharmacist and Unit Manager on 12-14-2017, and no other medication was found to be on the cart without an associate order. The DON reviewed the nurses that were scheduled to give medications via g-tube, and all nurses interviewed were able to describe the correct procedure. Systemic Changes All licensed staff, full time, part time, and PRN, have been re-educated on medication administration by the Assistant Director of Nurses (ADON)by 1-9-2018 to include the 5 rights of medication delivery and g-tube medication administration.	

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F 759	Continued From page 47 #15: Memantine (used to treat dementia) 10 milligrams (mgs) one tablet, potassium chloride (used to treat low levels of potassium) 20 milliequivalents (meq) one tablet, venlafaxine (used to treat depression) extended release (er) 150 mgs one capsule, divalproex (used to treat seizures, biplolar disorder, and migraine headaches) delayed release (dr) 125 mgs one tablet, and one multi-vitamin (used as a supplement) tablet. Five medications in total were documented and the nurse stated she had 5 total medications in the medicine cup. The nurse put all five medications in pudding for the resident. The nurse was observed administering the medications which had been placed in the pudding to the resident. Review of the physician's orders for Resident #15 revealed no orders for divalproex. Review of the Medication Administration Record (MAR) for Resident #15 revealed no scheduled dose or administration for divalproex of any dose. During an interview conducted with Nurse #7 on 12/13/17 at 10:21 AM she stated she had a bubble pack card with Resident #15's name and information for the divalproex medication but the MAR for Resident #15 did not have a scheduled dose for the divalproex. The nurse stated the divalproex medication may have "fallen off" of the MAR. The nurse further stated she was unable to find a scheduled dose for the divalproex in the MAR. The nurse further stated she was also unable to find an order for divalproex in the physician's orders. The nurse stated she had talked to the Nurse Practitioner (NP) about the divalproex for Resident #15. The nurse stated both she and the NP were unable to find an order for the divalproex in the hard copy medical record	F 759	Monitoring The Director of Nurses, and/or her nurse manager, will perform medication administration audits, to include G-tube delivery of medications, randomly on varied shifts, to include weekends, of all nurses randomly weekly for 4 weeks and then monthly for 6 months then quarterly for 2 quarters to ensure medication rate is less than 5 percent. Results of the audits will be taken to QA by the DON and reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 759	Continued From page 48	F 759		

or in the Electronic Medical Record (EMR). The nurse stated the date on the bubble pack card of when the divalproex was filled by the pharmacy for Resident #15 was 11/19/17. The nurse further stated she had not checked the Resident #15's MAR prior to administering the divalproex.

During an interview conducted with Nurse #4, the Unit Manager, on 12/13/17 at 2:04 PM she stated Resident #15's name was on the bubble pack card of divalproex and the pharmacy had been informed and they were investigating. Nurse #4, the Unit Manager, stated it was the expectation for the nurse who is administering medication to a resident to review the resident's MAR as the nurse was popping the medication out of the bubble pack and preparing to administer the medication to a resident. In addition the Unit Manager stated an inservice/training had been initiated for the nurse, a medication error report for Resident #15 had been initiated, and the NP had been made aware.

During an interview conducted with Resident #15's on 12/13/17 at 3:32 PM he stated the dose of divalproex was low and the patient would need to have an observation period. He stated the resident may experience some mild sedation but he expected no major negative outcome from the medication. The physician stated a medication error report should be completed. The physician further stated it was expectation for residents to receive their ordered medications and not to receive medications which had not been ordered.

During an interview with the Director of Nursing (DON) on 12/13/17 at 4:50 PM she stated it was her expectation for residents to receive their correct medications and not to receive

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F 759	Continued From page 49 medications which were not ordered for the residents. 2. Resident # 48 was admitted to the facility on 7/23/15 and was re-admitted on 11/9/17 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 10/16/17 indicated that Resident #48's cognition was intact and he had a feeding tube. On 12/13/17 at 9:10 AM, Resident #48 was observed during the medication pass. Nurse #7 was observed to prepare and to administer the resident's medications including Allopurinol (used to treat gout) 300 milligrams (mgs.) 1 ½ tablets, Aspirin (used to treat pain, fever or inflammation) 81 mgs 1 tablet, Metoprolol (used to treat hypertension) 25 mgs ½ tablet, Plavix (used to prevent stroke, heart attacks and other heart problems) 75 mgs 1 tablet and Fluoxetine (used to treat depression) 20 mgs 1 tablet. Nurse #7 was observed to crush all the medications and dissolved in water. Then, she was observed to administer the dissolved medications one at a time via feeding tube without flushing the tube with water between each medication. On 12/13/17 at 9:20 AM, Nurse #7 was interviewed. She stated that she was supposed to flush the feeding tube with water between each medication but she forgot. On 12/14/17 at 3:15 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected nurses to flush the feeding tube with water between each medication.	F 759		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		1/11/18

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F 842	Continued From page 50 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 51 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interview, the facility failed to have an accurate and complete clinical records for 2 of 4 sampled residents reviewed for urinary catheter (Resident #79 & #41). Findings included: 1. Resident #79 was originally admitted to the facility on 9/1/16 and was re-admitted on 11/27/17 with multiple diagnoses including liver cirrhosis. The quarterly Minimum Data Set (MDS) assessment dated 11/6/17 indicated that Resident #79's cognition was intact and she did	F 842	F842 Resident Records-Identifiable Information Corrective Action A late entry has been made in the medical record by the charge nurse, to reflect the order given by the NP to discontinue the catheter for resident #79, as well as the reason it was not discontinued on 12/4/2017. Orders for catheter care for resident #41 has been entered into the	

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F 842	Continued From page 52 not have an indwelling urinary catheter. Resident #79's physician's orders were reviewed. On 12/1/17, there was an order to insert a urinary catheter for fluid management and to remove it on Monday (12/4/17). Resident #79's Medication Administration Record (MAR) for December 2017 was reviewed. The MAR indicated to remove the urinary catheter on 12/4/17. The box on the MAR for 12/4/17 was initialed by Nurse #7 and indicated that removal was on hold and to see nurse's notes. Resident #79's nurse's notes were reviewed. There was no entry for 12/4/17. On 12/10/17 at 4:30 PM, Resident #79 was observed in bed with an indwelling urinary catheter in place draining yellow urine attached to the urinary bag. On 12/11/17 at 9:19 AM, Resident #79 was observed in bed with an indwelling urinary catheter in place. The pad underneath the resident was observed soaked with urine. Resident #79 stated that her catheter was leaking and added that the catheter should have been removed a week ago but it was not. On 12/11/17 at 10:10 AM, Resident #79 was observed and the catheter was already removed. Resident #79's clinical records were reviewed. There was no order to continue the use of the urinary catheter on 12/4/17 and there was no order to discontinue the use of the urinary catheter on 12/11/17.	F 842	medical record by the charge nurse as well. Corrective Action for those having the potential to be affected An audit of all residents that had a catheter at the time of the survey were reviewed by the unit managers on 12-15-2017, in the medical record to confirm that complete orders were present. No other order was found to be not in the record. Systemic Changes Licensed staff, full time, part time and PRN have been inserviced by the DON by 1-9-2018, to ensure proper orders are entered into the record. Monitoring The Director of Nurses, and/or her nurse manager, will perform audits weekly of residents that require insertion or discontinuation of a catheter to ensure orders are followed, for one month and then monthly for one quarter, to determine if every catheter has complete orders written in the medical record. Results of the audits will be taken to QA by the DON and reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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On 12/13/17 at 2:35 PM, Nurse #7 was interviewed. She stated that she did not remove the catheter on 12/4/17 because Resident #79 did not have much urine output. Nurse #7 added that she had talked to the Nurse Practitioner who ordered to hold the removal but she did not document in the nurse's notes nor write an order to continue the use of the urinary catheter. Nurse #7 also indicated that she removed the urinary catheter on 12/11/17 as ordered by Nurse #2. She did not check if there was a physician's order for the removal or not.

On 12/13/17 at 4:30 PM, Nurse #2 was interviewed. She stated that she had talked with the Nurse Practitioner and she ordered to remove the urinary catheter on 12/11/17. Nurse #2 stated that she trusted the Nurse Practitioner to write an order for the removal but she did not.

On 12/14/17 at 3:15 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to make sure there was a doctor's order written to continue or discontinue the use of the urinary catheter and to document in the nurse's notes.

2. Resident #41 was admitted to the facility 12/6/13. Cumulative diagnoses included history of right hemiplegia (weakness that affects one side of the body) secondary to cerebrovascular accident and neurogenic bladder (dysfunction of the urinary bladder requiring the use of an indwelling catheter) and suprapubic catheter (catheter inserted through the abdominal wall into the bladder).

A Significant Change Minimum Data Set (MDS) dated 10/4/17 revealed Resident #41 was cognitively intact. Resident #41 had an indwelling

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F 842	Continued From page 54	F 842		

urinary catheter during the assessment period.

A Care Area Assessment (CAA) for urinary incontinence and indwelling catheter dated 10/12/17 stated Resident #41 had a suprapubic catheter due to a diagnosis of neurogenic bladder. He had frequent urinary tract infections/ kidney stones and was at risk for recurrent urinary tract infections.

A care plan dated 12/5/17 stated Resident #41 was at risk for urinary tract infections related to the use of a suprapubic catheter, urinary retention, neurogenic bladder and a history of urinary tract infections. Interventions included, in part, to change the catheter bag per protocol, change the suprapubic catheter per physician orders and provide catheter care per protocol.

A review of physician orders revealed there were no orders for catheter care/ changing of the suprapubic catheter for October 2017, November 2017 or December 2017.

A review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) for October, November and December 2017 revealed no documentation for catheter care/ changing the suprapubic catheter.

On 12/12/17 at 4:38 PM, an interview was conducted with Resident #41. He stated the nurses cleaned around his suprapubic catheter site and changed the catheter if it needed changes.

On 12/12/17 at 4:39 PM, an interview was conducted with Nurse #3. She said catheter care for Resident #41 was provided by licensed staff

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F 842	Continued From page 55 every shift. She said she was not sure if catheter care and changing the suprapubic catheter was documented on the MAR or the TAR. On 12/ 13/17 at 10:40 AM, an interview was conducted with Nurse #4. She stated Resident #41 returned to the facility from the hospital on 9/27/17. At that time, the facility was in the process of changing computer programs and the physician orders for the catheter care and changing of the catheter was not on the physician orders or added to the MAR or TAR. She stated she obtained physician orders for catheter care and changing of the catheter on 12/12/17. Nurse #4 stated nursing staff just routinely did his catheter care because he had been a resident at the facility for a long time and it was habit to clean the catheter site and change if problems arose. On 12/13/17 at 10:45 AM, an interview was conducted with Nurse #5. She stated she routinely provided catheter care for Resident #41. When asked where the care was documented, she stated she had not documented the care anywhere. She said it should have been documented on the TAR. On 12/14/17 at 3:28 PM, an interview was conducted with the Director of Nursing. She stated she expected to have physician orders written for suprapubic catheter care/ changing of the suprapubic catheter and documentation of the catheter care/ changing of the suprapubic catheter should have been documented on the TAR.	F 842		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i)	F 865		1/11/18

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F 865	Continued From page 56 §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and to monitor the interventions that the committee put into place in December 2016. This was for the two (2) recited deficiencies (MDS accuracy and comprehensive care plan) which were originally cited on 12/14/16 during the recertification survey and on the current recertification survey of 12/14/17. The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. Findings included: This tag is cross referred to: 1.641 - Accuracy of assessments: Based on record review and staff interview, the facility failed	F 865	F865 QAPI Program/Plan Corrective Action The assessment for resident #56 and #48 has been redone and transmitted by the MDS Coordinator on December 14th, 2017, to include the hospice diagnosis and life expectancy for resident #56, and the diagnoses of depression and hyperlipidemia for resident #48. Corrective Action for those having the potential to be affected On December 15th, all residents assessments that were performed in the past 3 months were reviewed by the MDS/Care Plan Nurse to determine if there were any residents that required an	

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F 865	Continued From page 57 to complete the MDS accurately in the areas of hospice and life expectancy (Resident #56) and diagnoses (Resident #48) for 2 of 27 sampled residents reviewed. During the recertification survey of 12/14/16, the facility was cited F278 for failure to accurately complete the MDS assessment in the areas of hospice, prognosis, urinary catheter and medications. 2. F656 - Develop comprehensive care plan: Based on record review and staff interview, the facility failed to develop comprehensive plan of care in the areas of hospice (Resident #56) and behavior (Resident #12) for 2 of 27 sampled residents reviewed. During the recertification survey of 12/14/17, the facility was cited F279 for failure to develop a comprehensive care plan in the areas of wandering behavior and use of urinary catheter. On 12/14/17 at 1:42 PM, the Administrator and the Director of Nursing were interviewed on the facility's QAPI program. The Administrator stated that the facility had a QAPI committee consisted of the Medical Director, Administrator, Director of Nursing, Pharmacy Consultant and all the department heads. The committee had met monthly. The Administrator stated that he was aware that MDS accuracy and comprehensive care plan were repeat deficiencies from last year survey. He indicated that the facility had hired a part time MDS Nurse but it didn't work out so he had to hire a new person who will be starting next week.	F 865	additional diagnosis added to the MDS. No other resident was found to need a diagnosis added to the MDS. Systemic Changes The MDS nurse has been re-educated by the regional nurse consultant by 1-9-18, to ensure that all the diagnoses are captured in the new Point Click Care medical record system, to include life expectancy for hospice patients, and not to rely that they all migrated to the new system. The Business Office Manager and the MDS Coordinator have been instructed by the Administrator to review the census every day to ensure capture of anyone admitted to hospice without the MDS Coordinator knowing. The Quality Assurance Performance Improvement (QAPI) committee has been in-serviced by the Administrator on 1-9-2018, on the procedure for developing and implementing appropriate plans of action to correct identified quality concerns. Education included determining the root cause of the identified concern, identifying, implementing and monitoring the corrective action plan and recognizing when an action plan may need to be revised. Monitoring The Director of Nurses, and/or her nurse manager, will perform audits bi-weekly for one month and then monthly for one quarter, to determine if all diagnoses are captured on the MDS and if the hospice	

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 _____	C 12/14/2017

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

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F 865	Continued From page 58	F 865	patients assessment also includes life expectancy. Results of the audits will be taken to QA by the DON and reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out. The QAPI committee will continue to monitor audits brought to the committee and will either resolve them if there is demonstrated continuance of compliance, or will modify plans as necessary and will continue to monitor the issue.	