| | | ID HUMAN SERVICES | | | | M APPROVED |
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| | S FOR MEDICARE & | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIO | E CONSTRUCTION | | O. 0938-0391 E SURVEY |
| | CORRECTION | IDENTIFICATION NUMBER: | · / | | | IPLETED |
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| | | 345421 | B. WING | | 02 | 2/14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | DBE | (X5) COMPLETION DATE |
| E 000 | Initial Comments | | E 000 | | | |
| F 000 | | 8.73, Emergency t ID #PVRD11. | F 000 | 0 | | |
| | The Statement of De 3/26/19 at tags F756 | ficiencies was amended on and F758. | | | | |
| F 550 | the results of the facil Resolution meeting d F-756 and F-758. The of both of these citatic level. Additionally, inf | vided to the facility based on ity's Informal Dispute eleting an example from tag e scope and severity levels ons was changed to a D ormation was included in tag e results of the IDR. Event cise of Rights | F 550 | 5 | | 3/29/19 |
| SS=G | §483.10(a) Resident The resident has a rig self-determination, ar access to persons an outside the facility, in this section. §483.10(a)(1) A facilit | Rights. ght to a dignified existence, nd communication with and d services inside and cluding those specified in ty must treat each resident | | | | |
| | promotes maintenand her quality of life, reco individuality. The facil promote the rights of | and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and the resident. | | | | |
| | | SUPPLIER REPRESENTATIVE'S SIGNATUR | E | TITLE | | (X6) DATE |
| Electroni | cally Signed | | | | | 03/11/2019 |

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

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 | |
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| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345421 | B. WING | | | | C 14/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | - | | |
| THE LAU | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | SUMMARY ST, (EACH DEFICIENC' REGULATORY OR I | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | | |
| F 550 | §483.10(a)(2) The fac access to quality care severity of condition, must establish and m practices regarding tr provision of services of residents regardless of \$483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The resi- free of interference, co- reprisal from the facilit rights and to be supp- exercise of his or her subpart. This REQUIREMENT by: Based on record revi- resident and staff inter- honor the resident 's wander alarm system wheelchair which resi- he "felt like a dog on a failed to ensure the re- were treated with resi- council meetings (Re- | cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her i the facility and as a citizen used States. cility must ensure that the his or her rights without a, discrimination, or reprisal sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this is not met as evidenced ew, observation, and rview, the facility failed to request to remove the | F | 550 | The Laurels of Chatham wishes to have this submitted plan of correction stand its written allegation of compliance. Our alleged compliance is 3-29-19. Preparation and/or execution of this play of correction does not constitute admission to, nor agreement with, either the existence of or the scope and seven of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and executed to ensure continuing complia with regulatory requirements. | as ur an er vrity of d/or | | |

Facility ID: 923099

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
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| | CORRECTION | IDENTIFICATION NUMBER: | | | | | PLETED |
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| | | 345421 | B. WING | | | 02/ | 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | I | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| | | | | 72 | 2 CHATHAM BUSINESS PARK | | |
| THE LAU | RELS OF CHATHAM | | | Ρ | ITTSBORO, NC 27312 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | < | (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI | | COMPLETION DATE |
| IAG | | | | | DEFICIENCY) | | |
| | | | | | | | |
| F 550 | Continued From page | e 2 | F 5 | 550 | | | |
| | 1. | | | | | | |
| | | | | | F550 Resident Rights | | |
| | | mitted to the facility on | | | | | |
| | | ses of anxiety, insomnia and | | | Corrective Action: | | |
| | seizure disorder. | | | | On 2/13/19 the wanderguard was | • | |
| | A review of Desident | #88 's nurses ' note dated | | | removed from resident #88 s wheelch | | |
| | | revealed the resident exited | | | The facility counseled nurse #1 on the right to privacy during the scheduled | | |
| | | to the front patio with other | | | resident council meeting on 2-15-19. I | n | |
| | residents and a staff | | | | addition, all staff will be educated by 3 | | |
| | | until staff was ready to | | | 19, or they will not be scheduled until t | | |
| | | ent outside. The resident | | | are educated. Education sessions are | | |
| | | e staff member in protest | | | going on currently at various times, giv | /en | |
| | | ge (written by Nurse #2). | | | by the Assistant Director of Nurses (ADON). | | |
| | A review of Resident | #88 ' s quarterly Minimum | | | | | |
| | Data Set (MDS) date | d 12/2/18 revealed an intact | | | Identification of others potentially at ris | sk: | |
| | cognition. | | | | Other residents with wanderguard | | |
| | | | | | bracelets are potentially at risk. Resid | | |
| | | ent 's care plan updated | | | with wanderguards were audited by th | | |
| | | Is and interventions for | | | Director of Nurses (DON)to ensure the | | |
| | | self-care deficit for activities | | | had physician order for wanderguard, | | |
| | | secondary to spinal cord | | | listed on the resident s care card, the | | |
| | contractures, and sei | efused personal care, pain, | | | an elopement assessment that indicat the resident is at risk, residents at risk | | |
| | | | | | elopement are listed in the elopement | | |
| | A review of Resident | #88 's quarterly MDS dated | | | book, and that cognitively resident is | | |
| | | resident had adequate | | | appropriate for wanderguard. If any o | f | |
| | | and was understood and | | | these residents had wanderguards du | | |
| | | gnition was unable to be | | | the last Minimum Data Set assessmer | - | |
| | | ent had other behaviors not | | | (MDS) the MDS will be checked to ens | sure | |
| | | s and rejection of care. The | | | accuracy of coding. Any discrepancie | S | |
| | | ensive assistance of 2 staff | | | will be corrected as identified. All | | |
| | | ed mobility and of 1 staff for | | | residents who attend resident council | | |
| | | active diagnoses were | | | meetings are potentially at risk. | | |
| | neurogenic bladder, o | | | | Sustamia Changes | | |
| | | driplegia, polyneuropathy, | | | Systemic Changes: | ¢ | |
| | - | d other cord compression. I as needed and scheduled | | | The Assistant Director of Nursing/Staf Development Coordinator will complet | | |
| | | | | | | U | |

Facility ID: 923099

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| | S FOR MEDICARE & | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MI II TIE | PLE CONSTRUCTION | OMB NO. 0938-03 (X3) DATE SURVEY |
|--------------------------|--|---|---------------------|--|--|
| | CORRECTION | IDENTIFICATION NUMBER: | · / | G | COMPLETED |
| | | | | | С |
| | | 345421 | B. WING | | 02/14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | CODE |
| THE LAU | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI | CTION SHOULD BE COMPLETIO D THE APPROPRIATE DATE |
| F 550 | Continued From page | e 3 | F 55 | 50 | |
| | an elopement risk. On 02/11/19 at 9:15 a conducted with Resid stated that the staff w wheelchair and called 10/17/18. The reside to put a wander alarm door alarm when app and he refused so sta wheel chair. The resi the wander alarm on resident stated that w alarmed, and he felt the not like the alarm and with an alarm that hav like a prisoner in the fill concerns regarding h The resident admitted a nurse and used fou allowed to exit the build does not want to be a he cannot live alone. On 2/11/19 an observ wheel chair (out of the an expiration date of was motorized and the to travel throughout the | lent #88. The resident vas rude to him by pulling the d the police on him on ent stated that the staff tried in (bracelet that triggers a roached) on his extremity aff placed the device on his ident stated he did not want his wheel chair. The when he neared the door it trapped. The resident does d feels like a dog on a leash d tried to run away and feels facility. The resident had no is care, meals, or staffing. d that he threw hot coffee on I language when he was not ilding alone. The resident at the facility, but he is aware vation of Resident #88 ' s e, and a bracelet wander ttached to the side of his e resident ' s reach) and had 5/2019. The wheel chair he resident was independent he facility. | | education to staff on Resinclude the use of Wander and the right to have a remeeting uninterrupted by have been developed that doors to the activity room aware to not enter. The A has been educated to let or Director of Nurses kno anyone enters during the immediate corrective acti Monitoring: Residents with wandergu audited by the Director of the Unit Nurse Managers months then monthly for ensure appropriate docur use of wanderguards. The Activities Director wil Administrator monthly for interruptions by staff in th council meetings. Results of the audits will Quality Assurance (QA) O DON and be reviewed at Quality Assurance meetir recommendations. The A be responsible to ensure | erguard bracelets sident council staff. New signs it will go on the to make staff activity Director the Administrator w right away if meeting so that on can be taken. ards will be Nurses and/or , bimonthly for 2 1 month to mentation and I report to the 3 months any e resident be taken to the Committee by the the monthly og for any further Administrator will any further |
| | stated she was regula Resident #88. NA #3 NA #3 stated that she | m an interview was ng Assistant (NA) #3 who arly assigned on day shift to 8 was assigned on 10/19/18. 9 remembered the resident ont porch with other residents | | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 |
|--------------------------|---|---|---------------------|-----|---|-------------------|--|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | ST | IREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | ELS OF CHATHAM | | | 72 | 2 CHATHAM BUSINESS PARK | | |
| | | | | PI | ITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE |
| F 550 | was angry, had increat resistive to care on 10 stated that the resident usual, there was no c believed the resident able to go outside alo made comments about On 2/13/18 at 3:00 pm conducted with NA #2 regularly assigned to assigned on 10/18/18 she remembered whet the front door to sit or residents on 10/17/18 independent outside of for a staff member to resident was accompa- entered back into the The resident was ang 10/18/18 and persona- refused. The resident couple of days. The re- because he does not use foul language wh staff or cooperate. No #2 stated that she wa resident had a wande wander risk. NA #2 w resident had a wande wheel chair. NA #2 si observed the resident and the wander alarm requested and demor | n 10/17/19. The resident ased behaviors, and was 0/19/18 for her shift. NA #3 nt was offered his care as hange on this date. It was was angry about not being ne. The resident had also ut not wanting to be here. n an interview was 2 who stated she was Resident #88 and was 3. NA #2 commented that en the resident went outside n the porch with other 5. The resident was not of the facility and had to wait accompany him. The anied to the porch but building shortly thereafter. ry on her evening shift al care was offered and t was not his usual self for a resident verbalized anger want to be at the facility, will en he is mad and not talk to ursing was made aware. NA s aware that in the past the r alarm because he was a vas not aware that the r alarm attached to his tated that she currently t had gone to the front door n would alarm. NA #2 was histrated that the resident's wander alarm attached was | F 5 | 550 | | | |
| | Ci 2/10/19 at 0.20 pl | | | | | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 |
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| STATEMENT C | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL ⁻ A. BUILDI | | | (X3) DATE COMP | SURVEY LETED | |
| | | 345421 | B. WING | | | | (/02 | C 14/2019 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | • | - | |
| | ELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PARK | | | |
| | | | | P | ITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | ILD BE | | (X5) COMPLETION DATE |
| F 550 | Continued From page conducted with Nurse day-shift assigned to h has had a decline of v and desire to get out of everything including of increased confusion. was not aware the resion his wheel chair and resident requested the removed. The resider wander alarm, was no elopement book, and wander guard. Nurse resident was an elope a wander alarm on his present. Nurse #3 co was a risk months age decline. On 2/13/19 at 3:25 pm conducted with Nurse evening-shift assigned resident has had a de decreased ADLs and refusal of everything in medication, and increa- stated that she was no wander alarm on his v wanted it taken off. No resident was alert and needs known and if he taken off his wheel ch honored. Nurse #4 st order for a wander alarm to | e 5 #3 who was regularly Resident #88. The resident weakness, decreased ADLs of bed, a refusal of are and medication, and Nurse #3 stated that she sident had a wander alarm d was not aware that the e wander alarm be nt had no order for a ot documented in the was not care planned for a #3 was aware that the ement risk in the past (wore s person), but not at mmented that the resident o but not at this time due to an an interview was #4 who was regularly d to Resident #88. The foline of weakness, desire to get out of bed, a ncluding care and ased confusion. Nurse #3 ot aware the resident had a wheel chair and that he lurse #4 agreed that the d oriented able to make his e wanted the wander alarm air his request should be rated the resident had no arm, was not documented in and was not care planned prevent elopement. Nurse | | 550 | | | | |
| | #4 was not aware that elopement risk. | I THE TESIDENT WAS AN | | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 APPROVED 0. 0938-0391 |
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| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | _ | (02/ | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | 5 | STREET ADDRESS, CITY, ST | TATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | 2 CHATHAM BUSINESS F PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 550 | who stated she was a wander alarm bracele and that he wanted it that the resident was needed the wander al The DON was aware keep a wander alarm and that was why the wheel chair. After bei agreed the resident h wander alarm bracele there was no physicia alarm bracelet and wa wander alarm manufa placing the bracelet o for safety reasons. Th would remove the brac | n an interview was irector of Nursing (DON) ware Resident #88 had a et attached to his wheel chair taken off. The DON stated an elopement risk and larm to prevent elopement. that the resident would not bracelet on his extremity bracelet was placed on the ing informed, the DON ad the right to refuse the et. The DON was not aware an order for the wander as not aware that the acturer does not endorse in a resident 's wheel chair he DON then stated she acelet. | F 550 | | | | |
| | 2/12/19 at 1:30 PM w residents (Residents a and #91) who were ac facility's Resident Cou in the resident day roo the door that read "Re progress". During the the day room door, er being invited in, and u She indicated that she | I meeting was conducted on ith 6 alert and oriented #35, #40, #45, #80, #87, ctive participants in the uncil. The meeting was held om and a sign was hung on esident Council meeting in e meeting, Nurse #1 opened ntered the room without utilized the vending machine. e was sorry for interrupting urse #1 exited the room the their meetings were | | | | | |
| | frequently interrupted needing to get someth needing to give a resi | - | | | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 |
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| F 550 | disrespectful as it disr they had to stop talkin the room. The resider had one meeting a ma should wait until the n the room. An interview was com Director on 2/12/19 at Resident Council meet always hung a sign of Council meeting was meeting was in progre Resident Council meet interrupted by staff en meeting. She stated residents felt disrespe room during the meet not a surprise to her a stopped talking when their conversation was staff member exited. An interview was cont 2/13/19 at 5:28 PM. S entered the day room sign on the door that a was in progress. She to access the vending vending machine in th room. She stated that resident council mem meeting interruption. An interview was cont Nursing (DON) on 2/1 stated that her expect | e 7 ted that they felt this was cupted their meeting and og until the staff member left its indicated that they only onth and they felt the staff neeting was over to enter ducted with the Activities 2:00 PM following the eting. She stated that she in the door when a Resident held to alert staff that a ess. She reported that the etings were sometimes itering the room during the that she had not known the ected by staff entering the ing but indicated that it was as the residents normally staff entered the room and sn' t reconvened until the ducted with Nurse #1 on She acknowledged that she on 2/12/19 after seeing the a Resident Council meeting e explained that she needed g machine and that the only he facility was in the day is she had not known the bers were bothered by the | F | 550 | | | |

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| | | MEDICAID SERVICES | | | | 0938-039 | |
|--------------------------|--|---|---------------------|---|------------------------------|----------------------------|--|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | (X3) DATE S COMPLE | | |
| | | 345421 | B. WING | | C 02/14 | 4/2019 | |
| NAME OF PI | ROVIDER OR SUPPLIER | · | • | STREET ADDRESS, CITY, STATE, ZIP COL | DE | | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | | |
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| F 550 | Continued From page | e 8 | F 55 | o | | | |
| | for their meetings to lunless there was an | be uninterrupted by staff emergency. | | | | | |
| F 565 | Resident/Family Grou | up and Response | F 56 | 5 | з | 8/29/19 | |
| SS=E | CFR(s): 483.10(f)(5)(| i)-(iv)(6)(7) | | | | | |
| | | ident has a right to organize | | | | | |
| | | ident groups in the facility. rovide a resident or family | | | | | |
| | | vith private space; and take | | | | | |
| | | th the approval of the group, | | | | | |
| | | d family members aware of | | | | | |
| | upcoming meetings in | | | | | | |
| | | ther guests may attend hily group meetings only at | | | | | |
| | the respective group' | | | | | | |
| | | provide a designated staff | | | | | |
| | | ed by the resident or family | | | | | |
| | | and who is responsible for | | | | | |
| | | and responding to written | | | | | |
| | requests that result fr | | | | | | |
| | • | consider the views of a up and act promptly upon | | | | | |
| | | ecommendations of such | | | | | |
| | • | sues of resident care and life | | | | | |
| | in the facility. | | | | | | |
| | | be able to demonstrate their | | | | | |
| | response and rationa | | | | | | |
| | | e construed to mean that the nt as recommended every | | | | | |
| | request of the resider | • | | | | | |
| | §483.10(f)(6) The res participate in family g | | | | | | |
| | | , capo. | | | | | |
| | | ident has a right to have | | | | | |
| | family member(s) or o | | | | | | |
| | representative(s) mee families or resident re | et in the facility with the | | | | | |
| | | | | | | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 | |
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| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED | |
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| | | | | 7 | 2 CHATHAM BUSINESS PARK | | | |
| THE LAUR | ELS OF CHATHAM | | | | PITTSBORO, NC 27312 | · | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 565 | by: Based on record revi residents and staff, the repeat concerns repore meetings for 4 of 4 concerns The findings included Review of the monthly minutes dated 11/6/18 concern of nurses put in their hand instead of Response to Residen dated 11/8/18 indicate placing resident medi- of a pill cup. This forr Director of Nursing (D Review of the monthly minutes dated 12/4/18 repeat concern of nur- medications in their h- cup and a new conce- changed on the reside Response to Residen dated 12/6/18 indicate observations were on changed on shower d by the DON and the A Review of the monthly minutes dated 1/1/19 concerns of nurses put | is not met as evidenced ew, and interviews with e facility failed to resolve rted during Resident Council insecutive months. y Resident Council meeting 3 included, in part, the ting residents' medications of using a pill cup. The t Council Meeting form ed no mention of nurses cations in their hand instead in was signed by the iON) and the Administrator. y Resident Council meeting 3 included, in part, the ses putting residents ' ands instead of using a pill rn of bed linens not being ents ' shower days. The t Council Meeting form ed medication pass going and linens were being ays. This form was signed | F | 565 | F565 Resident/Family Group Response Corrective Action: The Director of Nurses (DON) has investigated the repeated issues that h been brought up in Resident Council a has not been able to identify any partic nurse that is popping the medication in their hand. She has been doing audits residents on bath day to ascertain if the sheets are being changed on bath day and she has been coming in on night s to determine call bell response time. Sh has not been able to confirm the concerns. Results of her audits will be relayed back to Resident Council at the next meeting. The Activity Director has been educated to bring any repeated concerns from Resident Council to the administrators attention immediately. T DON has interviewed the residents tha attend resident council to obtain any additional specific information that may help with any necessary corrective acti Results will be shared in the next coun meeting held in April. Identification of others potentially at ris All residents have the potential to be affected by this alleged deficient practic As the audits have been extensive, not other resident has been found to be affected. | ave nd ular to of e , hift he t , on. cil k: ce. | | |
| | new concern with call | ents ' shower days, and a lights not being answered shift. The Response to | | | Systemic Changes: The concerns that come out of Resider | nt | | |

Facility ID: 923099

If continuation sheet Page 10 of 132

| | OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | | PLE CONSTRUCTION | | <u>NO. 0938-03</u> ATE SURVEY |
|--------------------------|------------------------|---|---------------------|--|---------------|----------------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | · , | G | · · · | MPLETED |
| | | | | | | С |
| | | 345421 | B. WING | | | 02/14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | 72 CHATHAM BUSINESS PARK | | |
| THE LAUP | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETIC DATE |
| F 565 | Continued From page | <u>-</u> 10 | F 56 | 5 | | |
| | | | 1.50 | Council will be noted on the F | losponso to | |
| | | eting form dated 1/3/19 n Nursing Assistants (NAs) | | Resident Council form. These | • | |
| | were interviewed abo | | | now be sent to the Administra | | |
| | | s reported that they changed | | fill out concern forms as appro | | |
| | the bed linens on res | | | will forward them to the appro | | |
| | | lits were conducted, and the | | department manager to addre | | |
| | results were noted to | not reflect the allegation. | | the form is returned to the Ad | ministrator, | |
| | • • | t observed nurses passing | | he will upload the concern for | | |
| | medications and edu | | | Electronic Risk Management | | |
| | | control precautions. This | | (ERMA), our online tracking to | | |
| | form was signed by th | he DON and the | | will determine if there is any r | | |
| | Administrator. | | | concerns or patterns to addre Department managers will be | | |
| | Review of the monthl | y Resident Council meeting | | attend if invited to Resident C | | |
| | | included, in part, repeat | | discuss repeated concerns. | | |
| | | putting medications in their | | | | |
| | | Il cups, bed linens not being | | Monitoring: | | |
| | | ents' shower days, and call | | The Director of Nurses, and/o | r her nurse | |
| | lights not being answ | ered timely. The Response | | manager, will perform audits I | oi-weekly for | |
| | to Resident Council N | leeting form dated 2/12/19 | | one month and then monthly | | |
| | | cerns related to nursing | | quarter, of all interviewable re | | |
| | | ent council meeting were all | | determine if the reported issue | | |
| | | neetings". Staff were noted | | medications being popped int | | |
| | to be educated and ra | | | instead of med cups, bed line | | |
| | | of action was for nurses to ere changed on shower days | | changed on shower days, and call bell response, has been a | | |
| | | ass observations to continue | | and resolved. Results of the | | |
| | | s form was signed by the | | reviewed at the monthly Qual | | |
| | DON and the Adminis | | | Assurance Committee meetin | | |
| | | | | further recommendations. Re | | |
| | A Resident Council m | neeting was conducted on | | Council concerns will be mon | tored via the | |
| | 2/12/19 1:30 PM with | | | ERMA system to further deter | | |
| | | ctive participants in the | | are any patterned or unresolv | | |
| | facility's Resident Co | | | The Administrator will be resp | | |
| | | d repeat concerns over the | | ensure any further recommen | | |
| | past several months | | | the Quality Assurance and Pe | | |
| | | ands instead of in pill cups, changed on the residents ' | | Improvement committee (QAF carried out. | i) ale | |
| | ped intens not being (| I lights not being answered | | | | |

Facility ID: 923099

If continuation sheet Page 11 of 132

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 |
|--------------------------|--|--|---------------------|-----|-------------------------------|---|-------------------|--|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING _ | | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STA | TE, ZIP CODE | •= | |
| | | | | 72 | 2 CHATHAM BUSINESS PA | RK | | |
| THE LAUF | RELS OF CHATHAM | | | Ρ | ITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | K | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY) | | (X5) COMPLETION DATE |
| F 565 | these concerns had n asked what the facility regarding these repea- indicated they were in been re-educated. An interview was com- Director on 2/12/19 at Resident Council mee- was aware that the re- concerns with nurses hands instead of in pi- changed on the reside lights not being answer after each of the reside completed a Respons Meeting form and gav She indicated the DO form and she gave the Activities Director stat response to the reside meeting. She indicated they reported that it w it up on another Resp Meeting form and gav An interview was com- 2/12/19 at 2:40 PM. S aware of the resident concerns with nurses hands instead of in pi- changed on the resident concerns with nurses hands instead of in pi- changed on the resident that nurses and NAS I DON stated that the re- | attendees all stated that of been resolved. When of 's response was to them at concerns the group formed the facility staff had ducted with the Activities 2:00 PM following the sting. She confirmed she sident council had repeated putting medications in their I cups, bed linens not being ents ' shower days, and call ered timely. She stated that ent council meetings she e to Resident Council re it to the DON to address. N wrote a response on the e form back to her. The ed that she presented the ents at the next monthly ed that she asked the nad been resolved and if as a repeat issue she wrote onse to Resident Council e it to the DON again. ducted with the DON on She stated that she was council 's repeated putting medications in their I cups, bed linens not being ents ' shower days, and call ered timely. She indicated had been re-educated. The esidents had also been | | 565 | DI | EFICIENCY) | | |
| | asked to report any co | be addressed with the | | | | | | |

Facility ID: 923099

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| | MENT OF HEALTH AN S FOR MEDICARE & I | D HUMAN SERVICES | | | | FORM | D: 04/10/2019 MAPPROVED D. 0938-0391 |
|--------------------------|--|---|-------------------|-----|--|-------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| THE LAUF | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 565 | next resident council i that she expected cor | a 12 rather than waiting until the meeting. The DON stated incerns discussed at the etings to be addressed and | F | 565 | | | |
| F 580 SS=D | | | F | 580 | | | 3/29/19 |
| | (i) A facility must immediate consult with the resider consistent with his or representative(s) whee (A) An accident involve results in injury and his physician intervention (B) A significant changemental, or psychosocid deterioration in health status in either life-thm clinical complications) (C) A need to alter trea a need to discontinue treatment due to advect commence a new form (D) A decision to transfersident from the facil §483.15(c)(1)(ii). (ii) When making notified (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must a resident and the reside when there is- | ediately inform the resident; ent's physician; and notify, her authority, the resident in there is- ring the resident which as the potential for requiring ; ge in the resident's physical, ial status (that is, a , mental, or psychosocial eatening conditions or ; atment significantly (that is, an existing form of erse consequences, or to in of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the ent representative, if any, or roommate assignment | | | | | |

If continuation sheet Page 13 of 132

| CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0638-032 AND PLAN OF CONFECTION (X) PROVIDERUBURIENCES (X) PROVIDERUBURIENCES (X) PROVIDERUBURIENCES (X) PROVIDER USENUPUER (X) PROVIDER USENUES (X) USENUES | | - | ID HUMAN SERVICES | | | FORM | M APPROVED |
|---|-------------|--|---|---------|---|----------------------------|------------|
| VMME OF PROVIDER OR SUPPLICE 345421 NVMC OD214/2019 NAME OF PROVIDER OR SUPPLICE STREETADRESS. CITY. STATE_2P CODE STREETADRESS. CITY. STATE_2P CODE THE LAURELS OF CHATHAM T2 CHATHAM SUBJEES PARK PTTSBORO, N.C 27312 COMPARIANCE CORRECTION NUMBER FRACTORING INFORMATION PRETX TREMANDERS PARK CONCENTRATION CONCENTRATION <td>STATEMENT (</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td></td> <td></td> <td>(X3) DATE</td> <td>SURVEY</td> | STATEMENT (| OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | (X3) DATE | SURVEY |
| IMME OF PROVIDER OR SUPPLIER STREET ADDRESS, GITX, STREET, ZP CODE THE LAURELS OF CHATHAM INTEGEN ADDRESS, DARK (MID) PREDX TAG INTEGENCY, DESCRETE PROVIDERS TAGK TAGK (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. F 580 (IV) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). F 580 Notification §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part. A facility and resident #120, part. (B) A Integen the policies that apply to room changes between its different locations under § 483.15(c)(9). F580 Notification | | | 345421 | B. WING | | | - |
| THE LAURELS OF CHATHAM PITTSBORO, NC 27312 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (CACH CORRECTIVE ACTION SHOLL DB E (CACH CORRECTIVE ACTION SHOLD AT (I) I do (U) O THE SACIUME (I) The facility failed notify the prolices that apply to room changes between its different locations under \$433.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff, Psychiatric Nurse Practitioner (PNP) and Responsible Party (PP) interviews, the facility failed notify the RP of newly prescribed psychotropic medications for 1 (Resident #120) of 1 reviewed for notification of changes. The findings included: Resident #120 was admitted on 3/22/18 with cumulative diagnoses of Metabolic Encephalopathy, Diabetes, Seizures. Chronic Kidney Diseases (Step Apnea, Pneumonia and Pseudobulbar Affect (PBA). Review of a consent for Psychiatric Services was F580 Notification free inden | NAME OF PI | ROVIDER OR SUPPLIER | L | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PHTBD SUMMARY STREMENT OF DEFICIENCIES REGULTORY OR LSC IDENTIFYING INFORMATION PROVIDER'S FLAW OF CORRECTIVE ACTION BIOLOBIE (EACH ODRECTIVE ACTION SHOULD BE (EACH ODRECTION THE APPROPRIATE BEFORE The findings included: Resident #120 was admitted on 3/22/18 with cumulative diagnoses of Metabolic Encephalopathy, Diabetes, Seizures. Chronic Kidney Disease, Sheep Aprea, Pheumonia and Pseudobulbar Affect (PBA). Review of a consent for Psychiatric Services was F580 Notification free Starts Coher residents with orders for new psychotropic medications for I of Psychiatric Services was | | | | | 72 CHATHAM BUSINESS PARK | | |
| PREFIX TXG IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) PREFIX TXG IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY) COMPLETION DME F 580 Continued From page 13 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. F 580 F 580 F 580 F 580 V(I) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). F 580 F 580 F 580 F 580 S483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in \$483.5) must disclose in this admission agreement it ts physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under \$433.16(c)(9). F580 Notification This REQUIRENENT is not met as evidenced by: Based on staff, Psychiatric Nurse Practitioner (PNP) and Responsible Party (RP) interviews, the facility failed notify the RP of newly prescribed psychotropic medications of r 1 (Resident #120) of 1 reviewed for notification of changes. The findings included: F580 Notification Resident #120 was admitted on 3/22/18 with cumulative diagnoses of Metabolic Encephalopathy, Diabetes, Siezures. Chronic Kidney Diseases. Sleep Apnee, Renewmain and Pseudobulbar Affect (PBA). Identification of others potentially at risk: Other residents with orderes for new psychotropic medications are potentially at risk. A | THE LAUF | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | | |
| (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff, Psychiatric Nurse Practitioner (PNP) and Responsible Party (RP) interviews, the facility failed notify the RP of newly presoribed psychotropic medications of 1 (Resident #120) of 1 reviewed for notification of changes. The findings included: Resident #120 was admitted on 3/22/18 with cumulative diagnoses of Metabolic Encephalopathy, Diabetes, Seizures. Chronic Kidney Disease, Siez Apnea, Pneumonia and Pseudobulbar Affect (PBA). Review of a consent for Psychiatric Services was | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | BE | COMPLETION |
| Alighted by Resident #120 on 4/0/10. Infontitis was performed by the DON Resident #120's admission Minimum Data Set and/or Unit Nurse Managers on dated 4/8/18 indicated severe cognitive at time of survey. impairment with no exhibited behaviors. She was Systemic Changes: | F 580 | (B) A change in reside State law or regulatio (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a composite di §483.5) must disclose its physical configurat locations that compris part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on staff, Psyc (PNP) and Responsite facility failed notify the psychotropic medicat 1 reviewed for notificat findings included: Resident #120 was and cumulative diagnoses Encephalopathy, Diat Kidney Disease, Slee Pseudobulbar Affect (Review of a consent f signed by Resident # | ent rights under Federal or ns as specified in paragraph ecord and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced hiatric Nurse Practitioner ole Party (RP) interviews, the e RP of newly prescribed ions for 1 (Resident #120) of ation of changes. The dmitted on 3/22/18 with s of Metabolic betes, Seizures. Chronic ep Apnea, Pneumonia and (PBA). for Psychiatric Services was 120 on 4/6/18. ission Minimum Data Set d severe cognitive khibited behaviors. She was | F 58 | F580 Notification Corrective Action: It is duly noted that there is no documentation that Resident #120 s was notified of new psychotropic medication. Resident #120 no longer resides at facility. Identification of others potentially at ri Other residents with orders for new psychotropic medications are potentia at risk. An audit of residents that req proper notification for the previous 2 months was performed by the DON and/or Unit Nurse Managers on 2-18-2019.No other issues were iden at time of survey. | r isk: ally uired | |

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| | | | 0.00 | | OMB NO. 0938- |
|---|-------------------------|---|-----------------------------------|---|-------------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | | A. BUILDING | | с |
| | | 345421 | B. WING | | 02/14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 02/14/2013 |
| | | | | 72 CHATHAM BUSINESS PARK | |
| THE LAU | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE COMPLE |
| F 580 | Continued From page | - 14 | | | |
| 1 300 | Continued From page | | F 58 | | d = :t |
| | or antidepressant me | edications. | | The Director of Nurses (DON), an Managers, will identify new orders | |
| | Review of Resident # | 120's care plan dated | | psychotropic medications at clinic | |
| Review of Resident #120's care plan dated 4/10/18 read she was at risk for mood issues with history of restlessness, crying, sad facial | | - | | operations (which consists of the | |
| | | | and Assistant Director of Nurses, | | |
| | expressions and diag | nosis of depression. | | Unit Managers, the Rehab Directo | or, |
| | Interventions include | - | | Minimum Data Set Nurse, Social | |
| | | dered and Psychiatric | | Activities Director, Food Service | |
| | consults as needed. | | | and Medical Records Director) me | |
| | Deview of an initial of | voluction Develoption pote | | Monday through Friday and ensur | |
| | | valuation Psychiatric note esident #120 was being | | documentation for Responsible Pa notification is present in medical re | |
| | | ion. The note read that since | | Any alteration will be corrected as | - |
| | | ission, she had been tearful | | identified. DON will inservice Clin | |
| | | note indicated Resident #120 | | Operations team on this expectati | |
| | | 0.25 milligrams (mg) twice | | 3-15-19. ADON/staff developmer | - |
| | daily for anxiety and 2 | | | inservice licensed staff on the reg | ulation |
| | | e did not mention that the RP | | for RP notification by 3-21-19. Lic | |
| | was notified of the ne | ew psychotropic medications. | | staff will not be able to work prior inserviced. | to being |
| | | g notes did not indicate the | | | |
| | RP was notified of the | | | Monitoring: | . |
| | medications ordered | on 4/10/18. | | RP notification documentation of r | • |
| | Review of a Behavior | Data and Analysis | | started psychotropic medication w audited by the Director Of Nurses | |
| | | 20/18 read Resident #120 | | the Unit Nurse Managers, monthly | |
| | | with frequent crying and | | months as identified through the b | |
| | | e was seen by Psychiatrist | | management committee to ensure | |
| | | ribed Klonopin, Zoloft and | | RP notification is documented as | |
| | Nuedexta (PBA medi | cation). | | appropriate. | |
| | | | | Results of the audits will be taken | |
| | | ric note dated 4/24/18 read | | Quality Assurance (QA) Committee | |
| | | tarted on Nuedexta on | | DON and be reviewed at the mon | |
| | 4/17/18 for PBA and | there was noted elling out. Her Klonopin was | | Quality Assurance meeting for any recommendations. The Administr | |
| | | ree times daily on 4/17/18 | | be responsible to ensure any furth | |
| | | duced to 0.25 mg on 4/24/18. | | recommendations are carried out. | |
| | | ition that the RP was notified | | | |
| | | n or the increase then | | | |

Facility ID: 923099

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|---|--------------------|-----|---|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ŝ | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| THE LAU | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 580 | decrease in the dose by the PNP on 4/17/1 Review of the nursing RP was notified of the ordered 4/17/18 or th on 4/17/18 then decre 4/24/18. Review of a Physician 4/24/18 read he had a with the RP regarding Resident #120's Klon corrected. Review of a nursing r AM read Resident #1 Klonopin. The note di was notified. Review of a nursing r PM read Resident #1 directly to the hospita appointment. Review of a nursing r PM read the Neurolog hospital called and in #120's medications. F was reviewed with the admitted under Neurolog Review of the hospita 5/22/18 read Resider "downturn" in her me the use of multiple ps summary read Residen | of her Klonopin prescribed 8. g notes did not indicate the e new medication Neudexta e increase in the Klonopin ease in her Klonopin on n Progress Note dated a telephone conversation g a communication error in opin dosing but it was note dated 4/24/18 at 2:43 20 had new orders for id not mention that the RP note dated 5/18/18 at 11:23 20 was being admitted I from scheduled doctor's note dated 5/19/18 at 2:35 gy Department at the quired about Resident Resident #120's medications e caller and told she was plogy services. | F | 580 | | | |
| | not be restarted, the | Neudexta should not be t taper off was started on | | | | | |

Facility ID: 923099

If continuation sheet Page 16 of 132

| CENTER STATEMENT C | - | D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345421 | . , | E CONSTRUCTION | | FORM OMB NC (X3) DATE COMP | 2: 04/10/2019 MAPPROVED 0: 0938-0391 SURVEY LETED C 14/2019 |
|--------------------------|--|---|---------------------|---|--|-------------------------------------|---|
| NAME OF PR | ROVIDER OR SUPPLIER | | S | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | 2 CHATHAM BUSINESS F PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE) CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 580 | the RP stated he cons services but that he w medications Klonopin stated he made the a Neurologist on 5/18/1 was "not acting right" admitted to the hospit The RP stated the Ne medications because #10 worse. He stated in and discussed his of incident. In an interview on 2/1 Worker (SW) #1 state about the referral for I any medications were nurses would be resp with the RP. In a telephone intervie the PNP stated she w #120 for extreme anx stated after reviewing specific mention of a RP. The PNP stated anytime she saw a ne to call the RP at least if she was unable to r stated that if she spok been documented in I only assume that she that there was an elect that was set up for RF | ew on 2/13/18 at 9:46 AM, sented to Psychiatric vas never informed of the , Zoloft or Neudexta. He opointment with her 8 because Resident #120 and she was directly al from the appointment. urologist stopped all those they were making Resident the Medical Director called concerns at the time of the 3/18 at 10:43 AM, Social d she spoke with the RP Psychiatric services but if prescribed, the PNP or onsible to discussing that ew on 2/14/18 at 9:20 AM, as referred to Resident iety and calling out. She her notes, there was no obtaine conversation with the it was her policy that ew resident, she attempted once and leave a voicemail each the RP. The PNP te with the RP, it would have her note and that she could left a voicemail. She added ctronic communication portal Ps if they wished to | F 580 | | | | |
| | been documented in I only assume that she that there was an elec that was set up for RF participate. The PNP | ner note and that she could left a voicemail. She added ctronic communication portal | | | | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 // APPROVED). 0938-0391 |
|--------------------------|---|--|------------------------------|-------------------------------|---|-------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | ST | REET ADDRESS, CITY, STA | TE, ZIP CODE | | |
| | | | 72 | CHATHAM BUSINESS PA | RK | | |
| INE LAUP | RELS OF CHATHAM | | PI | TTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY) | | (X5) COMPLETION DATE |
| F 580 F 622 SS=D | reviewed Resident #1 the RP had requested participation in the po that was the only com see from the RP on the During an interview of Director of Nursing (D Director (MD) was un- further stated the auth 4/24/18 at 2:43 AM w who recently died. The expectation that the P have contacted the R the multiple psychotro Transfer and Discharg CFR(s): 483.15(c)(1)(§483.15(c) Transfer at §483.15(c)(1) Facility (i) The facility must per remain in the facility, at discharge the resident (A) The transfer or dis resident's welfare and cannot be met in the facility (C) The safety of indivention endangered due to the status of the resident; (D) The health of indive otherwise be endange (E) The resident has facility has facility otherwise be endanged | ad signed into the portal and 20's notes. She stated that it to discontinue his rtal usage in June 2018 and imunication she was able to be portal. In 2/14/18 at 11:54 AM, the OON) stated the Medical available for interview. She nor of the nursing note dated as completed by a nurse e DON stated it was her PNP or floor nurse would P prior to the prescribing of opic medications. ge Requirements i)(ii)(2)(i)-(iii) and discharge- requirements- ermit each resident to and not transfer or t from the facility unless- scharge is necessary for the the resident's needs facility; scharge is appropriate s health has improved dent no longer needs the the facility; viduals in the facility would | F 580 | | | | 3/29/19 |

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Facility ID: 923099

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| CENTER | MENT OF HEALTH AN S FOR MEDICARE & I | | | | | | FORM OMB NC |): 04/10/2019 / APPROVED). 0938-0391 |
|--------------------------|--|---|-------------------|-----|--|--|----------------|---|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | | | SURVEY LETED |
| | | 345421 | B. WING | | | _ | | _ 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, ST | | | |
| THE LAUF | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS P ITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 622 | under Medicare or Me Nonpayment applies i submit the necessary payment or after the t Medicare or Medicaid resident refuses to par resident who become admission to a facility resident only allowabl or (F) The facility ceases (ii) The facility may no resident while the app § 431.230 of this chap exercises his or her ri- discharge notice from 431.220(a)(3) of this of discharge or transfer or safety of the reside facility. The facility m that failure to transfer §483.15(c)(2) Docume When the facility trans- resident under any of in paragraphs (c)(1)(i) section, the facility m or discharge is docum medical record and ap communicated to the institution or provider. (i) Documentation in t must include: (A) The basis for the t (i) of this section. (B) In the case of para section, the specific re | edicaid) a stay at the facility. f the resident does not paperwork for third party hird party, including , denies the claim and the y for his or her stay. For a s eligible for Medicaid after , the facility may charge a e charges under Medicaid; a to operate. to transfer or discharge the beal is pending, pursuant to oter, when a resident ght to appeal a transfer or the facility pursuant to § chapter, unless the failure to would endanger the health nt or other individuals in the ust document the danger or discharge would pose. entation. sfers or discharges a the circumstances specified (A) through (F) of this ust ensure that the transfer nented in the resident's opropriate information is receiving health care | F | 622 | | | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | FOR | M APPROVED 0. 0938-0391 |
|--------------------------|---|---|---------------------|---|--|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` <i>`</i> | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 345421 | B. WING _ | | | C 2/ 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 622 | needs, and the service facility to meet the ne (ii) The documentatio (2)(i) of this section m (A) The resident's phy discharge is necessal (A) or (B) of this sectii (B) A physician when necessary under para this section. (iii) Information provice must include a minim (A) Contact information responsible for the ca (B) Resident represen contact information (C) Advance Directive (D) All special instruct ongoing care, as appi (E) Comprehensive c (F) All other necessal copy of the resident's consistent with §483. any other documenta a safe and effective the This REQUIREMENT by: Based on record revised with behaviors and fa documentation which facility could not meet of 1 resident reviewed (Resident #169). Findings included: | e available at the receiving ed(s). n required by paragraph (c) just be made by- visician when transfer or ry under paragraph (c) (1) on; and transfer or discharge is agraph (c)(1)(i)(C) or (D) of led to the receiving provider um of the following: on of the practitioner re of the resident. Intative information including a information tions or precautions for ropriate. are plan goals; ry information, including a discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ensure ansition of care. is not met as evidenced ew, and Nurse Practitioner, f interviews, the facility ent to remain in the facility | F | F622 Transfer and Discharge Requirements Corrective Action: Although resident #169□s wife a transfer to another facility, we at to provide timely transfer notifica the resident has discharged fror facility. Identification of others potentiall Any resident that is transferred to | re unable ation, as n our ly at risk: | |

Event ID: PVRD11

Facility ID: 923099

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| | | MEDICAID SERVICES | | | OMB NO. 0938- |
|--------------------------|---------------------------------|---|---------------------|---|--|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
| | | | A. BUILDIN | G | с |
| | | 345421 | B. WING | | 02/14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | • |
| | | | | 72 CHATHAM BUSINESS PARK | |
| | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE COMPLE THE APPROPRIATE DAT |
| F 622 | Continued From page | 20 | Ге | 22 | |
| F 022 | | | F 62 | | |
| | | s that included Alzheimer's | | level of care if we are una | |
| | | nsomnia, aphasia (impaired | | needs in our facility, and a | - |
| | language) and polyar | unnus. | | is being discharged for im safety of others, health of | |
| | A review of the most | recent comprehensive | | would be endangered, fai | |
| | | IDS) coded as a Significant | | services, or the facility wil | |
| | Change in Assessme | | | operate, can be affected b | |
| | revealed the resident | | | deficient practice and is ic | |
| | | dering noted one to three | | time of transfer if medical | |
| | | / look back period and no | | and for the remaining reas | |
| | | required supervision of one | | identified in the daily stan | |
| | | mobility and transfers and | | attended by all managers | |
| | | tensive assistance of one | | survey, the Social Worker | |
| | | ctivities of Daily Living | | previous two months of di | |
| | | ssistance for bathing. | | determine if any other res | • |
| | | bolotarioe for batting. | | affected by this alleged de | |
| | The most recent MDS | S coded as a Quarterly | | No other resident was fou | - |
| | | ed 12/11/18 revealed the | | affected. | |
| | | cognitive impairment and | | | |
| | displayed no wanderi | • | | Systemic Changes: | |
| | | dependent with supervision | | Any resident that is transf | erred to a higher |
| | | eceived limited to extensive | | level of care if we are una | - |
| | | staff member for all ADLs | | needs in our facility, and a | |
| | except for total assist | | | is being discharged for im | - |
| | | 5 | | safety of others, health of | |
| | Review of the care pl | an dated 12/18/18 included | | would be endangered, fai | |
| | wandering around the | | | services, or the facility wil | |
| | - | d episodes of thinking | | operate, will be given pro | |
| | | e his wife. There were no | | notice, utilizing the Depar | |
| | | ehaviors, discharge to home | | Assistance Form 9050, w | |
| | or assisted living facil | | | Home Notice of Transfer/ | - |
| | | - | | completed by and sent by | - |
| | Review of Resident # | 169's nursing notes | | Administrator, along with | |
| | | dmission he had behaviors | | party and the Ombudsma | |
| | such as wandering in | and out of rooms, moving | | will be entered into the ch | |
| | furniture, touching bli | nds, thinking female | | facility cannot meet the re | - |
| | | fe, urinating in inappropriate | | An order will be entered to | |
| | | He had an aggressive | | resident to where, what le | - |
| | | with another aggressive | | along with contact informa | |

Facility ID: 923099

If continuation sheet Page 21 of 132

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | · · · | E SURVEY |
|--------------------------|--|--|---------------------|---|--|---------------------------|
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | CON | IPLETED |
| | | 345421 | B. WING | | | C 2/14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | U. | 2/14/2019 |
| | | | | 72 CHATHAM BUSINESS PARK | | |
| THE LAUF | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| F 622 | Continued From page | e 21 | F 62 | 2 | | |
| F 022 | resident and an aggre roommate on 12/16/1 supervision was initia aggression were note Review of a physician mentioned the two ag the resident had prog which led to his need facility. He stated that despite psychiatric ar and the behavior dist residents in the mem- the resident could be psychiatric intentions the facility. A social service note social worker spoke w and informed her that Management center of and that other placen would be more condu Review of the interdis summary dated 12/37 was transferred to an (ALF) accompanied to section was marked a | essive episode with his 8, at which time one on one ited. No further reports of ed. In note dated 12/20/18 ggressive behaviors and that pressive memory problems of long-term care at the t the problem was worsening nd medication management urbance endangered other ory unit. He suggested that nefit from more intensive that were not available at dated 12/24/18 revealed the with the resident's spouse t the a Behavioral did not accept the resident hent would be looked at that ucive to the resident. Sciplinary discharge 1/18 revealed the resident Assisted Living Facility by his spouse. The behavior | F 623 | practitioner responsible for the resident. Advance directive info any special instructions, comprecare plan goals, and any other information will be provided to treceiving the resident. Monitoring: The Director of Social Services QA auditing tool, will review all bi-weekly for the next 2 months monthly for the next quarter to a proper notification is given for a transfers and discharges. The be reported by the Director of Service, to the monthly QAPI (CAssurance and Performance Improvement) meeting for any for recommendations. The Administic be responsible to follow up on a recommendations out of the QA committee. | rmation, ehensive pertinent he facility , using a discharges, , and then ensure that ny and all results will cocial Quality further strator will any | |
| | others, reading the ne outdoors, cooking gro activities. | al records revealed no | | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|--|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | ę | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 622 | Continued From page | 22 | F | 622 | 2 | | |
| | Resident #169 was tr Living Facility on 12/3 | ansferred to an Assisted | | | | | |
| | stated that Resident # and that he would go negative behaviors. S of the aggressive inci- (12/16/18) the two res there was not an emp which is why one to o psychiatry services w changes were made, She explained that the (IDT) felt like he would | irector of Nursing. She #169's behaviors fluctuated for days without any she explained that the night dent towards his roommate sidents were separated, but by room to move him to one supervision was initiated, ere involved, medication and activity was increased. e Interdisciplinary Team d do well in an ALF memory s high functioning with | | | | | |
| | felt the transfer was a had impulsive behavior destroying the proper Resident #169 would | dministrator. He stated he appropriate as the resident or issues and "he was ty". He further stated that have good behaviors and ods of aggressive behaviors. | | | | | |
| | 2/14/19 at 9:45am. SI admission the resider are told the facility co- the goal was to keep stated that at the time behaviors hospitalizat commitment (IVC) wa the hospital would har didn't feel the magistr | nts and responsible parties uld manage behaviors, but all the resident's safe. She of the aggressive | | | | | |

Facility ID: 923099

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| | - | D HUMAN SERVICES | | | | | FORM |): 04/10/2019 1 APPROVED |
|--------------------------|---|--|-------------------|-----|-------------------------------|--|-----------|---------------------------------|
| STATEMENT (| S FOR MEDICARE & I OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , <i>i</i> | | CONSTRUCTION | | (X3) DATE | 0. 0938-0391 SURVEY LETED |
| | | 345421 | B. WING | | | _ | (02/ | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| | | | | 73 | 2 CHATHAM BUSINESS P | ARK | | |
| THE LAUP | RELS OF CHATHAM | | | P | ITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 622 | residents and "we felt back there and their b a good fit". The social the inpatient behavior accept the resident, it been better due to his A phone interview wa Psychiatric Nurse Pra 9:50am. She stated t at the beginning of De him on 12/4/18 he had incident towards his re that medications were completed to rule out one on one had been assessed the resident he had thoughts of a f wife, one on one cont educated on deflectin instead of arguing wit someone was his wife with him on 12/27/18 behavior, no longer of supervision, had no a behaviors and was no resident's being his w then she was informe different facility. On 2/14/19 at 11:25at with the Ombudsman resident was admitted facility's memory care longer able to care for behaviors. She stated verbally told the reside | the safety of the other like with the group of men behaviors combined it wasn't worker explained that after al health program did not was felt an ALF would have a high function. s completed with the ctitioner (NP) on 2/14/19 at hat the resident was stable ecember and when she saw d had an aggressive bommate. She explained e altered, labs were any medical causes and started. She stated that she t again on 12/20/18 where female resident being his inued and the staff were g and redirecting him h him when he thought e. When she followed up he was back at his baseline in the one to one ggression or inappropriate ot obsessing over other ife. She stated that it was | F | 622 | | | | |

Facility ID: 923099

If continuation sheet Page 24 of 132

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 04/10/2019 APPROVED D: 0938-0391 |
|--------------------------|---|--|---------------------|-----------------------------|--|-------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | _ | | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| | | | 7 | 2 CHATHAM BUSINESS F | PARK | | |
| THE LAUP | RELS OF CHATHAM | | F | PITTSBORO, NC 27312 | : | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 622 | Continued From page or a written notice. | : 24 | F 622 | | | | |
| F 623 SS=D | to Resident #169's wi call. No return call wa responsible party. Notice Requirements | Before Transfer/Discharge | F 623 | | | | 3/29/19 |
| | the reasons for the milanguage and manner facility must send a correpresentative of the of Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the noti- paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, the discharge required un made by the facility at resident is transferred (ii) Notice must be ma- before transfer or disc (A) The safety of indiv be endangered under this section; | Ters or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the Nate oudsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or ider this section must be t least 30 days before the l or discharged. ade as soon as practicable | | | | | |

Event ID: PVRD11

Facility ID: 923099

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| | MENT OF HEALTH AN | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | 0: 04/10/2019 1 APPROVED 0. 0938-0391 |
|--------------------------|---|---|---------------------|---|--|------|---|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , <i>i</i> | PLE CONSTRUCTION | | | LETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, S | TATE, ZIP CODE | | |
| THE LAU | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 623 | this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten notice specified in par must include the follor (i) The reason for tra (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such reques to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailin telephone number of the protection and ad developmental disabil C of the Developmental and Bill of Rights Act codified at 42 U.S.C. | r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; hefer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: nefer or discharge; of transfer or discharge; nich the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how orm and assistance in and submitting the appeal s (mailing and email) and the Office of the State budsman; y residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, | F 62 | 23 | | | |

Facility ID: 923099

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 | | |
|--------------------------|---|---|---------------------|--|------------------------------------|--|--|
| STATEMENT | DF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · · | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
| | | 345421 | B. WING | | 02/14/2019 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | | |
| THE LAU | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | | |
| F 623 | disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individ §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification prit to the State Survey A State Long-Term Carr the facility, and the re- well as the plan for the relocation of the resion 483.70(I). This REQUIREMENT by: Based on record revis facility failed to notify writing of the reason for when 2 of 2 sampled (Residents #8 and #1 Findings included: 1. Resident #8 was a 7/3/15 with multiple d Hypertension and An: Minimum Data Set (M | sabilities, the mailing and ephone number of the or the protection and ils with a mental disorder e Protection and Advocacy uals Act. es to the notice. he notice changes prior to or discharge, the facility bients of the notice as soon he updated information in advance of facility closure closure, the individual who is he facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate lents, as required at § ' is not met as evidenced ew and staff interview, the the responsible party (RP) in for the discharge/transfer residents were discharged 69). | F 62 | F623 Notice Requirements before Transfer/Discharge Corrective Action: Resident #8 continues to live in the facility. We are unable to provide notification requirements for resident #169, as the resident is no longer in ou facility. Identification of others potentially at ris Any resident that is transferred to a hig level of care if we are unable to meet the | k: her | | |

Facility ID: 923099

If continuation sheet Page 27 of 132

| | | MEDICAID SERVICES | | | | |
|--------------------------|-------------------------------|---|---------------------|--|--------------------------------|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | · · · | |
| | | | | | 0 |) |
| | | 345421 | B. WING | | | 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | DE | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETIO DATE |
| F 623 | Continued From page | e 27 | F 62 | 13 | | |
| | and decision making | | 1 02 | needs in our facility, and any | resident that | |
| | | prosionio. | | is being discharged for impre | | DBE COMPLÉTION RIATE DATE Atthat DATE Atthat |
| | Review of Resident # | *8's nurse's notes revealed | | safety of others, health of inc | | |
| | | ed to the hospital on 5/16/18 | | would be endangered, failur | | |
| | | (G) placement, 8/3/18 for | | services, or the facility will co | | |
| | | iring blood transfusion, | | operate, can be affected by | | |
| | | eplacement and 11/2/18 for iring blood transfusion. | | deficient practice and is iden time of transfer if medically r | | |
| | | | | and for the remaining reasor | • | |
| | Review of Resident # | 8's electronic medical | | identified in the daily stand u | | |
| | | t the RP was not notified in | | attended by all managers. A | | |
| | - | dent was discharged to the | | survey, the Social Worker re | | |
| | hospital. | | | previous two months of disc determine if any other reside | • | |
| | On 2/14/19 at 8:40 A | M, the Unit Coordinator was | | affected by this alleged defic | | |
| | | ted that nurses were calling | | No other resident was found | | |
| | | him that the resident was | | affected. | | |
| | discharged to the hos | spital but not in writing. | | | | |
| | | | | Systemic Changes: | | |
| | | AM, the Director of Nursing | | Any resident that is transferr | • | |
| | , , | ed. She stated that she ation that the RP has to be | | level of care if we are unable needs in our facility, and any | | |
| | notified in writing whe | | | is being discharged for impre | | |
| | | spital. The DON further | | safety of others, health of inc | | |
| | | ses were calling the RP to | | would be endangered, failur | | |
| | - | e resident was discharged to | | services, or the facility will ce | | |
| | the hospital but not ir | n writing. | | operate, will be given proper | - | |
| | | | | notice, utilizing the Departme | | |
| | 2) Resident #169 way | s admitted to the facility on | | Assistance Form 9050, whic Home Notice of Transfer/Dis | - | |
| | | s that included Alzheimer's | | will now be completed by an | | |
| | | nsomnia and polyarthritis. | | Administrator, along with the | | |
| | | | | party and the Ombudsman. | | |
| | | num Data Set (MDS) coded | | will be entered into the chart | - | |
| | - | sment and dated 12/11/18 | | facility cannot meet the resid | | |
| | impairment. He was | had severe cognitive | | An order will be entered to d resident to where, what leve | - | |
| | | nobility and received limited | | along with contact informatic | | |
| | | ce from one staff member | | practitioner responsible for the | | |

Facility ID: 923099

If continuation sheet Page 28 of 132

| STATEMENT | OF DEFICIENCIES | MEDICAID SERVICES | | LE CONSTRUCTION | | |
|--------------------------|---|---|---------------------|--|-------------|--|
| | CORRECTION | IDENTIFICATION NUMBER: | , , | | · · · | |
| | | | AL DOLDING | | | С |
| | | 345421 | B. WING | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | - | STREET ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | 72 CHATHAM BUSINESS PARK | | |
| THE LAUP | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETIO DATE |
| F 623 | Continued From page | a 28 | F 62 | 2 | | |
| . 020 | - | ily Living (ADLs) except for | 1 02 | resident. Advance directive in | formation | |
| | total assistance with | | | any special instructions, comp | orehensive | |
| | Resident #169 was ti | ransferred to an Assisted | | care plan goals, and any othe information will be provided to | | |
| | Living Facility on 12/3 | | | receiving the resident. | | D BE PRIATE COMPLETION DATE DATE |
| | Review of the medica | al records revealed no | | | | |
| | documentation of a w responsible party. | vritten notice provided to the | | Monitoring: The Director of Social Service | es, using a | |
| | | | | QA auditing tool, will review a | • | |
| | - | on 2/13/19 at 2:00pm, Social | | bi-weekly for the next 2 month | | |
| | | t she was aware transfer | | monthly for the next quarter to | | |
| | - | s should be provided for all | | proper notification is given for | | |
| | | ers to the responsible urther stated that since she | | transfers and discharges. Th be reported by the Director of | | |
| | | contact with the resident's | | Service, to the monthly QAPI | | |
| | | greement was received a | | Assurance and Performance | (duality | |
| | written discharge not | - | | Improvement) meeting for any recommendations. The Admir | | |
| | On 2/13/19 at 3:45pn | n, an interview was | | be responsible to follow-up or | | |
| | completed with the A | dministrator. He stated that | | recommendation from the QA | committee | |
| | | en notice was required to be | | with additional training to be p | | |
| | | onsible parties/residents | | the Clinical Resource Special | ist, as | |
| | | transfers were made. He | | indicated. | | |
| | - | nce Improvement Plan for /29/19 and stated that it was | | | | |
| | | orrect education to the social | | | | |
| | | b gets discharge and transfer | | | | |
| | | d that the corrective action | | | | |
| | | sident in question or written | | | | |
| | notices provided to re | esponsible parties/residents. | | | | |
| | | Performance Improvement | | | | |
| | | ead in part that on 1/29/19 | | | | |
| | | ved from an outside agency | | | | |
| | | ge information of Resident ker stated that the wife was | | | | |
| | | isagree with the discharge. | | | | |
| | | those having potential to be | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | I | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 623 | months were reviewer resident's provided to 1/29/19. No corrective about written notices residents. On 2/14/19 at 11:25a occurred with the Om written notice was no wife when a transfer discussed on 12/24/1 On 2/14/19 at 12:15p to Resident #169's wit call. No return call war responsible party. An interview was con | I transfers for the past two d with a list of all discharged the Ombudsman on e action was mentioned to responsible parties or m a phone interview budsman. She stated that a t provided to the resident's from the facility had been 8. m a phone call was placed fe with a request for a return is received from the ducted with the | F | 523 | | | |
| F 641 SS=E | was his expectation f written transfer and d responsible party/res Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on record rev facility failed to code assessment accurate (Resident #270 and # #57 and #81), active bowel and bladder (R | | F | 541 | F641 Accuracy of Assessments: Corrective Action: Corrections have been made in the are of falls for Resident #270 and #28, medications for Residents #57 and #81 active diagnosis for Resident #8, bowl | , | 3/29/19 |

Event ID: PVRD11

Facility ID: 923099

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 345421 B. WING 02/14/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK THE LAURELS OF CHATHAM PITTSBORO, NC 27312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 641 Continued From page 30 F 641 sampled residents. bladder for Resident #119, and range of motion for Residents #41 and #61 on the The findings included: Minimum Data Set assessment (MDS), by the MDS nurse. Corrections were 1. Resident #270 was admitted on 9/1/17 with completed the week of February 18th, and diagnoses that included dementia. transmitted the same week. A review of the incident reports for Resident #270 Identification of others potentially at risk: indicated she had a fall on 10/5/18 with Residents that have had falls, are on complaints of pain to her elbow and a fall on medications, have diagnosis s and/or 12/15/18 with no injury. require range of motion, are subject to this alleged deficient practice, and are The quarterly Minimum Data Set (MDS) identified through the care plan process. assessment dated 12/27/18 indicated Resident At the time of the survey, all resident s #270' s cognition was severely impaired. She assessments that were performed in the was assessed with one fall with no injury since past 3 months were reviewed by the her previous MDS assessment (10/2/18). MDS/Care Plan Team to determine if there were any residents that required An interview was conducted with MDS Nurse #1 corrections to the MDS. No other resident on 2/14/19 at 10:08 AM. She stated that she was found to need corrections. coded Resident #270 's 12/27/18 guarterly MDS in the area of falls. The 10/5/18 incident report Systemic Changes and the 12/15/18 incident report for Resident The MDS nurse has been re-educated by #270 were reviewed with MDS Nurse #1. She the regional nurse consultant on 03-15revealed she had not been made aware of the 2019 to ensure that all falls, residents 10/5/18 fall for Resident #270. She explained requiring range of motion, active that the incident reports were documented on diagnosis s, bowl and bladder, and hard copy forms and that she depended on staff counting of medications that require care to review all falls during the morning meetings, so plans, are identified and care planned for. she was made aware of any new incidents. She The MDS nurse will attend each daily stated the 12/27/18 MDS for Resident #270 was clinical meeting to ensure items are not coded inaccurately for falls. missed. An interview was conducted with the Director of Monitoring Nursing (DON) on 2/14/19 at 11:54 AM. She The Director of Nurses, and/or her nurse stated that she expected the MDS to be coded manager, will perform audits bi-weekly for accurately. one month and then monthly for one guarter, to determine if all falls, residents requiring range of motion, active

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PVRD11

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| | | | ()(0) 1411 | | OMB NO. 0938-039 |
|---|---|---|---------------------|--|---|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
| | | 345421 | B. WING | | C 02/14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, 2 | |
| THE LAUI | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK | |
| | 1 | | | PITTSBORO, NC 27312 | 1 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | D ITE |
| F 641 | Continued From page | e 31 | F 64 | 41 | |
| 2. Resident #28 was admi 11/2/18 with diagnoses that disorder.A review of the incident re revealed he had one fall w | | admitted to the facility on | | diagnosis □s, and accur medications on the MDS the MDS. Results of the reviewed at the monthly Assurance Committee r further recommendation Administrator will be res ensure any further reco | S, are captured on audits will be v Quality neeting for any ns. The sponsible to |
| a ' | 's cognition was seve | m Data Set (MDS) 4/19 indicated Resident #28 erely impaired. He was s since his previous MDS | | carried out. | |
| | on 2/14/19 at 10:08 A coded Resident #28 ' the area of falls. The Resident #28 was rev She revealed she had the 2/3/19 fall for Res that the incident repo hard copy forms and to review all falls duri she was made aware | ducted with MDS Nurse #1 AM. She stated that she s 2/4/19 quarterly MDS in 2/3/19 incident report for viewed with MDS Nurse #1. d not been made aware of sident #28. She explained rts were documented on that she depended on staff ng the morning meetings, so of any new incidents. She S for Resident #28 was or falls. | | | |
| | Nursing (DON) on 2/2 | ducted with the Director of 14/19 at 11:54 AM. She cted the MDS to be coded | | | |
| | | admitted to the facility on s that included psychotic | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED D. 0938-0391 |
|--------------------------|--|--|---------------------|---|--|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED |
| | | 345421 | B. WING | | | | C / 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | I | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIZ TAG | REFIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION DATE |
| F 641 | Continued From page | 2 32 | F | 641 | | | |
| | period of his 1/4/19 N through 1/4/19) indica | #57 ' s Medication d (MAR) for the look back IDS assessment (12/29/18 ated he received routine tic medication) on 7 of 7 | | | | | |
| | 's cognition was intac antipsychotic medical the review period. Th | 4/19 indicated Resident #57 ct. He received tion on 7 of 7 days during ne Antipsychotic Medication #57 was coded to indicate | | | | | |
| | on 2/12/19 at 4:35 PM coded the medication 1/4/19 quarterly MDS miscoded the Antipsy section of Resident # stated that this sectio to indicate that antips | ducted with MDS Nurse #1 <i>A</i> . She stated that she is section of Resident #57 ' s . She revealed that she chotic Medication Review 57 ' s 1/4/19 MDS. She n should have been coded ychotics had been received routine basis only. She is an error. | | | | | |
| | Nursing (DON) on 2/1 | ducted with the Director of 14/19 at 11:54 AM. She ted the MDS to be coded | | | | | |
| | 10/8/18 and was disc with diagnoses that in | admitted to the facility on harged home on 10/25/18 included cerebral palsy, ostomy status and pressure | | | | | |

Facility ID: 923099

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 |
|--------------------------|--|--|--------------------|-------|---|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l` ' | | E CONSTRUCTION | (X3) DATE | |
| | | | A. BUILDI | ING . | | | C |
| | | 345421 | B. WING | | | 02 | /14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAU | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ЗE | (X5) COMPLETION DATE |
| F 641 | Continued From page | 33 | F | 641 | 1 | | |
| | as an admission asse assessed the residen impaired cognition an on one to two staff me Daily Living (ADL's) to assessment had docu catheter and ostomy was coded as always of not rated due to ex Review of the baselin revealed the resident an ileostomy. Review of physician of showed the need to m condom catheter was sacral wound healing On 2/13/19 at 5:00pm conducted with the M confirmed that the resident ashould have been coor An interview was com Nursing on 2/14/19 at was her expectation f correctly. | d required total dependence embers for all Activities of o include eating. The umentation that an external were present, however he incontinent of urine instead ternal catheter status. We care plan dated 10/9/18 had a condom catheter and orders for October 2018 nonitor and assure the in place every shift for what interview was DS Nurse #1, who sident had an external ary incontinence section ded as not rated. Inpleted with the Director of t 11:50am. She stated it for the MDS to coded | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORI | M APPROVED D. 0938-0391 |
|--------------------------|--|---|-------------------|-----|---|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED |
| | | 345421 | B. WING | | | | C / 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | L | I | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 641 | Quarterly assessmen revealed she was cog oriented and able to r received supervision ADL's except needing staff member for trans diagnoses of anxiety It was coded that she antianxiety during the Review of the Januar resident received 5 da 1/5/19, 1/6/19, 1/7/19 On 2/13/19 at 8:25am conducted with the M confirmed that Reside of an antianxiety durin stated that marking he An interview was com Nursing on 2/14/19 at was her expectation f correctly. | S coded as a modified t and dated 1/11/19, gnitively intact, alert and nake needs known. She of one staff member for g limited assistance of one sfers. She was marked with disorder, COPD and cancer. received 6 days of an e 7 day look back period. y 2019 MAR's revealed the ays of an antianxiety on the interview was DS Nurse #1. She ent #81 received only 5 days ing the look back period and er for 6 days was an error. Inpleted with the Director of t 11:50am. She stated it for the MDS to coded | F | 641 | | | |
| | Review of the most re | ecent MDS coded as a | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED D. 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|-----------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | |
| | | 345421 | B. WING | | | | C / 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | • | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 7 | 72 CHATHAM BUSINESS PARK | | |
| THE LAUP | RELS OF CHATHAM | | | F | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 641 | Significant Change as 1/30/19 revealed the intact. He received lin assistance of one star include eating. He wa impairment to upper of Review of the residen 1/7/19 revealed there complications of left s CVA. Review of a physiciar 12/19/18 noted Resid facial drooping and he Review of the Admiss revealed the resident motion to one side of extremity. On 2/12/19 at 1:40pm interview were condu- was lying in his bed w observed with left side An interview was con- 2/12/19 at 3:10pm wh meal trays so that he since he was unable f On 2/14/19 at 10:00a conducted with the M confirmed that limitati assessment dated 1/3 error. | Assessment and dated resident was cognitively mited to extensive ff member for all ADL's to as not coded with any or lower extremities. At's active care plan dated was a care plan present for sided hemiplegia due to a progress note dated lent #41 had a CVA with left emiplegia present. Sion MDS dated 12/13/18 had limitation in range of his upper and lower and the addition of the set | F | 641 | | | |

Facility ID: 923099

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 |
|--------------------------|--|---|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED |
| | | 345421 | B. WING | | | | C / 14/2019 |
| NAME OF F | ROVIDER OR SUPPLIER | | • | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAU | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 641 | was her expectation f correctly. 7. Resident #8 was a 7/3/15 with multiple d depression. The qua (MDS) assessment d Resident #8 had men problems. The assess Resident #8 had rece medication for 7 days period. The assessment 8 did not have a diagent Resident #8 had a ph 5/19/18 for Zoloft (and milligrams (mgs) - giv (G) tube three times a The November 2018 Record (MAR) reveal received Zoloft from N On 2/12/19 at 4:23 Pl interviewed. She rev verified that Resident during the assessment The MDS Nurse state coded the diagnosis of quarterly MDS assess she missed it. On 2/14/19 at 11:52 A (DON) was interviewed she expected the MD accurately. | for the MDS to coded dmitted to the facility on iagnoses including rterly Minimum Data Set ated 11/11/18 indicated that nory and decision making asment further indicated that ived an antidepressant during the assessment eent indicated that Resident gnosis of depression. ysician's order dated tidepressant drug) 50 re 0.5 tablet via gastrostomy a day for depression. Medication Administration ed that Resident #8 had November 5-11, 2018. M, the MDS Nurse #1 was iewed the records and #8 had received Zoloft nt period for depression. ed that she should have of depression on the sment dated 11/11/18 but M, the Director of Nursing ed. The DON stated that S assessment to be coded | F | 641 | | | |

If continuation sheet Page 37 of 132

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAU | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 641 F 656 SS=D | depression and anxie Data Set (MDS) asse revealed that Resider range of motion (ROM Resident #61's care p risk for contracture ar right hand and right e applied twice a day. On 2/11/19 at 9:45 Al AM, Resident 61 was hand/elbow contracte On 2/13/19 at 8:15 Al interviewed. She ver right hand/arm was co order for splint for the that she should have assessment dated 1/8 ROM on upper extrem On 2/14/19 at 11:52 A (DON) was interviewed she expected the MD accurately. Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res resident rights set for §483.10(c)(3), that into objectives and timefra medical, nursing, and | ty. The quarterly Minimum ssment dated 1/8/19 nt #61 had no impairment in <i>A</i>) on upper extremity. Nan dated 1/8/19 included at ad the approaches included lbow extension splint to be <i>A</i> and on 2/13/19 at 8:57 observed with his right d. M, the MDS Nurse #1 was ified that Resident #61's ontracted and he had an a contracture. She stated coded the quarterly MDS B/19 with impairment in nity but she missed it. AM, the Director of Nursing ed. The DON stated that S assessment to be coded comprehensive Care Plan ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and | | 641 | | | 3/29/19 |

Facility ID: 923099

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|--|--------------------|--|--|------------------------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED C | |
| | | 345421 | B. WING | | | | ; 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, 0 | CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSI PITTSBORO, NC | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH | VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 656 | assessment. The con describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483. provided due to the re under §483.10, incluo treatment under §483 (iii) Any specialized ser rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv)In consultation with resident's representation (A) The resident's goa desired outcomes. (B) The resident's pre- future discharge. Fac whether the resident's community was assess local contact agencies entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on record revi interview, the facility f interventions related to | nprehensive care plan must - re to be furnished to attain nt's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse .10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its nt's medical record. In the resident and the ive(s)- als for admission and ference and potential for lities must document a desire to return to the seed and any referrals to a and/or other appropriate se. In the comprehensive care in accordance with the n in paragraph (c) of this is not met as evidenced ew, observation, and staff ailed to implement care plan o falls (Resident #270) and hent (Resident #61) for 2 of | F | Plans Corrective Ac The care pla | op Comprehensive Care ction ns that are developed and o the care cards for staff to | | |

Facility ID: 923099

If continuation sheet Page 39 of 132

| STATEMENT | OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | | LE CONSTRUCTION | | NO. 0938-039 ATE SURVEY |
|--------------------------|------------------------|---|---------------------|---|-----------------------------------|----------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | , , | 3 | | MPLETED |
| | | | | | | С |
| | | 345421 | B. WING | | | 02/14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | | |
| | | | | 72 CHATHAM BUSINESS PARK | | |
| THE LAUP | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETIO DATE |
| F 656 | Continued From page | o 20 | | | | |
| F 000 | | 6.39 | F 65 | | | |
| | The findings: | | | know how to care for the | • | |
| | 1 Resident #270 wa | s initially admitted to the | | are assigned to for reside been updated to include t | | |
| | | most recently readmitted on | | and the care card has bee | | |
| | | s that included dementia, | | resident #61, to include co | | |
| | anxiety, and repeated | | | management. Intervention | | |
| | | | | residents are being carrie | | |
| | The quarterly Minimu | ım Data Set (MDS) | | monitored. | | |
| | assessment dated 10 | 0/2/18 indicated Resident | | | | |
| | #270' s cognition was | s severely impaired. She | | Corrective Action for those | e having the | |
| | | d no rejection of care. | | potential to be affected | | |
| | | issessed with wandering | | At the time of the survey, | | |
| | | s during the MDS 7 day | | had an assessment and r | | |
| | review period. She r | - | | cards updated in the past | | |
| | | ed mobility and transfers, | | were reviewed by the Min | | |
| | | valking in corridor and | | care plan (MDS) nurse, a | | |
| | | unit, and supervision with ig in room. Resident #270 | | managers. to determine if are being carried out for f | | |
| | | ith range of motion and she | | contractures. No other res | | |
| | | evices. She had no falls | | to not be receiving planne | | |
| | - | DS assessment (7/2/18). | | | | |
| | | | | Systemic Changes | | |
| | Resident #270 ' s car | re plan included the identified | | The MDS nurse has been | re-educated by | |
| | | all related injury due to | | the regional nurse consul | • | |
| | | e, vision, and dementia. | | 3-15-19,to ensure that all | | |
| | This area was most r | ecently revised on 10/3/18. | | contractures that are capt | ured on the | |
| | The interventions we | re all initiated on 3/22/18 and | | MDS, have person-center | ed care plans | |
| | included, in part, the | provision of clean | | developed for them. Nurs | es and Nursing | |
| | eyeglasses daily. | | | Assistants have been ree | | |
| | | | | regarding the implementa | | |
| | - | ted 12/15/18 indicated | | and contracture manager | • | |
| | | n observed fall at 5:20 PM in | | Assistant Director of Nurs | | |
| | the dining room area | | | meetings over the weeks 2-25-19. No staff will be s | | |
| | | rying to sit in a chair and review of the post incident | | work after 3-29-19 withou | | |
| | | /18 and completed by Unit | | inserviced first. | , penng | |
| | - | licated the post-incident | | | | |
| | | included, in part, to ensure | | Monitoring | | |
| | | eglasses were in place while | | The Director of Nurses, a | | |

Facility ID: 923099

If continuation sheet Page 40 of 132

| OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED |
|---|
| - |
| C — 02/14/2019 |
| STATE, ZIP CODE |
| PARK |
| 12 |
| R'S PLAN OF CORRECTION (X5) RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY) |
| form audits bi-weekly by ns on all shifts and all for one month and then quarter, to determine if acture management tured on the care plemented by staff. dits will be reviewed at ity Assurance Committee urther recommendations. r will be responsible to er recommendations are |
| |

If continuation sheet Page 41 of 132

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | FORI | D: 04/10/2019 M APPROVED D. 0938-0391 | |
|--------------------------|---|--|---------------------|---|-----------------|---|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | |
| | | 345421 | B. WING | | C 02/14/2019 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | · _·· | | |
| | | | 7 | 2 CHATHAM BUSINESS PARK | | | |
| THE LAU | RELS OF CHATHAM | | F | PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 656 | incident report for Res reviewed with NA #7. 1/31/19 fall for Reside was almost dinner tim trying to get all of the room. She reported t one of the tables in the tried to sit down but m She revealed that she impaired vision was th believed the resident the chair was located She further revealed th had her eyeglasses o #7 was unable to reca eyeglasses were at w An interview was com 2/14/19 at 9:00 AM. S worked regularly on th aware that Resident # and she had eyeglass be put on her when sl 1/31/19 incident reports was reviewed with NA 1/31/19 fall for Reside was almost dinner tim trying to get all of the room. She reported to one of the tables in the tried to sit down but m #8 was asked if Resident # the time of fall. She e | k intervention. The 1/31/19 sident #270 's fall was NA #7 stated that this ent #270 occurred when it he and she and NA #8 were residents into the dining hat Resident #270 was at e dining room area and she hissed the chair and fell. e thought Resident #270 's he cause of this fall as she was unable to see where when she went to sit down. that Resident #270 had not n at the time of the fall. NA all where Resident #270 's then she fell on 1/31/19. ducted with NA #8 on She stated that she had not he secured unit, but she was #270 had impaired vision ses that were supposed to he was out of bed. The t for Resident #270 's fall A #8. She stated that the ent #270 occurred when it he and she and NA #7 were residents into the dining hat Resident #270 was at e dining room area and she hissed the chair and fell. NA dent #270 had eyeglasses all. She stated that she was 270 had eyeglasses on at explained that Resident #270 er eyeglasses and placed | F 656 | | | | |

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 |
|--------------------------|---|--|---------------------|------------------------------|--|-------------------------------|--|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| | | 345421 | B. WING | | _ | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| | | | | 72 CHATHAM BUSINESS F | PARK | | |
| | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE) CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 656 | Continued From page | 42 | F 65 | 6 | | | |
| | An observation was c on 2/13/19 at 4:45 PM wheelchair at a table the secured unit. Her on the table in front of An interview was come 2/13/19 at 4:46 PM. S #270 had any vision p Resident #270 had im eyeglasses. She stat kept her eyeglasses of staff tried to encourag the eyeglasses, but th off. NA #6 revealed s eyeglasses were not present time. She ac she knew the eyeglas resident, she had not An interview was come on 2/14/19 at 10:08 A plan related to falls ar provision of clean eye with MDS Nurse #1. Resident #270 had im the use of eyeglasses Resident #270 had m revealed that Resider (10/5/18 fall, 12/15/18 occurred when she w chair. She stated that analysis of the falls it were related to impair | onducted of Resident #270 1. She was seated in a in the dining room area of eyeglasses were observed i her. ducted with NA #6 on She was asked if Resident problems. She indicated that upaired vision and she had ed that Resident #270 rarely on. She indicated that the le Resident #270 to wear hat she always took them he was aware the on Resident #270 at this knowledged that although ses were not on the put them back on her. ducted with MDS Nurse #1 M. Resident #270 's care nd the intervention of the uglasses daily was reviewed MDS Nurse #1 stated that upaired vision that required a. She revealed that ultiple falls. She further at #270 sustained 3 falls a attempting to sit in a | | | | | |
| | | sident #270 had her o reduce the risk of another ras asked what staff were | | | | | |

Facility ID: 923099

If continuation sheet Page 43 of 132

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 |
|--------------------------|---|---|--------------------|-----|---|------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 345421 | B. WING | | | | C / 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | · · | |
| THE LAUF | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 656 | expected to do when eyeglasses. She stat to put the eyeglasses An interview was com Nursing (DON) on 2/1 stated that she expect related to falls to be co prevent recurrence of 2. Resident #61 was a 4/3/18 with multiple di and depression. The (MDS) assessment da Resident #61 had no motion (ROM) on upp Resident #61's care p risk for contracture an right hand and right e applied twice a day for On 2/12/19 at 4:10 PI AM, Resident #61 wa hand/elbow contracte On 2/13/19 at 9:00 AI was interviewed. She assigned to Resident applying the splint du the NA care guide and should have the splini elbow 2 times a day for Non 2/13/19 at 9:05 AI interviewed. She stat Resident #61. Nurses | Resident #270 removed her red that staff were expected back in place. ducted with the Director of 13/19 at 5:10 PM. She ted care plan interventions consistently implemented to falls. admitted to the facility on iagnoses including anxiety quarterly Minimum Data Set ated 1/8/19 revealed that impairment in range of ber extremity. blan dated 1/8/19 included at d the approaches included lbow extension splint to be or 2 hours. M and on 2/13/19 at 8:57 s observed with the right d and with no splints noted. M, Nursing Assistant (NA) #1 e stated that she was #61 but she had not been ring her shift. NA #1 showed d stated that Resident #61 t on his right hand and right or 2 hours but she didn't ply. | F | 656 | | | |

| | DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | FORM | MAPPROVED 0. 0938-0391 |
|--------------------------|--|---|-----------|----------------------------|--|-----------|---------------------------|
| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE | |
| | | 345421 | B. WING _ | | | | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE 2 CHATHAM BUSINESS PARK | | |
| THE LAUF | RELS OF CHATHAM | | | | ITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION DATE | | | |
| F 656 F 657 SS=E | splint. She revealed t facility and this was h Resident #61. Nurse i Medication Administra indicated to remove th 6:00 PM but she didm order said for the splin the doctor's order for order indicated to app 2 hours. Nurse #1 ind should have been app removed at 10:00 AM removed at 6:00 PM. On 2/13/19 at 3:20 PM NA #2 stated that she Resident #61 on the s and she didn't know th supposed to wear spl elbow from 4:00 PM to On 2/13/19 at 9:15 AM was interviewed. She the NA to apply the sp check behind them. On 2/14/19 at 11:52 A (DON) was interviewed she expected nursing planned. Care Plan Timing and CFR(s): 483.21(b)(2)(0 §483.21(b) Comprehe §483.21(b)(2) A comp be- | that she was new to the er first time assigned to #1 further stated that the ation Record (MAR) he splint at 10:00 AM and 't know what the doctor's int application. She reviewed the splint and stated that the object at show and and applied at 4:00 PM and M, NA #2 was interviewed. eregularly cared for second shift (3 PM - 11 PM) hat Resident #61 was ints on his right hand and o 6:00 PM each day. M, the Nurse Coordinator e stated that she expected blints and for the nurses to AM, the Director of Nursing ed. The DON stated that to apply the splints as care I Revision (i)-(iii) ensive Care Plans orehensive care plan must I days after completion of | | 656 | | | 3/29/19 |
| F 657 | splint. She revealed t facility and this was h Resident #61. Nurse i Medication Administra indicated to remove th 6:00 PM but she didn order said for the splin the doctor's order for order indicated to app 2 hours. Nurse #1 ind should have been app removed at 10:00 AM removed at 6:00 PM. On 2/13/19 at 3:20 PM NA #2 stated that she Resident #61 on the s and she didn't know th supposed to wear spl elbow from 4:00 PM to On 2/13/19 at 9:15 AM was interviewed. She the NA to apply the sp check behind them. On 2/14/19 at 11:52 A (DON) was interviewed she expected nursing planned. Care Plan Timing and CFR(s): 483.21(b)(2)(§483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 | that she was new to the er first time assigned to #1 further stated that the ation Record (MAR) he splint at 10:00 AM and 't know what the doctor's int application. She reviewed the splint and stated that the object at show and and applied at 4:00 PM and M, NA #2 was interviewed. eregularly cared for second shift (3 PM - 11 PM) hat Resident #61 was ints on his right hand and o 6:00 PM each day. M, the Nurse Coordinator e stated that she expected blints and for the nurses to AM, the Director of Nursing ed. The DON stated that to apply the splints as care I Revision (i)-(iii) ensive Care Plans orehensive care plan must I days after completion of | | | | | 3/29/19 |

Facility ID: 923099

If continuation sheet Page 45 of 132

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 | |
|--------------------------|--|--|--------------------|--|---|--|----------------------------|--|
| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTR | | (X3) DATE COM | E SURVEY PLETED | |
| | | 345421 | B. WING | | 0 | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | STREET AD | DRESS, CITY, STATE, ZIP CODE | • | | |
| THE LAU | RELS OF CHATHAM | | | | AM BUSINESS PARK RO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE | |
| F 657 | (ii) Prepared by an infincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and the resident and the resident and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determinor as requested by th (iii)Reviewed and revite the reach assest comprehensive and quasessments. This REQUIREMENT by: Based on observation interview, the facility for care plans in the area #28 and #88), falls (R behaviors (Resident # residents. The findings included 1. Resident #270 was facility on 9/1/17 and | terdisciplinary team, that inted to vsician. with responsibility for the responsibility for the I and nutrition services staff. cticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the juarterly review T is not met as evidenced in, record review, and staff failed to review and revise as of wandering (Residents tesident #270), and #9) for 4 of 27 sampled : s initially admitted to the most recently readmitted on a that included dementia, | F | Corre Resid Resid updat being has b and th been updat Minim nurse Corre | Y Care Plan Timing and Revisio ective Action lent #88 is currently out of the f lent #28 s care plan has been ted to reflect no wanderguard is used. Resident #270 s carep een updated to include recent the careplan for Resident #9 has updated to include behaviors. T tes have been completed by the num Data Set (MDS) care plan e, during the week of February fections were transmitted February ections were transmitted February | acility. an falls Fhese e 18. | | |

Facility ID: 923099

If continuation sheet Page 46 of 132

| | OF DEFICIENCIES | MEDICAID SERVICES | | PLE CONSTRUCTION | | NO. 0938-03 ATE SURVEY |
|--------------------------|--------------------------|---|---------------------|---------------------------------------|--------------|---------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | . , | G | · · · · | MPLETED |
| | | | A. BOILDIN | 5 | | С |
| | | 345421 | B. WING | | 02/14/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | 1 | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | 72 CHATHAM BUSINESS PARK | | | | |
| THE LAU | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOUL | | (X5) COMPLETIC DATE |
| | | | | | | |
| F 657 | Continued From page | e 46 | F 65 | 57 | | |
| | The quarterly Minimu | ım Data Set (MDS) | | | | |
| | |)/2/18 indicated Resident | | Corrective Action for those hav | ing the | |
| | #270' s cognition was | s severely impaired. She | | potential to be affected | | |
| | had no behaviors and | d no rejection of care. She | | At the time of the survey, all re | sidents that | |
| | required the limited a | ssistance of 1 for bed | | had an assessment in the past | three | |
| | mobility and transfers | | | months were reviewed by the I | | |
| | - | nd locomotion on/off the unit, | | Data Set (MDS) assessment c | | |
| | | set up only for walking in | | nurse, and/or the nurse manag | | |
| | | had no impairment with | | determine if comprehensive ca | | |
| | - | she utilized no mobility | | have been updated for all rece | | |
| | | falls since her previous | | wandering behaviors, and behaviors | | |
| | MDS assessment (7/ | 2/18). | | general. No other resident was | | |
| | | | | not have timely updated care p | lans or | |
| | | e plan included the identified | | care cards. | | |
| | | Il related injury due to | | | | |
| | | e, vision, and dementia. | | Systemic Changes | | |
| | | ecently revised on 10/3/18. | | The MDS nurse has been re-e | - | |
| | I he interventions we | re all initiated on 3/22/18. | | the regional nurse consultant of | | |
| | | | | to ensure that all falls, behavio | | |
| | An incident report dat | | | wandergurads are captured tin | | |
| | | n observed fall at 2:45 PM in | | person-centered care plans an | | |
| | - | of the secured unit that | | updated on the care cards. The | | |
| | | n. A Nursing Assistant (NA) | | nurse is now going to the daily | | |
| | | #270 trying to sit in a chair or when she slid down the | | team meeting and is revising c | are plans | |
| | 1 | w on the door handle. There | | and care cards as necessary. | | |
| | | ide to Resident #270 's care | | Monitoring | | |
| | plan related to falls at | | | The Director of Nurses, and/or | her nurse | |
| | | | | manager, will perform audits bi | | |
| | An incident report dat | ted 12/15/18 indicated | | one month and then monthly for | • | |
| | - | n observed fall at 5:20 PM in | | quarter, to determine if there a | | |
| | the dining room area | | | residents who have had wande | | |
| | - | ying to sit in a chair and | | episodes, falls, and/or behavio | • | |
| | | ere were no revisions made | | of the audits will be reviewed a | | |
| | | care plan related to falls after | | monthly Quality Assurance Co | | |
| | this 12/15/18 fall. | | | meeting for any further recomm | | |
| | | | | The Administrator will be respo | | |
| | An interview was con | ducted with UM #1 on 2/3/19 | | ensure any further recommend | | |
| | | 5/18 incident report was | | carried out. | | |

Event ID: PVRD11

Facility ID: 923099

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| | | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | 04/10/2019 APPROVED 0938-0391 |
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| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| | | 345421 | B. WING | | | C 02/1 | 4/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, STATE | , ZIP CODE | •= | |
| | | | 7 | 2 CHATHAM BUSINESS PAR | < | | |
| THE LAU | RELS OF CHATHAM | | | ITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIV CROSS-REFERENCE | AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY) | | (X5) COMPLETION DATE |
| F 657 | cause analysis for this impaired vision and in UM #1 explained that had both occurred wh attempting to sit in a c A nursing note dated (Nurse #6) was notifie #270 was trying to sit missed the chair land An incident report dat by Nurse #6 indicated observed fall at 5:45 I of the secured unit. N as caregivers for Res fall. There were no re #270 's care plan rela 1/31/19 fall. The NA care guide for recently revised on 2/ Resident #270 was a observed when trying An interview was com- on 2/14/19 at 10:08 A care guide was review She stated that the fa putting dates on the N were able to know wh implemented. She re of observing Resident to sit down was put in following her 12/15/18 fall. She explained the | She indicated that the root is fall was Resident #270 's inpaired depth perception. this fall and the 10/5/18 fall en Resident #270 was chair. 1/31/19 indicated the nurse ed by an NA that Resident in a chair for dinner and ing on the floor. ed 1/31/19 and completed I Resident #270 had an PM in the dining room area IA #7 and NA #8 were noted ident #270 at the time of the evisions made to Resident ated to falls after this r Resident #270, most 1/19, indicated that fall risk and she was to be to sit down. ducted with MDS Nurse #1 M. Resident #270 's NA ved with MDS Nurse #1. cility had just recently began IA care guides so that they en interventions were ported that the intervention t #270 when she was trying place on the NA care guide B fall and before her 1/31/19 at the root cause analysis of 15/18 fall was impaired | F 657 | | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | : 04/10/2019 APPROVED . 0938-0391 |
|--------------------------|---|---|---------------------|---|--|-----------------------|---|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | _ | (02/ [,] | ; 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA | ATE, ZIP CODE | | |
| THE LAU | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS P/ PITTSBORO, NC 27312 | ARK | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY) | | (X5) COMPLETION DATE |
| F 657 | Resident #270 was at Resident #270 's car reviewed with MDS N intervention of observ she was trying to sit of care plan. She revea revised Resident #27 falls when she added An interview was com Nursing on 2/13/19 at she expected interver root cause analyses t plans interventions to falls. 2. Resident #28 was a 11/2/18 with diagnose and psychosis. The admission Minim assessment dated 11 #28 's cognition was assessed with wande days and a wander el use. Resident #28 's activ on 2/11/19, included t and exit seeking. The area included, in part, (an electronic alert sy the facility exit doors of | that the 10/5/18 fall, 1/19 fall all occurred when tempting to sit in a chair. e plan related to falls was urse #1. She confirmed the ing Resident #270 when lown was not added to her led that she should have 0 's interventions related to it to the NA care guide. ducted with the Director of 5:10 PM. She stated that titions developed through o be added to the care prevent the recurrence of admitted to the facility on as that included dementia um Data Set (MDS) /2/18 indicated Resident severely impaired. He was ring behaviors on 1 to 3 opement alarm was not in e care plan, last reviewed he focus area of wandering e interventions for this focus , ensure that wanderguard stem that alarms and locks when cognitively impaired ring behaviors attempt to | F 657 | | | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 |
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| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , í | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | _ | | C 14/2019 |
| NAME OF PR | ROVIDER OR SUPPLIER | | • | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAUF | ELS OF CHATHAM | | | | 2 CHATHAM BUSINESS P | ARK | | |
| | | | | P | ITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 657 | Continued From page functioning daily. | e 49 | F | 657 | | | | |
| | on 2/13/19 at 11:44 A ambulating with a stea | ady gait in a common area the facility. He had no | | | | | | |
| | stated that Resident # place. NA #6 further | ducted with Nursing 2/13/19 at 11:45 AM. She ⁄28 had no wanderguard in stated that no residents on e facility had wanderguards. | | | | | | |
| | on 2/14/19 at 10:08 A plan related to wande the wanderguard was #1. She stated that the accurate and confirme wanderguard. She ex Resident #28 was firs unit and had a wande to the secured unit sh the wanderguard was revealed that Resider wandering should hav | ducted with MDS Nurse #1 M. Resident #28 's care ring and the intervention of reviewed with MDS Nurse his intervention was not ed that Resident #28 had no cplained that she thought t admitted to an unsecured rguard but was moved back ortly after admission and removed. MDS Nurse #1 ht #28 's care plan related to we been revised and the anderguard should have | | | | | | |
| | Nursing on 2/13/19 at she expected care pla reviewed and revised of the resident. 3) Resident #9 was at 7/30/18 with diagnose | ducted with the Director of 5:10 PM. She stated that an interventions to be to reflect the current status dmitted to the facility on es that included vascular oral disturbance, psychosis | | | | | | |

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| | | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 |
|--------------------------|--|--|---------------------|----|--|----------|-------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | | | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE LAUF | RELS OF CHATHAM | | | | CHATHAM BUSINESS PARK | | | |
| | | | | | TTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BI | | (X5) COMPLETION DATE |
| F 657 | Continued From page | 50 | F 6 | 57 | | | | |
| | (MDS) coded as a Sig Condition and dated of resident with severe of received extensive to two staff members for (ADL's) except for sup was marked with other directed towards other the look back period. Review of Resident # 11/30/19 revealed she cognitive impairment, care and an actual be at her spouse, but no the repetitive stateme Review of the nursing to present revealed the statements such as "H home, I love you, I ne distress noted. Review of the Behavia Reports dated 12/5/18 showed repetitive state Review of a PACE (P for the Elderly) physic 11/21/18 noted that th help throughout the d having any complaints On 2/12/19 at 4:00pm | 11/12/18 assessed the cognitive deficits. She total assistance of one to all Activities of Daily Living pervision with eating. She is behavioral symptoms not rs one to three days during 9's active care plan dated e was care planned for sun downing, resistance to havior of hitting and cursing care plan was present for nts that were made daily. notes from November 2018 re resident had repetitive Help me, where's Bill, take ed some water" with no or Data and Analysis 3, 1/4/19 and 2/8/19, tements were present. rogram of All-Inclusive Care ian progress note dated re resident called out for ay and the night despite not s. | | | | | | |
| | sitting in her wheelcha area. She was yelling | air (WC) in the common g out "help me" repeatedly l. Resident #9 was able to | | | | | | |

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
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| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE COMP | |
| | | 345421 | B. WING | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | : | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| THE LAU | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | (X5) COMPLETION DATE |
| F 657 | engage in simple con conversation ended th began. On 2/13/19 at 8:45am coming out of the dini She stated that she w and began to state "ta She was able to engather the conversation ender began. An interview was con #1 on 2/13/19 at 3:40 Social Workers mana care plans, but she w repetitive vocalization On 2/13/19 at 4:00pm completed with Social she was aware of Resiver vocalizations and it w include it on the care On 2/14/19 at 11:50an the Director of Nursin expectation for the care of 2/14/19 at 11:50an the Director of Nursin expectation for the care areflection of the reside 4. Resident #88 was add 11/17/17 with diagnos seizure, and injury of A review of Resident 10/17/18 at 5:00 pm r the building alone ont residents and a staff of | versation but when the ne repetitive statements A Resident #9 was observed ng room following breakfast. vas going to PACE that day ake me now" repeatedly. type in conversation but when ed, the repetitive statements ducted with the MDS Nurse pm. She explained that the ge the mood and behavior ould expect the resident's is to be care planned. An an interview was I Worker #1. She stated that sident #9's repetitive as an oversight to not plan. m an interview was held with g who stated that it was her re plan to be an accurate ent in behaviors. mitted to the facility on ses of anxiety, paraplegia, the spinal cord. #88 ' s nurses ' note dated evealed the resident exited o the front patio with other | F | 657 | | | |

Facility ID: 923099

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|---|--|---|-------------------|-----|---|------------------|----------------------------|
| CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 345421 | B. WING | | | | C / 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | I | : | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 657 | to October of 2018 dia interventions for elope alarm. A review of Resident : evaluation dated 11/3 verbalized he wanted motorized mobility de and was an elopemer A review of Resident : 12/2/18 revealed an in A review of the reside updated 1/16/19 did r an elopement risk or b bracelet. A review of Resident : Data Set (MDS) dated resident had adequate was unable to be asso required extensive as transfers and bed mo other activities of daily | ent outside (first sole ent outside). ent 's prior care plans back d not reveal goals and ement potential or wander #88 's Risk for Elopement 0/18 revealed the resident to leave the facility, had a vice (motorized wheel chair) nt risk. #88 's quarterly MDS dated ntact cognition. ent 's current care plan not identify the resident as having a wander alarm #88 's quarterly Minimum d 1/18/19 revealed the e hearing, clear speech and understands. The cognition essed. The resident sistance of 2 staff for all bility and of 1 staff for all | F | 657 | | | |
| | that the staff tried to p | um an interview was ent #88. The resident stated out a wander alarm (bracelet arm when approached) on | | | | | |

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| | | D HUMAN SERVICES | | | | | FORM |): 04/10/2019 MAPPROVED |
|--------------------------|---|--|-------------------|---------|--|--|-----------|---------------------------------|
| STATEMENT (| S FOR MEDICARE & I OF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | | (X3) DATE | 0. 0938-0391 SURVEY LETED |
| | | 345421 | B. WING | | | _ | (02/ | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STA | ATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PA PITTSBORO, NC 27312 | ARK | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | I IX | PROVIDER'S (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY) | | (X5) COMPLETION DATE |
| F 657 | his extremity and he r device on his wheel c On 2/11/19 at 9:15 an of Resident #88 's wh alarm bracelet was at The bracelet was test On 2/13/19 at 2:00 pm conducted with NA #3 regularly assigned on NA #3 stated that she had gone onto the fro without supervision or had made comments about not wanting to b aware that the residen the past (wore a wand not at present. On 2/13/18 at 3:00 pm conducted with NA #2 regularly assigned to commented that she resident went outside porch with other resid resident was not inde a staff member to acc On 2/13/19 at 3:25 pm conducted with Nurse evening-shift assigned #4 stated that she wa had a wander alarm of the resident was an e On 2/13/19 at 4:10 pm conducted with the Di | refused so staff placed the hair. In an observation was done heel chair and a wander tached to the lower left side. ed to be working. In an interview was 8 who stated she was day shift to Resident #88. In remembered the resident int porch with other resident int porch with other resident to multiple staff members be here. Nurse #3 was int was an elopement risk in der alarm on his person), but In an interview was Resident #88. NA #2 remembered when the the front door to sit on the ents last October. The pendent and had to wait for company him. In an interview was e #4 who was regularly d to Resident #88. Nurse s not aware the resident on his wheel chair and that lopement risk. | F | 657 | | | | |

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| | MENT OF HEALTH AN | D HUMAN SERVICES | | | | | FORM | D: 04/10/2019 MAPPROVED D. 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|---|-------------------|--|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | | (X3) DATE COMF | SURVEY PLETED |
| | | 345421 | B. WING | | | _ | | C /14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAU | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS P PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | (EACH CORREC CROSS-REFEREN | EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 657 F 688 SS=E | wander alarm bracele and was an elopemer wander alarm to preve was not aware that th wander alarm bracele On 2/14/19 at 1:30 pr conducted with MDS was responsible for th development and revi that the resident had a his wheel chair or was MDS Coordinator con- elopement risk should of care. Increase/Prevent Dec CFR(s): 483.25(c)(1)- §483.25(c) Mobility. §483.25(c)(1) The fac resident who enters th range of motion does range of motion does range of motion unles condition demonstrate of motion is unavoida §483.25(c)(2) A reside motion receives appro- services to increase r prevent further decrea §483.25(c)(3) A reside receives appropriate a assistance to maintain the maximum practica reduction in mobility is | At attached to his wheel chair of trisk and needed the ent elopement. The DON ere was no care plan for the at and elopement risk. In an interview was Coordinator who stated she he residents ' care plan sion. She was not aware a wander alarm device on is an elopement risk. The firmed the resident ' s d be on the resident ' s d be on the resident ' s plan erease in ROM/Mobility (3) willity must ensure that a he facility without limited not experience reduction in is the resident's clinical es that a reduction in range ble; and ent with limited range of | | 657 | | | | 3/29/19 |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | FORM |): 04/10/2019 APPROVED 0. 0938-0391 |
|--------------------------|--|--|---------------------|---|--|---|
| STATEMENT C | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | C 14/2019 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 02/ | 14/2013 |
| | | | | 72 CHATHAM BUSINESS PARK | | |
| THE LAUR | ELS OF CHATHAM | | | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 688 | Continued From page Based on record revi and physician intervie the splints as ordered #61) and failed to prov (Resident #39) to mai decrease in range of r residents reviewed for Findings included: Resident #61 was adr 4/3/18 with multiple di and depression. Resident #61 had a d to wear right elbow ex hand T-bar splint. The twice a day (morning) each time. The order required total assist w for nursing to apply. The quarterly Minimum assessment dated 1/8 #61 had no impairment on upper extremity. Resident #61's care p risk for contracture an right hand and right el applied twice a day for The Nurse Aide (NA) | e 55 ew, observation, and staff w, the facility failed to apply by the physician (Resident vide range of motion ntain or prevent further motion for 2 of 3 sampled r range of motion. mitted to the facility on agnoses including anxiety octor's order dated 6/28/18 tension splint and right e splinting schedule was and afternoon) for 2 hours indicated that the resident ith the splint application and m Data Set (MDS) 8/19 revealed that Resident in in range of motion (ROM) and dated 1/8/19 included at of the approaches included bow extension splint to be r 2 hours. | F 68 | DEFICIENCY) | t facility. ill be n rative ntinued ative nge of ed by the dints and ge of t risk: lints and ge of t risk. A py, of rders ded by the dints and ge of t risk. A py, of rders ded as as been Set a, to a clear to s). The ure that it ation nind | |
| | guide included to app right hand T bar splint | ly right elbow extension and twice a day for 2 hours. t specify the times of the | | Nursing in conjunction with therap complete an audit to determine w residents are not on Restorative N that would require passive range motion (PROM) with care. This a | hat Nursing of | |

Facility ID: 923099

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345421 B. WING 02/14/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK THE LAURELS OF CHATHAM PITTSBORO, NC 27312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 688 Continued From page 56 F 688 On 2/12/19 at 4:10 PM and on 2/13/19 at 8:57 identify what joints require PROM and this AM, Resident #61 was observed with the right information will be recorded on care cards hand/elbow contracted and with no splints noted. OR the CNA documentation system Point of Care. On 2/13/19 at 9:00 AM, Nursing Assistant (NA) #1 was interviewed. She stated that she was Systemic Changes: assigned to Resident #61 but she had not been CNA s and licensed staff have been applying the splint during her shift. NA #1 showed inserviced by the ADON/staff development the NA care guide and stated that Resident #61 Coordinator the week of March 11th for should have the splint on his right hand and right full time, part time, and PRN staff. Staff elbow 2 times a day for 2 hours but she didn't not inserviced by March 29 will not be able know what time to apply. to work until educated on splint wearing schedules, passive range of motion On 2/13/19 at 3:20 PM, NA #2 was interviewed. exercises, as well as where this NA #2 stated that she regularly cared for information can be found for reference Resident #61 on the second shift (3 PM - 11 PM) and documentation. and she didn't know that Resident #61 was supposed to wear splints on his right hand and Monitoring: elbow from 4:00 PM to 6:00 PM each day. Audits will be completed by the Director of Nurses and/or the Assistant Director of On 2/13/19 at 9:05 AM, Nurse #1 was Nurses, weekly for residents with splints interviewed. She stated that she was assigned to to ensure wearing schedules are being Resident #61. Nurse #1 stated that she didn't followed and observation of 2 residents per week for PROM to ensure provision of know that Resident #61 was supposed to have a splint. She revealed that she was new to the PROM is being provided for 4 weeks and facility and this was her first time assigned to then monthly for 2 months. The results Resident #61. Nurse #1 further stated that the will be reported by the DON, to the Medication Administration Record (MAR) monthly QAPI (Quality Assurance and indicated to remove the splint at 10:00 AM and Performance Improvement) meeting for any further recommendations. The DON 6:00 PM but she didn't know what the doctor's order said for the splint application. She reviewed will be responsible to follow-up on any the doctor's order for the splint and stated that the recommendation from the QA committee. order indicated to apply the splints twice a day for 2 hours. Nurse #1 indicated that the splints should have been applied at 8:00 AM and removed at 10:00 AM and applied at 4:00 PM and removed at 6:00 PM. On 2/13/19 at 9:15 AM, the Unit Coordinator was

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORI | M APPROVED D. 0938-0391 |
|--------------------------|---|---|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED |
| | | 345421 | B. WING | | | | C / 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| THE LAUF | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 688 | interviewed. She stat to apply the splints ar behind them. On 2/14/19 at 11:52 A (DON) was interviewed she expected nursing ordered. The DON co- hand and elbow splin 2 hours at 8:00 AM ar 2. Resident #39 was ad 8/19/14 with diagnose damage, tracheostom abnormal posture, an A review of Resident dated 6/19/18 reveale and lower extremities sides. Resident #39 had a p specified therapy sen achieved goals. The r to get out of bed into times per week for up decrease risk of skin with environment to for Resident #39 had a p for restorative nursing Resident #39 had a p for staff to place a pill A review of Resident | ted that she expected the NA and for the nurses to check AM, the Director of Nursing ed. The DON stated that to apply the splints as onfirmed that Resident #61's t were to be applied daily for and 4:00 PM. mitted to the facility on es to include anoxic brain by, contracture, convulsions, d muscle spasm. #39 's Minimum Data Set ed range of motion of upper was impaired on both hysician order dated 7/6/18 vices discontinued due to resident was recommended high-back wheel chair 3-4 o to 2 hours per day to breakdown and to interact ullest potential. | F | 688 | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | 2: 04/10/2019 1 APPROVED 2: 0938-0391 |
|--------------------------|---|--|---------------------|--|--|-----------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | _ | (02/ [,] | ; 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | 2 CHATHAM BUSINESS PA PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 688 | The resident required ADLs. The relevant a seizure, persistent an tracheostomy, contract and muscle spasm. A review of the Residu 12/18/18 revealed go contractures and pote related to non-function for the resident not to contractures and inter alignment, therapy ev devices, report finding as ordered. No interview was identified. The n had no task for passiv On 2/11/19 at 9:30 an of Resident #39 who of the bed elevated. to severe contracture hands and had a rolle hands. The resident bilateral legs including ankles with severe for pillow between his kn protectors to reduce p On 2/13/19 at 10:30 a conducted with the Di who stated the reside restorative nursing at months of look back i aware of the resident and commented that the facility with contract | sistent and vegetative state. extensive, total care for all active diagnoses were d vegetative state, cture, abnormal posture, ent #39 ' s care plan dated als and interventions for ential for further contractures nal mobility. The goal was develop any further rventions were body aluation for assistive gs to physician, and splints rention for range of motion ursing assistant care card ve range of motion an observation was done was in his bed with the head The resident had moderate of his arms, wrists, and ed wash cloth inside of both had severe contractures to g his hips, knees, and ot drop. The resident had a ees and bilateral heel pressure. am an interview was rector of Nursing (DON) | F 688 | | | | |

Facility ID: 923099

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 // APPROVED). 0938-0391 |
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| STATEMENT OF DEFIC | CIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF PROVIDER | R OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | CUATUAM | | | 73 | 2 CHATHAM BUSINESS PARK | | |
| THE LAURELS O | | | | P | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) | | (X5) COMPLETION DATE |
| when comm to pro- On 2/ condu Resic positi devic On 2/ condu #39 v wash that ti motio when staff t contra not av task of On 2/ condu #39 v wash that ti motio when staff t contra not av task of On 2/ condu #39 v wash that ti motio when staff t contra not av task of On 2/ condu #39 v wash that ti motio vhen staff t contra not av task of On 2/ condu stated signifi treatr requi motio contra there there had n servic Vou Condu | nented that the c poide passive ran (13/19 at 10:50 a ucted with Nurse dent #39. Nurse on on his side ar es and exited the (13/19 at 10:50 a ucted with Nurse vas severely con clothes to each he resident was no the resident was no on treatment (resident rec- to move his legs actures. Nurse # ware of nursing a problem provideo (14/19 at 12:50 p ucted with Resided the resident was ficant contracture nent. The physic re and expect co on therapy to prev- actures. The phy- was an order for py services (date not received regu- ces since therapy d have had exper- acture of his joint (14/19 at 2:30 pm | was provided. The DON ontractures were too severe age of motion. m an observation was #4 was assigned to #4 observed the resident ' s ad pressure prevention e room. m an interview was #4 who stated Resident tracted and received rolled hand. Nurse #4 also stated not receiving range of torative nursing) other than eived a bath it required 2 due to the severity of the t4 commented that she was assistant care card having I passive range of motion. m an interview was ent #39 ' s physician who is admitted with fairly is that can worsen without cian felt the resident would ntinued passive range of vent worsening visician commented that f nursing rehabilitation after ed 7/12/18). If the resident lar passive range of motion v discharged (7/6/18) he rienced increased | F | 688 | | | |

If continuation sheet Page 60 of 132

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 04/10/2019 MAPPROVED D. 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|-------------------|--|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | IREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | | | |
| | | | | P | ITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| | receive as least passi nursing assistants to p On 2/14/19 at 3:00 pm conducted with the Re stated that the resider on 7/6/18 and nursing following for continued discharged to staff nu nursing) and they wou resident was not a ca lower extremities due contracture. The resi severe. The Director resident since 7/16/18 contractures were at B Free of Accident Haza CFR(s): 483.25(d)(1)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observation interview the facility fa interventions for a res 1 of 8 residents (Resi falls. One of these fa | who had contractures to ve range of motion by prevent further contracture. In an interview was chabilitation Director who int last had therapy services of rehabilitation was not d range of motion. Therapy rsing (not restorative uld be responsible. The indidate for splints on the to the severity of the dent's contractures were thad not assessed the and was not aware if the baseline. ards/Supervision/Devices (2) | | 688 | F 689 Free from accidents Corrective Action Resident #270'□s care card has been updated by the Minimum Data Set Nurs (MDS) at the time of survey to reflect th fall risk and to reflect history and dates falls as well as the interventions have | ne | 3/29/19 |

Event ID: PVRD11

Facility ID: 923099

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| | | | | | | NO. 0938-03 |
|--------------------------|-------------------------------|---|---------------------|--|---|---------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | . , | ATE SURVEY OMPLETED |
| | | | A. BUILDING | | | С |
| | | 345421 | B. WING | | _ | 02/14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA | | 02/14/2010 |
| | | | | 72 CHATHAM BUSINESS PA | ARK | |
| THE LAU | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE IEFICIENCY) | (X5) COMPLETIO DATE |
| F 689 | Continued From page | - 61 | F 68 | 30 | | |
| | The findings included | | 1.00 | | ident #270 has had an | |
| | | | | | inues to choose to not | |
| | Resident #270 was in | nitially admitted to the facility | | wear her glasses fre | | |
| | | ecently readmitted on 2/7/19 | | plan has been upda | | |
| | with diagnoses that ir | ncluded dementia, anxiety, | | | | |
| | repeated falls and fra | ctured right femur. | | | r those who have the | |
| | | | | potential to be affec | | |
| | The quarterly Minimu | | | | y, all care cards were | |
| | | 0/2/18 indicated Resident s severely impaired. She | | reviewed by the Direction the unit managers. | | |
| | - | d no rejection of care. She | | - | ost recent quarterly fall | |
| | | ssistance of 1 for bed | | risk assessment that | | |
| | mobility and transfers | | | high risk for falls to | | |
| | | d locomotion on/off the unit, | | was noted on the ca | | |
| | | ip only for walking in room, | | care card was found | d to be affected by this | |
| | and extensive assista | | | alleged deficient pra | actice. | |
| | | o impairment with range of | | | | |
| | | ed no mobility devices. She | | Systemic changes | | |
| | | steady, but able to stabilize | | | lents that have had a | |
| | | r moving from seated to lking, turning around and | | | to the daily clinical ops | |
| | • • | irection while walking, and | | team, and will be up | by the interdisciplinary | |
| | | e toilet. She was steady at | | | DS Care Plan Nurse, | |
| | | o surface transfers. She had | | <u> </u> | change in fall risk. All | |
| | | vious MDS assessment | | | een in- serviced the | |
| | (7/2/18). | | | week of March 11th | | |
| | | | | Development Coord | dinator, to include | |
| | | e plan included the identified | | information on the c | | |
| | | Il related injury due to | | | all risk. No staff will be | |
| | | e, vision, and dementia. | | allowed to work after | er March 29, if not | |
| | | ecently revised on 10/3/18. | | inserviced. | | |
| | The goals were to be | nent (3/26/19) and free from | | Monitoring | | |
| | falls due to side effec | | | Monitoring The Director of Nurs | ses using a OA | |
| | | The interventions were all | | auditing tool, will rev | | |
| | | nd included, in part, the | | weekly for the next | | |
| | provision of clean eye | - | | | care cards weekly for | |
| | | ns were to administer | | the next two months | - | |
| | | ed, abnormal involuntary | | and all falls are avail | ilable for the aide to | |

Facility ID: 923099

If continuation sheet Page 62 of 132

| TATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | · , | E CONSTRUCTION | (X3) DAT | O. 0938-039 |
|--------------------------|---|--|---------------------|--|--|---------------------------|
| ND PLAN OF | - CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | CON | IPLETED |
| | | 345421 | B. WING | | | C |
| | ROVIDER OR SUPPLIER | 575721 | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | 2/14/2019 |
| | | | | 2 CHATHAM BUSINESS PARK | | |
| THE LAU | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETIO DATE |
| F 689 | Continued From page | <u>- 62</u> | F 689 | | | |
| | 89 Continued From page 62 movement scale (AIMS) assessment every 6 months, behavior management per protocol, complete fall risk per protocol, encourage guest to wear non-skid foot wear when out of bed, assist guest as needed, keep items of frequent use within reach, low bed, observe for fatigue and/or unsteadiness and encourage rest periods. Review of the fall risk assessment dated 9/14/18 and signed as complete by Unit Manager (UM) #1 on 10/2/18 indicated Resident #1 had no falls in the previous 3 months. She was assessed as intermittently confused, ambulatory, and incontinent. She had adequate vision (with or without assistive device) and a normal gait/balance. Resident #270 took 3-4 at risk medications and had 3 or more at risk conditions and was at low risk for falls. | | | review, as well as the fall risk. I the DON and Unit Managers w random audits of residents to e interventions are in place as ca for. The results will be reported DON, to the monthly QAPI (Qu Assurance and Performance Improvement) meeting for any recommendations. The DON w responsible to follow-up on any recommendation from the QA o with additional training to be pr the Clinical Resource Specialis indicated. | ill conduct ensure are planned d by the lality further vill be committee ovided by | |
| | indicated Resident #2 2:45 PM in the living r unit that resulted in el Assistant (NA) witnes sit in a chair positione down the door and hi handle. The immedia recurrence was to ma by the door. A review dated 10/8/18 and co the post-incident follo Resident #270 ' s sup prevent the recurrence care plan revision rela- risk interventions after | essed Resident #270 trying to ed near a door when she slid t her elbow on the door ate interventions to prevent ake sure nothing was close v of the post incident analysis impleted by UM #1 indicated ow up/action plan was for pervision to be modified to be of a fall. There was no ated to Resident #270 ' s fall | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 |
|--------------------------|--|--|---------------------|-----|--|-------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | 02/ |) 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIZ TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 689 | were reviewed with U how Resident #270 's after the 10/5/18 fall. sure, but she thought monitoring of Resider this "closer" monitorin Resident #270 's card Review of the fall risk and signed as comple- indicated Resident #1 previous 3 months. S intermittently confuse- incontinent. She had without assistive devia- jerking, shuffling), and pattern when walking Resident #270 took 3 had 3 or more at risk for falls. Review of the inciden indicated Resident #2 5:20 PM with no injury the secured unit. Res in a chair and missed intervention to preven for injury. A review of dated 12/17/18 and co indicated the post-inc was to ensure Resider in place while she was her eye exam. Review of the resident | analysis for Resident #270 M #1. UM #1 was asked s supervision was modified She stated that she wasn ' t it meant for "closer" at #270. She verified that g had not been added to e plan related to falls. assessment dated 12/14/18 ete by UM #1 on 12/18/18 had 1-2 falls in the She was assessed as d, ambulatory, and adequate vision (with or ce), gait problems (such as d a change in her gait through doorways. -4 at risk medications and conditions and was at risk t report dated 12/15/18 ?70 had an observed fall at y in the dining room area of ident #270 was trying to sit the chair. The immediate it recurrence was to assess if the post incident analysis ompleted by UM #1 ident follow up/action plan ent #270 ' s eyeglasses were s awake and to check on | F | 589 | | | |

If continuation sheet Page 64 of 132

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|--|-------------------|-----|---|-----------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| | | | | 7 | 72 CHATHAM BUSINESS PARK | | |
| THE LAU | RELS OF CHATHAM | | | F | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ЗE | (X5) COMPLETION DATE |
| F 689 | Continued From page | 9 64 | F | 689 | | | |
| | at 3:30 PM. The 12/14 12/17/18 post inciden were reviewed with U Resident #270 had no the time of the fall. S cause analysis for this impaired vision and ir UM #1 explained that had both occurred wh attempting to sit in a of Resident #270 had ar she stated that she w that the Medical Reco scheduled appointme An interview was con 2/13/19 at 4:25 PM. S responsible for sched the residents. She in provider came to the that Resident #270 w provider for an exami stated that she contag and they indicated the Resident #270 until 1 appointment had pass would have made her appointment May of 2 that because Resider thought to be caused confirmed that Reside for an eye examinatio Review of the nursing indicated the nurse (N NA that Resident #27 | ants for eye examinations. ducted with the MRD on She confirmed that she was luling eye examinations for dicated that the eye care facility twice per year and as last seen by this eye care nation in May of 2018. She cted this eye care provider ey were unable to see year from her previous sed. She reported that this next eye examination 2019. The MRD indicated ht #270 ' s 12/15/18 fall was by impaired vision She ent #270 had not been seen on since March of 2018. | | | | | |

Facility ID: 923099

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| CENTER | | D HUMAN SERVICES | | | | FORM | 0: 04/10/2019 1 APPROVED 0: 0938-0391 |
|--------------------------|--|--|---------------------|---|---|------|---|
| | CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | - | COMP | |
| | | 345421 | B. WING | | | | _ 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, S | | | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PITTSBORO, NC 2731 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE | 'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 689 | resident was transferr easier transportation assisted into bed she loudly when her right Resident #270 was m Nurse Practitioner (Ni ordered x-rays of the knee, and right ankle. received and were all dislocation. The NP y results were faxed for Review of the inciden completed by Nurse # had an observed fall a room area of the secu in right hip. NA #7 an caregivers during the noted that the immedi recurrence was re-ed waiting for assistance incident analysis date UM #1 indicated the p plan was for x-rays, a Therapy evaluation. revision related to Re interventions after the An interview was com 2/14/19 at 8:50 AM. S worked on the secure and was not very fam resided on that unit. was reviewed with Nu had not observed this | initially denied pain or essed by the nurse. The red to a shower chair for to her room and as she was began to cry and scream leg was touched or moved. redicated for pain and the P) was contacted and she right hip, right thigh, right X-ray results were negative for fracture or was notified and the x-ray ther review. treport dated 1/31/19 f6 indicated Resident #270 at 5:45 PM in the dining ured unit. This fall resulted d NA #8 were noted as time of the fall. Nurse #6 fate interventions to prevent ucation to Resident #270 on . A review of the post d 2/1/19 and completed by post incident follow up/action n eye exam, and Physical There was no care plan sident #270 ' s fall risk | F 68 | 89 | | | |

Facility ID: 923099

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | FO | ED: 04/10/2019 RM APPROVED NO. 0938-0391 |
|--------------------------|---|--|---------------------|--|------------------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | (X3) DA | TE SURVEY MPLETED |
| | | 345421 | B. WING | | | C)2/14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | 5 | STREET ADDRESS, CITY, STATE, ZIP COD | ЭЕ | |
| | RELS OF CHATHAM | | 7 | 2 CHATHAM BUSINESS PARK | | |
| | | | 1 | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 689 | Continued From page the unsecured unit. | 966 | F 689 | | | |
| | worked on the secure familiar with Resident Resident #270 had im eyeglasses but alway and staff were suppos her but she revealed this task. NA #7 expla when the eyeglasses she just took them rig explained she though helping Resident #270 were so old, and she needed an eye exami prescription for new e acknowledged her aw intervention of making eyeglasses were on w was listed on her NA incident report for Res reviewed with NA #7. #8 were assigned on 2nd shift (3:00 PM to that they shared respor residents on the unit. also a nurse who wor nurse split their time to and one of the other of stated this 1/31/19 fall when it was almost di #8 were trying to get a dining room. She staf ambulatory, and she windependently. She re- | She stated that she regularly d unit and that she was #270. NA #7 indicated that ipaired vision and she had s took her eyeglasses off sed to put the eyeglasses on they didn ' t always perform ined that most of the time were put on Resident #270 ht back off. She further t the eyeglasses weren ' t 0' vision because they thought Resident #270 nation to get an updated yeglasses. NA #7 vareness that this g sure Resident #270 ' s when she was out of bed care guide. The 1/31/19 sident #270 ' s fall was She indicated she and NA the secured unit during the 11:00 PM) on 1/31/19 and | | | | |

Facility ID: 923099

If continuation sheet Page 67 of 132

| | | D HUMAN SERVICES //EDICAID SERVICES | | | | FORM |): 04/10/2019 APPROVED 0. 0938-0391 |
|--|---|---|---------------------|--|--|-----------------------|---|
| STATEMENT OF DE AND PLAN OF COR | EFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | _ | (02/ ⁻ |) 14/2019 |
| NAME OF PROVID | DER OR SUPPLIER | | • | STREET ADDRESS, CITY, ST | TATE, ZIP CODE | - | |
| THE LAURELS | S OF CHATHAM | | | 72 CHATHAM BUSINESS F PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| fell. are are the was Sha imp bel the and tim Res sit tha pre sha 1/3 dov An 2/1 woo 1/3 was fall alm tryi roo the sha sit fall alm tryi fall alm tha sha tha pre sha 1/3 dov | a assisting other re- ea at the time of the e fall happen. She w is with Resident #27 e revealed she thou paired vision was the lieved the resident we chair was located d she did not have b e of the fall. The N esident #270 was to down was reviewed at she was aware R evious fall when tryi e had not been obs 1/19 at the time of wn safely. interview was cond 4/19 at 9:00 AM. S rked regularly on the 1/19 incident report is reviewed with NA for Resident #270 nost dinner time and ing to get all of the form. She reported R e tables in the dining down but missed the e was in the living re at trying to get other e dining room area a Resident #270. Sh 70 was ambulatory, ing room independ d not observed the | 67 d she was in the living room actual fall, but she heard vas unable to recall if NA #8 70 at the time of the fall. ught Resident #270 ' s he cause of this fall as she was unable to see where when she tried to sit down her eyeglasses on at the IA care guide that indicated be observed when trying to d with NA #7. She indicated esident #270 had a ing to sit down but revealed erving the resident on this fall to ensure she sat ducted with NA #8 on he stated she had not he secured unit. The t for Resident #270 ' s fall . #8. She stated the 1/31/19 occurred when it was d she and NA #7 were residents into the dining Resident #270 was at one of g room area and she tried to he chair and fell. She stated bom area of the secured residents from that area to at the time of the 1/31/19 fall he indicated that Resident and she walked to the ently. She stated that she fall, but she heard the fall d that she was not aware | F 68 | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 04/10/2019 // APPROVED). 0938-0391 |
|--------------------------|---|---|-------------------|-----|--|---|-------------------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | 5 | STREET ADDRESS, CITY, STATI | E, ZIP CODE | - | |
| THE LAU | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PAR PITTSBORO, NC 27312 | RΚ | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORRECTI CROSS-REFERENCI | AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY) | | (X5) COMPLETION DATE |
| F 689 | sit down but she was needed help to sit down vision. She verified the Resident #270 at the ensure she sat down Resident #270 had ey the fall and stated that Resident #270 had ey fall. She explained the removed her eyeglass random spots on the Review of the NA card most recently dated 2 Resident #270 was a observed when trying to ensure her eyeglass out of bed. This care Resident #270 's right elevated as tolerated dressing to be left on. A nursing note dated Resident #270 continued discomfort to the right needed (PRN) pain mas well as muscle rub noted. The NP saw F (2/1/19). A nursing note dated Resident #270 was in pain as needed indication pain when moved. Resident pain when moved. Resident | previous falls when trying to aware that the resident wn because she had bad hat she was not observing time of 1/31/19 fall to safely. NA #8 was asked if yeglasses on at the time of at Resident #270 frequently ses and placed them in secured unit. e guide for Resident #270, /1/19, indicated that fall risk, she was to be to sit down, and NAs were ses were on when she was guide also indicated that it lower extremity was to be and for her right hip 2/1/19 indicated that ued to have pain and thip and leg. Routine and as hedication was administered oream with some relief Resident #270 this morning 2/2/19 indicated that bed and was medicated for ated the NP on-call was #270 screamed and cried in esident #270 had no bruising on-call indicated to continue | F | 689 | | | | |

Facility ID: 923099

If continuation sheet Page 69 of 132

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | 2: 04/10/2019 1 APPROVED 2: 0938-0391 |
|--------------------------|---|---|---------------------|-------------------------------|---|-----------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | _ | (02/ ⁻ | ; 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, STA | ATE, ZIP CODE | | |
| | | | 7 | 2 CHATHAM BUSINESS P | ARK | | |
| THE LAU | RELS OF CHATHAM | | P | ITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA REFICIENCY) | | (X5) COMPLETION DATE |
| F 689 | needed pain medicati with effective results. Nursing notes dated 2 Resident #270 contin- pain during patient ca examined by nurse. another x-ray was orce right hip. The x-ray re- indicated a right hip fr displacement. The pho order was received to the Emergency Room treatment. Hospital records indice admitted on 2/4/19 for femur fracture (a fract thigh bone). This fem through open treatme hip fracture was repain back to the facility on An observation was co on 2/13/19 at 4:45 PM wheelchair at a table the secured unit. Her on the table in front or An interview was com 2/13/19 at 4:46 PM. S #270 had any vision p Resident #270 had im eyeglasses. She stat kept her eyeglasses of encourage Resident # eyeglasses, but she a | 2/4/19 indicated that ued to complain of right hip re and when she was The NP was contacted and lered for Resident #270 's esults were obtained and facture with mild ysician was notified and an transfer Resident #270 to a for evaluation and transfer Resident #270 was r an intertrochanteric right ture of the upper part of the fur fracture was repaired ant of right intertrochanteric red and she was discharged 2/7/19. onducted of Resident #270 M. She was seated in a in the dining room area of eyeglasses were observed f her. ducted with NA #6 on She was asked if Resident oroblems. She indicated that opaired vision and she had ed that Resident #270 rarely on. She stated staff tried to #270 to wear the always took them off. NA #6 are the eyeglasses were not | F 689 | | | | |

If continuation sheet Page 70 of 132

| | MENT OF HEALTH AN S FOR MEDICARE & I | D HUMAN SERVICES | | | | | FORM |): 04/10/2019 1 APPROVED 0. 0938-0391 |
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| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | | 02/ | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP | CODE | | |
| | | | | 72 | 2 CHATHAM BUSINESS PARK | | | |
| | RELS OF CHATHAM | | | Р | ITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIA | | (X5) COMPLETION DATE |
| F 689 | Continued From page | 270 | F | 689 | | | | |
| | on 2/14/19 at 10:08 A care guide was review She stated that the 2/ care guide was relate elevating Resident #2 leaving her right hip d that this was added at from the hospital on 2 2/1/19 even though th when she returned fro surgery. MDS Nurse NA care guide interve Resident #270 when a and ensuring her eye was out of bed were i guide after the 12/15/ root cause analysis of fall was impaired visio perception. She furth 10/5/18 fall, 12/15/18 occurred when Reside sit in a chair. Resider to falls was reviewed confirmed the interver #270 when she was th added to her care pla should have revised F interventions related to the NA care guide after An interview was com Nursing (DON) on 2/1 stated she expected i through root cause ar to prevent recurrence included the intervent | she was trying to sit down glasses were on when she in place on the NA care 18 fall. She reported that the f Resident #270 ' s 12/15/18 on and impaired depth er explained that that the fall, and 1/31/19 fall all ent #270 was attempting to int #270 ' s care plan related with MDS Nurse #1. She intion of observing Resident rying to sit down was not in. She revealed that she Resident #270 ' s o falls when she added it to | | | | | | |

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If continuation sheet Page 71 of 132

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 |
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| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | i í | | CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
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| F 689 F 700 SS=D | guide intervention) an were on when she wa (NA care guide and ca reported that the facili Resident #270 in for a December 2018, but they were able to obta stated that it was diffine provider to complete a residents in a timely fa their eye care provide every 6 months. The why no other interven they were unable to g scheduled until March Bedrails CFR(s): 483.25(n)(1)- §483.25(n) Bed Rails. The facility must atter alternatives prior to in a bed or side rail is us correct installation, us rails, including but not elements. §483.25(n)(2) Review bed rails with the reside representative and ob to installation. §483.25(n)(3) Ensure | ad ensuring her eyeglasses as out of bed were in place are plan intervention). She ity had been trying to get an eye exam since that the earliest appointment ain was in March 2019. She cult to find an eye care eye examinations for their ashion. She reported that er came to the facility once DON was unable to explain tions were attempted when et an eye examination of 2019. | | 700 | | | 3/29/19 |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | FORM | D: 04/10/2019 MAPPROVED D. 0938-0391 |
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| | ELS OF CHATHAM | | | 2 CHATHAM BUSINESS PARK | | |
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| F 700 | Continued From page | 72 | F 700 | | | |
| | recommendations and and maintaining bed in This REQUIREMENT by: Based on record revir resident and staff inte assess the resident for before use and failed benefits of using side 2 residents reviewed f Findings included: Resident #88 was adr 11/17/17 with diagnos insomnia, seizure, and A review of the Deterr form dated 12/6/17 re improved or maintaine status and the device question whether the restraint or not" was in A review of the Pre-re Evaluation form (to evi interventions to side in the form had no signal believed this form was time as the Determina "Number 8 for other in results of the interven Number 10 have all in | d specifications for installing ails. is not met as evidenced ew, observation, and rview, the facility failed to or alternative to side rails to assess the risk and rail (Resident #88) for 1 of for side rails. mitted to the facility on ues of anxiety, paraplegia, d injury of the spinal cord. mination of Device Usage vealed the side rails ed the resident ' s functional was an enabler. The device (side rails) was "a not completed. estraint Intervention valuate alternative ails before use) revealed ture and no date (it was s completed at the same ation of Device Usage form). neterventions, Number 9 tions attempted, and terventions been attempted | F 700 | F700 Bedrails Corrective Action: We are unable to correct this alleged deficient practice for Resident #88, a is not in the facility. We will reassess when he returns. Identification of others potentially at r Residents that have side rails on thei bed, have had their medical record reviewed by the DON and/or unit managers, to determine if the Determ of Device Usage has been utilized ar completed. The form was reviewed for completeness and accuracy by the n managers. The audit was completed week of 3-11-19. No other side rail w found to be in use without proper, completed documentation. Systemic Changes: The nurse managers have been re-educated by the Director of Nursin March 11th, regarding the use of sid rails, and the proper filling out of the Device Usage form. Side rails will no used as an intervention unless decide | sk: ine d urse the as g, on e be | |
| | benefit analysis for the not identified as being A review of Resident a | #88 ' s quarterly Minimum 1 12/2/18 revealed the | | upon in the clinical operational meeti and then only after the appropriate for are filled out in their entirety. The clin team will review new admissions for device audit form to ensure it is filled completely as well. | rms cal he | |

Facility ID: 923099

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| CENTER STATEMENT (AND PLAN OF NAME OF P | - | D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345421 | . , | NG | CONSTRUCTION | | FORM OMB NO (X3) DATE COMPI | LETED |
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| F 700 | A review of the resider 1/16/19 revealed goal self-care deficit for ac secondary to spinal c goal resident will not t period and intervention bilateral side rails. A review of Resident t 1/18/19 revealed the hearing, clear speech understands. The con assessed (the resident The resident required staff for all transfers a staff for all other (ADL On 02/11/19 at 9:15 a conducted with Resid stated he wanted and hold of. On 2/13/19 at 2:00 pr conducted with Nursin stated the resident wa rails during care. On 2/13/19 at 3:00 pr conducted with NA #2 regularly assigned to liked to hold on to the rails) during care and The resident was not own. On 2/13/19 at 3:20 pr conducted with Nurse | ent 's care plan updated ls and interventions for tivities of daily living (ADLs) ord injury and at risk for fall, fall through the next review on for fall prevention 1/2 #88 's quarterly MDS dated resident had adequate and was understood and gnition was unable to be nt refused to answer staff). extensive assistance of 2 and bed mobility and of 1 .s). m an interview was ent #88. The resident used the side rails to grab n an interview was ng Assistant (NA) #3 who as able to hold on to the side n an interview was Resident #88. The resident side rail (has bilateral side preferred to have them. able to get out of bed on his | F7 | 700 | Monitoring The Director of Nurses, using a auditing tool, has reviewed all re that use side rails, to ensure that residents that are using side rails had the Determine of Device Usa Pre-Restraint Intervention Form completed. We will review new admissions side rails weekly for and then monthly for two months same documentation. The result reported by the DON, to the mor (Quality Assurance and Perform. Improvement) meeting for any fu recommendations. The DON will responsible to follow-up on any recommendation from the QA co with additional training to be prov the Clinical Resource Specialist, indicated. | esidents t all s have age and 4 week s, for the ts will be nthly QA ance urther I be ommittee vided by | d a s e API | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
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| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| NAME OF P | ROVIDER OR SUPPLIER | | 1 | s | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAU | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 700 F 732 SS=C | had observed the resi during care and cann- with or without the sid On 2/13/19 at 4:10 pr conducted with the Di who stated she was m s side rail assessment would expect the enti- accurate. Posted Nurse Staffing CFR(s): 483.35(g)(1)- §483.35(g) Nurse Sta §483.35(g)(1) Data re- must post the followin- basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categ- unlicensed nursing st resident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must po- specified in paragraph daily basis at the beg- (ii) Data must be post (A) Clear and readable | ident hold the side rail of exit the bed on his own le rails. In an interview was rector of Nursing (DON) not aware that Resident #88 ' t had incomplete areas and re form to be completed and a Information (4) ffing Information. equirements. The facility information on a daily and the actual hours worked pories of licensed and aff directly responsible for t: | | 700 | | | 3/29/19 |

Event ID: PVRD11

Facility ID: 923099

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| | MENT OF HEALTH AN S FOR MEDICARE & I | | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 |
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| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| NAME OF P | ROVIDER OR SUPPLIER | | - | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
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| THE LAU | RELS OF CHATHAM | | | | ITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 732 | staffing data. The fac written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fa posted daily nurse sta 18 months, or as requis greater. This REQUIREMENT by: Based on record revi interview, the facility f staffing information ac inaccurate actual hou unlicensed nursing sta facility's name on the staffing information re Findings included: On 2/13/19 at 4:05 PM information forms for 2/10/19, 2/11/19, 2/12 observed. The forms the facility and the act Registered Nurse (RM | access to posted nurse cility must, upon oral or enurse staffing data for review at a cost not to y standard. data retention cility must maintain the affing data for a minimum of ured by State law, whichever is not met as evidenced ew, observation and staff ailed to post the daily nurse courately as evidenced by rs worked for licensed and aff and by not entering the form for 2 of 2 weeks eviewed. M, the daily nurse staffing the last 2 weeks including 2/19 and 2/13/19 were did not include the name of tual hours worked for N, Licensed Practical Nurse s (NAs) were not accurate. read: 8 actual hours worked 36 actual hours worked 16 actual hours worked 72 actual hours | F | 732 | F732 Posted Nurse Staffing Corrective Action: The posted staffing form has been updated to include the pre-printed nam of the facility and is hand calculated, no an excel sheet. Identification of others potentially at rist The staffing sheet is a single sheet of paper and does not put others at risk. Systemic Changes: The staffing clerk and the night shift nurses have been educated on the updated form, by the Assistant Director Nurses the week of 3-11-19. The poste staffing form has been updated to inclu the pre-printed name of the facility and hand calculated, not an excel sheet nor where the formulas can become unintentionally broken. The night shift nurse on station is now putting out the nursing staff information sheet after determining the staffing for each shift. staffing sheet is updated each shift by | ot k: of de is w, The | |

Event ID: PVRD11

Facility ID: 923099

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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 、 <i>'</i> | | | E SURVEY IPLETED |
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| | | 345421 | B. WING | VING | | 2/14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z | IP CODE | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
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| F 732 | Continued From page | 976 | F 7 | 32 | | |
| | 7-3 shift - 0 RN 12 NAs worked | 8-actual hours worked 104 actual hours | | staffing clerk, or the cha station one. | rge nurse on | |
| | 3-11 shift - 2 RN 11-7 shift - 1 LPN 7 NAs worked On 2/12/19, the form 7-3 shift - 0-RN 12 NAs 3-11 shift - 1 RN 10 NAs 11-7 shift - 1 LPN 5 NAs On 2/13/19, the form 7-3 shift - 0 -RN - 11 - NAs 3-11 shift- 2 -RN 11-7 shift - 1 - RN 7 NAs | 8 - actual hours worked 104 actual hours worked 36 actual hours worked 96 actual hours worked 16 actual hours worked 72 actual hours worked | | Monitoring The Director of Nurses, auditing tool, will review staffing sheet, weekly for months, and then will re- monthly for the next two ensure that the staffing s posted. The results will H DON, to the monthly QA Assurance and Performa Improvement) meeting for recommendations. The H responsible to follow-up recommendation from the with additional training to the Clinical Resource Sp indicated. | the daily posted in the next 2 view randomly months, to sheet is accurately be reported by the vPI (Quality ance or any further DON will be on any ne QA committee o be provided by | |
| | for completing and point information form. She trained by the Staff D (SDC) to complete the entering the number of per shift. She was too the actual hours work the hours were not ac | ted that she was responsible osting the daily nurse staffing e stated that she was evelopment Coordinator e form electronically by of RN, LPN and NAs worked d that the computer filled in ed and she didn't know that ccurate. The Scheduler also t know that the form needed | | | | |

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| | - | D HUMAN SERVICES | | | | | FORM | D: 04/10/2019 |
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| STATEMENT (| S FOR MEDICARE & I | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | CONSTRUCTION | | (X3) DATE | 0. 0938-0391 SURVEY PLETED |
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| THE LAUP | RELS OF CHATHAM | | | Р | ITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | | (X5) COMPLETION DATE |
| | completing and postir information. The SDC was supposed to calc worked after the Sche of RN, LPN and NAs. had not been monitor information and she w hours worked were not not include the facility On 2/14/19 at 10:40 <i>A</i> interviewed. He state administrator had cha staffing information fo the staff entered the r NAS, the computer w the actual hours work stated that he was no include the facility's new worked were not accu Drug Regimen Review CFR(s): 483.45(c)(1)(1) §483.45(c) Drug Regi §483.45(c)(2) This rev of the resident's medi irregularities to the att facility's medical direc and these reports mut- (i) Irregularities include | ng the daily nurse staffing indicated that the computer ulate the actual hours eduler entered the number The SDC stated that she ing the nurse staffing vas not aware that the actual of accurate and the form did of accurate and the form did of the daily nurse rm. He indicated that after number of RN, LPN and as supposed to calculate ed. The Administrator t aware that the form did not ame and the actual hours irrate. w, Report Irregular, Act On 2)(4)(5) men Review. Ig regimen of each resident east once a month by a view must include a review cal chart. armacist must report any rending physician and the stor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph | | 732 | | | | 3/29/19 |

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| | | | | | | MB NO. 0 | | |
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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | | (X3) DATE SUF COMPLET | | |
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| | | 345421 | B. WING | | | С | 0040 | |
| | ROVIDER OR SUPPLIER | 070721 | | | | 02/14/ | 2019 | |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK | | | | | |
| THE LAUF | RELS OF CHATHAM | | PITTSBORO, NC 27312 | | | | | |
| | | | | FILL | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | ĸ | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | (X5) OMPLETION DATE | |
| F 756 | Continued From pag | e 78 | F 7 | 756 | | | | |
| | | noted by the pharmacist | | | | | | |
| | | ust be documented on a | | | | | | |
| | separate, written rep | | | | | | | |
| | | and the facility's medical | | | | | | |
| | director and director | of nursing and lists, at a | | | | | | |
| | | nt's name, the relevant drug, | | | | | | |
| | | ne pharmacist identified. | | | | | | |
| | () UI | ysician must document in the | | | | | | |
| | | cord that the identified | | | | | | |
| | | reviewed and what, if any, | | | | | | |
| | | en to address it. If there is to | | | | | | |
| | - | medication, the attending cument his or her rationale in | | | | | | |
| | the resident's medica | | | | | | | |
| | §483.45(c)(5) The fa | cility must develop and | | | | | | |
| | maintain policies and | I procedures for the monthly | | | | | | |
| | | that include, but are not | | | | | | |
| | | es for the different steps in | | | | | | |
| | | os the pharmacist must take | | | | | | |
| | | tifies an irregularity that | | | | | | |
| | | n to protect the resident. | | | | | | |
| | | T is not met as evidenced | | | | | | |
| | by: Based on record rev | view, and Pharmacy | | | F756 Drug Regimen Review | | | |
| | | interview, the Pharmacy | | | | | | |
| | | eport drug irregularities to | | 6 | Corrective Action: | | | |
| | | ian and or Director of Nursing | | | The physician discontinued the antibiotic | c | | |
| | for 2 of 8 sampled re | | | | for resident #74 at the time of survey. He | | | |
| | | tions. The Pharmacy | | | has made recommendations regarding | | | |
| | Consultant failed to a | | | t | the PRN psychotropic medication for | | | |
| | | c without an active infection | | | Residents #74 and it was discontinued o | | | |
| | | ate (Residents #74), failed to | | | 3-5-19. The pharmacist recommendation | n | | |
| | address the use of a | | | | for PRN psychotropic for Resident #57 | | | |
| | | tion without a stop date | | | has been acted upon and discontinued. | . | | |
| | | #57), failed to address the | | | The Nurse Manager has also for resider | | | |
| | need for Abnormal In | voluntary Movement Scale | | # | #74 completed an Abnormal Involuntary | | | |
| | (AIMC) ++ (+ (| assess for extrapyramidal | | | Movement Scale (AIMS) test. | | | |

Facility ID: 923099

If continuation sheet Page 79 of 132

| | OF DEFICIENCIES | MEDICAID SERVICES | | LE CONSTRUCTION | | NO. 0938-03 ATE SURVEY |
|--------------------------|-----------------------|---|---------------------|--|--------------------------------|---------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | | | · · · · | MPLETED |
| | | | | | | С |
| | | 345421 | B. WING | | | 02/14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | · | | STREET ADDRESS, CITY, STATE, ZIP CO | DDE | |
| THE LAU | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK | | |
| | 1 | | | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETIC DATE |
| F 756 | Continued From page | 7 9 | F 75 | 6 | | |
| | 1.0 | t #74). The facility also | 175 | Identification of others poter | ntially at risk. | |
| | | armacy recommendations for | | All residents that have chror | | |
| | Resident #57. | | | and are prescribed antibiotic | | |
| | | | | that are prescribed PRN psy | /chotropic⊡s, | |
| | Findings included: | | | and those that are routinely | | |
| | | | | antipsychotics and require a | | |
| | | s admitted to the facility on | | are potentially at risk for this | - | |
| | 10/8/18 with multiple | erly Minimum Data Set | | deficient practice and are ide the monthly pharmacy revie | | |
| | | ated 1/14/19 indicated that | | | vv. | |
| | | vere cognitive impairment | | Systemic Changes: | | |
| | | an antibiotic for 7 days | | The pharmacist at the time of | of survey is no | |
| | during the assessme | nt period. | | longer servicing our facility. independent consultant pha | | |
| | - | hysician's order dated | | provide consulting services | | |
| | | toin (an antibiotic) 100 | | one quarter starting March 1 | | |
| | | capsule by mouth daily for | | consultant pharmacist will a | | |
| | | Infection (UTI) prevention. | | antibiotic use, PRN psychot if AIMS testing has been cor | • | |
| | Review of the laborat | ory reports revealed that | | timely, during the monthly d | • | |
| | | have a urinalysis nor urine | | review. The pharmacist will | | |
| | culture done since ad | - | | their executive summary and | | |
| | | | | response rate from the prev | | |
| | | acy Consultant's monthly | | reported. In order to preven | | |
| | | (DRR) was conducted. The | | omission of AIMS tests, all r | | |
| | | that Resident #74's drug | | receiving antipsychotics will information order added to t | | |
| | - | d on 10/27/18, 11/27/18, . The DRR notes did not | | Medication Administration R | | |
| | | n use of the antibiotic. The | | indicating that the resident is | | |
| | | the indefinite use of the | | antipsychotic and requires a | | |
| | - | active infection and without a | | minimally every 6 months. | | |
| | stop date. | | | be timed so it will alert staff | | |
| | | | | The Nurse Manager will be | | |
| | | Pharmacy Consultant was | | put this order in upon admis | | |
| | | at 2:52 PM. The Pharmacy | | a an antipsychotic is started | | |
| | | his notes and stated that ot enough information from | | pharmacy drug regimen will the Medical Director to be a | | |
| | | o support the use of the | | within the week received. If | | |
| | | c without a stop date, he | | Administrator will address w | | |

Facility ID: 923099

If continuation sheet Page 80 of 132

| CENTER | S FOR MEDICARE & I | | | | | D: 04/10/2019 APPROVED D: 0938-0391 |
|--------------------------|--|---|---------------------|---|---|---|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 · / | E CONSTRUCTION | | C |
| | | 345421 | B. WING | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 756 | Director of Nursing (D Pharmacy Consultant aware of the Antibiotic use antibiotic only wh infection, to prevent u antibiotic and to preve antibiotic. He did not not address or identify antibiotic for Resident An interview with the was conducted on 2/1 stated that she expec Consultant to address physician including th antibiotic without a sto 1b. Resident #74 was 10/8/18 with multiple | ed it with the Physician or ION) but he did not. The further stated that he was c stewardship program, to en there was an active nnecessary use of the ent resistance to an comment as to why he did y the indefinite use of #74. Director of Nursing (DON) 4/19 at 11:52 AM. The DON ted the Pharmacy a drug irregularities to the e use of prophylactic op date. | F 756 | Medical Director. Monitoring An independent consultant pharmac will provide the monthly drug regime review, for at least one quarter as al The results will be reported to the Di of Clinical Services of the provider pharmacy and to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. In addition, respontime will be reported to the committee well via the executive summary, pro by the consultant. The Administrato be responsible to follow-up on any recommendation from the QA comm with additional training to be provide the Clinical Resource Specialist, as indicated. | n pove. rector e r nse e as <i>r</i> ided r will ittee | |
| | Resident #74 had sev and she had not recei medication during the Resident #74 had a p 10/8/18 for lorazepam medication) 0.5 millig mouth every 6 hours a anxiety/agitation. | assessment period. hysician's order dated o or Ativan (anti-anxiety rams (mgs) 1 tablet by as needed (PRN) for | | | | |
| | (MARs) revealed that Ativan once in Novem AM), once in Decemb | tion Administration Records Resident #74 had received Iber 2018 (11/27/18 at 8:14 er 2018 (12/20/18 at 8:18 2019 (1/3/19 at 5:41 AM | | | | |

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If continuation sheet Page 81 of 132

| | | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 APPROVED 0. 0938-0391 |
|--------------------------|--|---|---------------------|--|--|-------------------|---|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | _ | | C 14/2019 |
| NAME OF PF | ROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | 2 CHATHAM BUSINESS P/ PITTSBORO, NC 27312 | ARK | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY) | | (X5) COMPLETION DATE |
| F 756 | 2019. Review of the Pharma drug regimen review (DRR notes revealed t regimen was reviewed 12/24/18 and 1/27/19 address the use of the date to the physician (DON). Interview with the Pha conducted on 2/13/19 Consultant reviewed the should have addre Ativan without a stop because Resident #74 once or twice a month why he did not address PRN Ativan without a An interview with the was conducted on 2/1 stated that she expect Consultant to address physician including the medication without a stop 1c. Resident #74 was 10/8/18 with multiple of dementia. The quarter | M) and none in February acy Consultant's monthly (DRR) was conducted. The hat Resident #74's drug d on 10/27/18, 11/27/18, . The DRR notes did not e PRN Ativan without a stop or the Director of Nursing armacy Consultant was at 2:52 PM. The Pharmacy his records and stated that essed the use of the PRN date to the physician 4 was not using it often only h. He did not comment as to as or identify the use of the stop date to the physician. Director of Nursing (DON) 14/19 at 11:52 AM. The DON ted the Pharmacy a drug irregularity to the e use of PRN psychotropic stop date. | F 756 | | EFICIENCY) | | |
| | and she had received | rere cognitive impairment an antipsychotic during the assessment | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 APPROVED 0. 0938-0391 |
|--------------------------|---|--|---------------------|---|--|-------------------|---|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | _ | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | S | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAU | RELS OF CHATHAM | | | 2 CHATHAM BUSINESS P PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 756 | Resident #74 had a p 10/8/18 for Seroquel 25 mgs., 1 tablet by n psychosis. Review of the Medica (MARs) revealed that Seroquel twice a day 2018 through Februar Review of the electron that there was no AIM Resident #74. An interview with the 2/12/19 at 3:20 PM w that she was respons test on admission and verified that Resident AIMS test should hav admission. She state completion of an AIM admission. Review of the Pharma drug regimen review 12/24/18 and 1/27/19 address the need for Interview with the Pha conducted on 2/13/19 Consultant reviewed Resident #74 was on should have been dor | hysician's order dated (antipsychotic medication) nouth twice a day for tion Administration Records Resident #74 had received as ordered from October 9, ry 13, 2019. nic medical records revealed IS test completed for Unit Manager (UM) on as conducted. She stated ible for completing the AIMs d every 6 months. The UM #74 was on Seroquel and e been completed on ed that she missed the S test for Resident #74 on acy Consultant's monthly (DRR) was conducted. The that Resident #74's drug d on 10/27/18, 11/27/18, . The DRR notes did not AIMS test to the DON. armacy Consultant was o at 2:52 PM. The Pharmacy his records and stated that Seroquel and AIMS test ne on admission and every 6 that he failed to address the | F 756 | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|--------------------------|--|---|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT O | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | E CONSTRUCTION | (X3) DATE COMI | E SURVEY PLETED |
| | | 345421 | B. WING | | | | U /14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | I | | ę | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 756 | Continued From page | 83 | F | 756 | 3 | | |
| | was conducted on 2/ stated that she expect Consultant to address physician and or DOM | Director of Nursing (DON) 14/19 at 11:52 AM. The DON ted the Pharmacy s drug irregularity to the N including the need for ts receiving antipsychotic | | | | | |
| | | admitted to the facility on that included psychosis. | | | | | |
| | last written on 3/6/18 medication) 75 milligr | #57's medical record on orders included an order for Seroquel (antipsychotic rams (mg) in the evening ten 3/7/18 for Seroquel 50 | | | | | |
| | 's cognition was seve behaviors, no rejectio | 4/19 indicated Resident #57 erely impaired. He had no in of care, and had received tion on 7 of 7 days during | | | | | |
| | drug regimen reviews from March 2018 thro conducted. A DRR d recommendation was Reduction (GDR) of S indication in the medi | been responded to and/or | | | | | |
| | | 57 ' s current physician d on 2/13/19 and revealed eroquel 75 mg in the | | | | | |

Facility ID: 923099

If continuation sheet Page 84 of 132

| | - | D HUMAN SERVICES | | | | FORM | 0: 04/10/2019 APPROVED |
|--------------------------|---|---|---------------------|-------------------------|---|-----------|---------------------------------|
| STATEMENT (| S FOR MEDICARE & I DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , <i>i</i> | PLE CONSTRUCTION | _ | (X3) DATE | 0. 0938-0391 SURVEY LETED |
| | | 345421 | B. WING | | | (02/- | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | T | STREET ADDRESS, CITY, S | STATE, ZIP CODE | 02/ | 14/2013 |
| | | | | 72 CHATHAM BUSINESS | PARK | | |
| THE LAUF | RELS OF CHATHAM | | | PITTSBORO, NC 2731 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE | 'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 756 | in the morning continu An interview was cond Consultant on 2/13/19 that he had been corr since July 2018. He s recommendations to H DRR the following mon noticed that his recorr always responded to that it was regularly ta response from the phy recommendations. The reported that he though recommendations ead cases he waited for tw repeat recommendation responded to. The PH revealed he had not me physician related to he for a GDR of Seroque An interview was cont Nursing (DON) on 2/11 DON stated that Physic pharmacy recommend Physician #2 was pre- not available for intervi- that her expectation we respond to pharmacy month. She revealed aware on 2/13/19 by that his recommendation had been unaware of 2/13/19. | 8 order for Seroquel 50 mg ued to be active orders. ducted with the Pharmacy at 2:49 PM. He indicated upleting DRRs at the facility stated that he expected his be responded to by his next onth. He revealed he had mendations were not timely. He further revealed uking 2 months to receive a ysician for his ne Pharmacy Consultant ght about making repeat ch month, but that in most wo months and then made a on if it still had not been narmacy Consultant eceived a response from the is 12/23/18 recommendation | F 7 | 56 | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ę | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 756 | 3/6/18 with diagnoses anxiety, and insomnia The quarterly Minimu assessment dated 9/7 #57 's cognition was received antidepressa medication on 7 of 7 of period. A review of Resident Medication Administra indicated he received medication) 0.5 millig bedtime for anxiety, F medication) 30 mg or anxiety, and Trazodo medication) mg once A pharmacy recomme indicated that Reside Klonopin, and Trazod Pharmacy Consultant discontinuation of Tra Klonopin provided an This recommendation Physician #2 on 12/20 Trazodone was to be A physician 's order of discontinuation of Re Trazodone. An interview was con (UM) #1 on 2/13/19 a the Pharmacy Consul were given to her by f | a that included depression, a. m Data Set (MDS) 12/18 indicated Resident severely impaired, and he ant and antianxiety days during the MDS review #57 ' s October 2018 ation Record (MAR) Klonopin (antianxiety rams (mg) once daily at Remeron (antidepressant nce daily at bedtime for ne 50 (antidepressant daily at bedtime for sleep. endation dated 10/24/18 nt #57 was taking Remeron, lone at bedtime. The t recommended a izodone as Remeron and tianxiety and sleep benefits. n was agreed upon by 6/18 and he indicated that discontinued. dated 12/27/18 indicated a sident #57 ' s scheduled ducted with Unit Manager t 9:05 AM. She stated that Itant ' s recommendations the Director of Nursing I that she separated the | F | 756 | | | |

Facility ID: 923099

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| CENTER STATEMENT (AND PLAN OF NAME OF PI | ROVIDER OR SUPPLIER | ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345421 | , <i>i</i> | S | E CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 PROVIDER'S PLAN OF CORRECTION | FOR OMB NC (X3) DATE COMP 02 | D: 04/10/2019 M APPROVED D. 0938-0391 E SURVEY PLETED C 1/14/2019 |
|--|---|---|------------|-----|---|--|---|
| PRÉFIX TAG | , | Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | PREF | | (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | | COMPLETION DATE |
| F 756 | the recommendations that was located in the UM #1 stated when the his responses on the back to the medical re- received the forms. Se form back she normal action within a busine 10/24/18 pharmacy re- signed by Physician # with UM #1. She stat that this recommendata Physician #2 to respo- form and discontinued Trazodone on 12/27/1 Resident #57 received 12/26/18. An interview was come Consultant on 2/13/19 that he had been come regimen reviews (DRI 2018. He stated that recommendations to B DRR the following me noticed that his recom- always responded to that it was regularly ta- response from the phy- recommendations. The reported that he thoug- recommendations ead cases he waited for tw- repeat recommendations ead cases he waited for tw- repeat recommendations. The reported that he thoug- | d physician related he indicated that she placed is in the physician 's folder e medical records office. he physician had completed forms they were brought ecords office and she She stated once she got the Ily completed the required tess day. Resident #57 's ecommendation that was #2 on 12/26/18 was reviewed ted that she had not noticed ation took over 2 months for ond when she reviewed the d Resident #57 's 18. She verified that d Trazodone daily through ducted with the Pharmacy 9 at 2:49 PM. He indicated hpleting monthly drug Rs) at the facility since July he expected his be responded to by his next onth. He revealed he had nmendations were not timely. He further revealed aking 2 months to receive a ysician for his he Pharmacy Consultant ght about making repeat ch month, but that in most wo months and then made a on if it still had not been | F | 756 | | | |

Facility ID: 923099

If continuation sheet Page 87 of 132

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED D. 0938-0391 |
|--------------------------|---|---|-------------------|-----|---|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED |
| | | 345421 | B. WING | | | | C / 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 756 | Pharmacy Consultant one of those instance to receive a response discontinuation of Tra An interview was com at 11:54 AM. The DC responded to all phan She stated that Physi unreachable and was The DON reported that the physician to respond recommendations wit that she had been ma Pharmacy Consultant were regularly taking to. She stated that she information prior to 2/ 2c. Resident #57 was 3/6/18 with diagnoses anxiety, and insomnia The quarterly Minimul assessment dated 9/ #57 's cognition was received antidepressa medication on 7 of 7 of period. A Nurse Practitioner (indicated the addition (antidepressant medic twice daily as needed 's request. | 6/18 was reviewed with the t. He revealed that this was in which it took two months which delayed the zodone for Resident #57. ducted with the on 2/14/19 N stated that Physician #2 macy recommendations. cian #2 was presently not available for interview. at her expectation was for ond to pharmacy hin a month. She revealed ade aware on 2/13/19 by the t that his recommendations 2 months to be responded e had been unaware of this 13/19. admitted to the facility on a that included depression, a. m Data Set (MDS) 12/18 indicated Resident severely impaired, and he ant and antianxiety days during the MDS review NP) note dated 9/13/18 | F | 756 | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|-----------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE | |
| | | 345421 | B. WING | | | | C 1 4/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAU | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 756 | Trazodone 25 mg eve anxiety. There was n PRN Trazodone orde A review of Resident Medication Administra indicated he was not Trazodone. A review of Resident indicated he was not Trazodone. A pharmacy recomme addressed Resident # Trazodone and recom This recommendation PRN Trazodone orde 9/14/18 with no stop of A review of Resident MAR indicated he wa Trazodone. The Pharmacy Consu regimen review (DRR 11/27/18 indicated no made related to PRN A review of Resident MAR indicated he wa Trazodone. The Pharmacy Consu Resident #57 dated 1 recommendations we Trazodone. The pharmacy consul recommendation to d scheduled Trazodone | ery 12 hours PRN for o stop date for this 9/14/18 r. #57 ' s September 2018 ation Record (MAR) administered PRN #57 ' s October 2018 MAR administered PRN #57 ' s October 2018 MAR administered PRN endation dated 10/24/18 #57 ' s scheduled order for mended its discontinuation. had not addressed the r that was in place since date. #57 ' s November 2018 s not administered PRN eltant ' s monthly drug t) for Resident #57 dated recommendations were Trazodone. #57 ' s December 2019 s not administered PRN eltant ' s monthly DRR for 2/23/18 indicated no re made related to PRN | F | 756 | 6 | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 04/10/2019 APPROVED D: 0938-0391 |
|--------------------------|--|---|---------------------|---|--|-------------------|---|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | _ | | C 14/2019 |
| NAME OF PF | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAUR | RELS OF CHATHAM | | | 2 CHATHAM BUSINESS P PITTSBORO, NC 27312 | ARK | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 756 F 758 SS=D | discontinuation of Res PRN Trazodone. An interview was cond Consultant on 2/13/19 was aware of the regu psychotropic medicatil limited in duration. Re PRN Trazodone that of through 12/26/18 was Pharmacy Consultant made any recommend #57 ' s PRN Trazodon was unaware the regu medications applied to medications. An interview was cond Nursing (DON) on 2/1 DON stated that she e Consultant to identify PRN psychotropic me greater than 14 days. Free from Unnec Psyc CFR(s): 483.45(c)(3)(§483.45(e) Psychotro §483.45(c)(3) A psych | ated 12/27/18 indicated a sident #57 's scheduled and ducted with the Pharmacy 9 at 2:49 PM. He stated he ulation related to PRN ions needing to be time esident #57 's order for was in place from 9/14/18 reviewed with the . He revealed he had not dations related to Resident he. He explained that he ulation related to PRN o antidepressant ducted with the Director of 4/19 at 11:54 AM. The expected the Pharmacy and address the use of edications prescribed for chotropic Meds/PRN Use e)(1)-(5) | F 756 | |)EFICIENCY) | | 3/29/19 |
| | processes and behav but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; | ior. These drugs include, drugs in the following | | | | | |

Event ID: PVRD11

Facility ID: 923099

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| | | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 APPROVED). 0938-0391 |
|--------------------------|--|---|---------------------|--|---|------|---|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · / | E CONSTRUCTION | | | SURVEY LETED |
| | | 345421 | B. WING | | _ | | _ 14/2019 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | | | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS F PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 758 | Continued From page | 90 | F 758 | | | | |
| | (iii) Anti-anxiety; and (iv) Hypnotic | | | | | | |
| | Based on a comprehe resident, the facility m | ensive assessment of a sust ensure that | | | | | |
| | psychotropic drugs ar unless the medication | nts who have not used e not given these drugs i is necessary to treat a diagnosed and documented | | | | | |
| | drugs receive gradual behavioral interventio | nts who use psychotropic dose reductions, and ns, unless clinically effort to discontinue these | | | | | |
| | unless that medication | rsuant to a PRN order n is necessary to treat a ndition that is documented | | | | | |
| | are limited to 14 days §483.45(e)(5), if the a prescribing practitione appropriate for the PF beyond 14 days, he o | er believes that it is RN order to be extended r she should document their nt's medical record and | | | | | |
| | drugs are limited to 14 renewed unless the a | ttending physician or er evaluates the resident for | | | | | |

Facility ID: 923099

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | FOF | ED: 04/10/20 RM APPROVE O. 0938-039 |
|--------------------------|--|---|---------------------|--|------------|---|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | PLE CONSTRUCTION | | E SURVEY |
| | | 345421 | B. WING | | 02 | C 2/14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | 72 CHATHAM BUSINESS PARK | | |
| THE LAUF | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETIO DATE |
| F 758 | Continued From page | e 91 | F 75 | 58 | | |
| | | Γ is not met as evidenced | | | | |
| | Physician, Nurse Pra | | | 758 Unnecessary Psychotrop | bics | |
| | | s, the facility failed to ensure | | Corrective Action: | | |
| | · | l) psychotropic medications | | Residents #81, #9, #74 and # | | |
| | | duration (Residents #81, #9, to address a Gradual Dose | | (as needed) psychotropic drug were reviewed by physician a | - | |
| | | /chotic medication as | | discontinued or rewritten to pr | | |
| | | 57), failed to complete an | | an appropriate rationale and o | | |
| | Abnormal Involuntary | / Movement Scale (AIMS) | | Resident #57's medical record | d was | |
| | | for extrapyramidal symptoms | | reviewed by pharmacy for any | | |
| | | g antipsychotic medication) | | recommended dose reduction | | |
| | | also failed to address | | identification of duplicative me therapy and an Abnormal Invo | | |
| | period (Resident #57 reviewed for medicat | | | Moment Scale has been com | - | |
| | | | | Identification of others potenti | • | |
| | The findings included | 1: | | Residents who have orders fo | | |
| | 1) Decident #91 wee | originally admitted to the | | psychotropic drugs are potent | | |
| | | originally admitted to the a readmission date of | | and residents who receive psy medications are potentially at | | |
| | | es included malignant | | having a gradual dose reducti | | |
| | | d cervix, Chronic Obstructive | | duplicate therapy. Our pharm | | |
| | Pulmonary Disease (| COPD), anxiety disorder and | | completed a monthly medicat | ion review | |
| | | een under Hospice care | | on 2-28-2019, to determine if | | |
| | since 6/27/17. | | | any other PRN psychotropic n | | |
| | A rouious of the start | aion ordere revealed a | | that are not time limited and to | | |
| | | cian orders revealed a d 9/27/17 for Trazodone 100 | | if there are any gradual dose that should be attempted or a | | |
| | | edtime PRN insomnia and an | | duplicative therapy (these are | | |
| | | for Xanax 0.5mg every eight | | through the monthly pharmac | | |
| | | The orders did not include | | Recommendations from these | | |
| | | ns for the PRN Trazodone or | | have been completed on Med | | |
| | Xanax. | | | Recommendations to Physicia | | |
| | 0 | | | forwarded to physician for res | | |
| | | rs for Resident #81 revealed | | Based on the physician respo | | |
| | | /18 for Remeron 15mg one | | recommendation, orders have | | |
| | tablet by mouth at be | | | carried out by the Unit Manag | CI 3. | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 1 APPROVED 0. 0938-0391 |
|--------------------------|--|--|---------------------|-----|---|--|---|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 · <i>i</i> | | | (X3) DATE COMP | LETED |
| | | 345421 | B. WING | | | | _ 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | RELS OF CHATHAM | | | 72 | CHATHAM BUSINESS PARK | | |
| THE LAUP | | | | Pl | TTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIZ TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE |
| F 758 | Continued From page stimulation. | 92 | F | 758 | Systemic Changes: | | |
| | reviews revealed then dated 10/24/18 that ne recently started and F longer be needed. Di 100mg PRN. The phy recommendation on 1 wrote, "Hospice patien appropriate". Resident #81's most n (MDS) coded as a mo assessment and date | sician signed and dated the 2/25/18, disagreed and nt. All comfort measures are recent Minimum Data Set | | | ADON/staff development coordinator h inserviced licensed staff during the wee of March 11th and March 18th, to inclu- full time, part time and PRN staff, regarding the requirement that PRN psychotropic medications are time limit in duration not to exceed 14 days unless the provider believes that it is appropria for the PRN order to be extended beyo 14 days, and he or she documents their rationale in the resident s medical rec- and indicates the duration for the PRN order. If staff are not inserviced by Mar 29th, they will not be able to work. The | ek de sed ss ate ind ir ord | |
| | the 7 days during the A review of the Janua Administration Record resident had received and PRN Xanax 25 tin January. During a review of the noted that Resident # | ry 2019 Medication d (MAR) revealed the PRN Trazodone 13 times mes in the month of February 2019 MAR it was | | | Unit Manager nurses will review all new admission PRN psychotropic orders to ensure they are time limited. The pharmacist has been re-educated the Director of Clinical Services of the provider pharmacy on March 6th An independent consultant pharmacist(s) of provide consulting services for at least one quarter starting in March 2019. The consultant pharmacist will address the above issues during the monthly drug regimen review. | by will | |
| | #3 on 2/13/19 at 11:33 aware of the PRN psy that a one to two-wee be acceptable and if r the PRN medication it On 2/13/19 at 2:15pm conducted with Pharm | s completed with Physician 5 AM. He stated that he was vchotropic regulations, felt k adjustment period would esident continued to need t should be reevaluated. an interview was nacy Consultant #1. He was ommendation for the Xanax | | | Monitoring: Medication reconciliation chart checks done on newly admitted residents chart and a check to ensure that any PRN psychotropic medication has an appropriate duration and rationale will h a part of this check for ongoing monitoring. Also, orders are reviewed daily at clinical operations meetings an any orders for PRN psychotropic | arts be | |

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| | OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIP | LE CONSTRUCTION | (X3) DA | NO. 0938-03 ATE SURVEY |
|--------------------------|-----------------------|---|---------------------|--|-----------------------------------|---------------------------|
| ND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 3 | cc | MPLETED |
| | | 345421 | B. WING | | | C |
| NAME OF P | ROVIDER OR SUPPLIER | 575721 | | STREET ADDRESS, CITY, STATE, ZIP C | | 02/14/2019 |
| 0.002 01 1 | | | | 72 CHATHAM BUSINESS PARK | | |
| THE LAU | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETIO DATE |
| F 758 | Continued From page | a 93 | F 75 | 8 | | |
| 1 700 | | duration in his records. The | F 73 | medication will be reviewed | d for duration | |
| | Pharmacy Consultan | | | time limit and rationale. Of | | |
| | | be time limited in duration | | corrected as identified for o | | |
| | | y a recommendation for the | | monitoring. | | |
| | PRN Xanax was not | addressed with the | | An independent consultant | | |
| | physician. | | | will provide the monthly dru | | |
| | | | | review, for at least one qua | | |
| | | npleted with the Director of | | The results will be reported | | |
| | - | t 11:50am. She stated that tant was a safety net to | | of Clinical Services of the p pharmacy and to the month | | |
| | | s and should be making | | (Quality Assurance and Pe | • | |
| | | ions every month if original | | Improvement) meeting for | | |
| | medication recomme | ndations had not been | | recommendations. The Ad | ministrator will | |
| | responded to. She fu | | | be responsible to follow-up | | |
| | | chotropics to be time limited | | recommendation from the | | |
| | in duration. | | | with additional training to b the Clinical Resource Spec indicated. | | |
| | | idmitted to the facility on | | | | |
| | - | es that included vascular ioral disturbance, psychosis | | | | |
| | and anxiety disorder. | | | | | |
| | | recent MDS coded as a | | | | |
| | • | Condition assessment | | | | |
| | | ssed the resident with severe and received antipsychotic | | | | |
| | | days and antidepressant | | | | |
| | | day look back period. | | | | |
| | | cian orders revealed the | | | | |
| | following orders: | | | | | |
| | | 1/16/19 for Risperdal 0.75mg | | | | |
| | psychosis. | a day for anxiety related to | | | | |
| | | /18/19 for Trazodone 0.5mg | | | | |
| | by mouth two times a | | | | | |
| | | 1/23/19 for Rozerem 8mg by | | | | |
| | mouth at bedtime for | | | | | 1 |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 |
|--------------------------|--|--|-------------------|-----|---|-------------------|----------------------------|
| STATEMENT O | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ЗE | (X5) COMPLETION DATE |
| F 758 | Continued From page | 94 | F | 758 | 3 | | |
| | Trazodone 50mg Give | der dated 1/24/19 read: e 0.5 tablet by mouth every or anxiety. The order did not ⁻ duration for the PRN | | | | | |
| | was no pharmacy rec | ted 1/28/19 revealed there ommendation regarding a t for time duration of the | | | | | |
| | noted that Resident # | e February 2019 MAR it was 9 had been given PRN from 2/1/19 to 2/12/19. | | | | | |
| | #3 on 2/13/19 at 11:3 aware of the PRN psy that a one to two-wee be acceptable and if r | s completed with Physician 5 AM. He stated that he was ychotropic regulations, felt k adjustment period would resident continued to need t should be reevaluated. | | | | | |
| | unable to locate a rec Trazodone needing a The Pharmacy Consu psychotropics should and couldn't state wh | nacy Consultant #1. He was commendation for the PRN time duration in his records. | | | | | |
| | the physician with Pro for the Elderly (PACE | m a phone call was made to ograms of All-Inclusive Care). A message was left with a No return call was received cian. | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|--------------------------|---|---|-------------------|-----|---|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | E CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED |
| | | 345421 | B. WING | | | | C / 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | 9 | STREET ADDRESS, CITY, STATE, ZIP CODE | _ . | |
| THE LAUF | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 758 | Continued From page | | F | 758 | 3 | | |
| | Nursing on 2/4/19 at expectation was for a medications to be tim 3a. Resident #74 was | e limited in duration. admitted to the facility on | | | | | |
| | (MDS) assessment d | erly Minimum Data Set ated 1/14/19 indicated that vere cognitive impairment ived an antianxiety | | | | | |
| | 10/8/18 for lorazepan medication) 0.5 millig mouth every 6 hours | hysician's order dated n or Ativan (anti-anxiety rams (mgs) 1 tablet by as needed (PRN) for e order did not have a stop | | | | | |
| | (MARs) revealed that Ativan once in Novem AM), once in Decemb AM), twice in January | tion Administration Records Resident #74 had received aber 2018 (11/27/18 at 8:14 per 2018 (12/20/18 at 8:18 2019 (1/3/19 at 5:41 AM M) and none in February | | | | | |
| | 2/12/19 at 3:20 PM re aware of the regulation PRN psychotropic me indicated that she did | Unit Manager (UM) on evealed that she was not on regarding the use of the edications. The UM n't know that orders for PRN ion should have a stop date. | | | | | |
| | was conducted on 2/2 stated that she expect | Director of Nursing (DON) 14/19 at 11:52 AM. The DON ted the regulation to be e use of PRN psychotropic | | | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|------------------|----------------------------|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 345421 | B. WING | | | | C / 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | L | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 758 | medications by ensur | | F | 758 | | | |
| | 10/8/18 with multiple dementia. The quart (MDS) assessment d Resident #74 had sev and she had received | erly Minimum Data Set ated 1/14/19 indicated that /ere cognitive impairment | | | | | |
| | | hysician's order dated (antipsychotic medication) outh twice a day for | | | | | |
| | (MARs) revealed that | tion Administration Records Resident #74 had received as ordered from October 9, ry 13, 2019. | | | | | |
| | that there was no AIM | nic medical records revealed IS (Abnormal Involuntary t completed for Resident | | | | | |
| | 2/12/19 at 3:20 PM w that she was respons test on admission and verified that Resident AIMS test should hav admission. She state complete an AIMS test admission. | ed that she missed to st for Resident #74 on | | | | | |
| | An interview with the | Director of Nursing (DON) | | | | | |

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | : 04/10/2019 APPROVED . 0938-0391 |
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| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | (02/ [,] | C 14/2019 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA | TE, ZIP CODE | - | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PA PITTSBORO, NC 27312 | ARK | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFERENC | PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY) | | (X5) COMPLETION DATE |
| F 758 | stated that she expect residents receiving an admission. 4a. Resident #57 was 3/6/18 with diagnoses A review of Resident a revealed his medication last written on 3/6/18 medication) 75 million and an order last writting in the morning. The admission Minim assessment dated 3/1 #57 's cognition was no behaviors, and had medication on 7 of 7 of period. A review of Psychiatrin notes dated 5/15/18, 0 10/15/18, 11/28/18, an Resident #57 was stat behavioral problems, Resident #57 's currer reviewed on 2/13/19 a order for Seroquel 75 3/7/18 order for Seroo continued to be active Reduction (GDR) had Resident #57 's Sero An observation was c | (4/19 at 11:52 AM. The DON ted AIMS test completed for atipsychotic medication on admitted to the facility on a that included psychosis. #57's medical record on orders included an order for Seroquel (antipsychotic ams (mg) in the evening ten 3/7/18 for Seroquel 50 um Data Set (MDS) I3/18 indicated Resident severely impaired, he had d received antipsychotic days during the MDS review c Nurse Practitioner (PNP) 6/26/18, 7/31/18, 9/10/18, and 1/28/19 indicated ble with no acute issues, or aggression. ent physician orders were and revealed the 3/6/18 mg in the evening and the quel 50 mg in the morning to been attempted for quel. onducted of Resident #57 | F 75 | | | | |
| | An observation was c | onducted of Resident #57 1. He was ambulating on | | | | | |

| CENTER | S FOR MEDICARE & I | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM OMB NC |): 04/10/2019 1 APPROVED 0. 0938-0391 |
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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | | SURVEY LETED |
| | | 345421 | B. WING | | _ | | _ 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | | | |
| THE LAUF | RELS OF CHATHAM | | | 2 CHATHAM BUSINESS F PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE) CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 758 | Continued From page symptoms of behavio An interview was cond | ral issues. | F 758 | | | | |
| | | n 2/13/19. She stated that Resident #57 and reported m and rarely had any | | | | | |
| | phone on 2/14/19 at 9 she reviewed her note revealed that she sho Gradual Dose Reduct Resident #57. She st | tion (GDR) of Seroquel for ated that she planned to roquel with Resident #57 on | | | | | |
| | | - | | | | | |
| | | admitted to the facility on that included depression, a. | | | | | |
| | #57 's cognition was received antidepressa | 12/18 indicated Resident severely impaired, and he | | | | | |
| | Trazodone (antidepre milligrams (mg) every | 12 hours as needed (PRN) as no stop date for this | | | | | |

Facility ID: 923099

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | I | NTED: 04/10/2019 FORM APPROVED |
|--------------------------|--|--|---------------------|--------------------------------------|--|---|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | B NO. 0938-0391 DATE SURVEY COMPLETED |
| | | 345421 | B. WING | | | C 02/14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | ST | REET ADDRESS, CITY, STATE, | ZIP CODE | 02/14/2010 |
| | | | 72 | CHATHAM BUSINESS PARK | | |
| THE LAU | RELS OF CHATHAM | | PI | TTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY) | (X5) COMPLETION DATE |
| F 758 | Continued From page | 99 | F 758 | | | |
| | physician 's order ind Klonopin (antiany milligrams (mg) once Remeron (antide once daily at bedtime Trazodone (antide mg once daily at bedtime Trazodone (antide mg once daily at bedtime A pharmacy recomme indicated that Resider Klonopin, and Trazod Pharmacy Consultant discontinuation of Tra Klonopin provided an This recommendation Physician #2 on 12/20 Trazodone was to be A review of Resident October 2018, Noven 2018 Medication Adm indicated he was not Trazodone A physician 's order of discontinuation of Res Trazodone. An interview was con (UM) #1 on 2/13/19 at the Pharmacy Consul were given to her by to (DON). She indicated recommendations in the was located in the me | kiety medication) 0.5 daily at bedtime for anxiety pressant medication) 30 mg for anxiety epressant medication) 50 ime for sleep endation dated 10/24/18 nt #57 was taking Remeron, one at bedtime. The recommended a zodone as Remeron and tianxiety and sleep benefits. was agreed upon by 5/18 and he indicated that discontinued. #57 ' s September 2018, nber 2018, and December inistration Records (MARs) administered PRN dated 12/27/18 indicated a sident #57 ' s scheduled ducted with Unit Manager t 9:05 AM. She stated that tant ' s recommendations the Director of Nursing | | | | |

Facility ID: 923099

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| | MENT OF HEALTH AN S FOR MEDICARE & I | | | | | | FORM |): 04/10/2019 // APPROVED). 0938-0391 |
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| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , <i>'</i> | | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | - | |
| THE LAU | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAC | | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BI | | (X5) COMPLETION DATE |
| F 758 | to the medical records the forms. She stated back she normally con- within a business day pharmacy recommend Physician #2 on 12/26 #1. She stated that s recommendation took Physician #2 to respo- the form and discontin Trazodone on 12/27/7 Resident #57 received 12/26/18. She reveals regulation regarding t medications and had orders required a stop the PRN Trazodone of in place from 9/14/18 An interview was come Consultant on 2/13/19 s 10/24/18 pharmacy signed by Physician # with the Pharmacy Co this 10/24/18 pharmacy two months to receive physician which delay Trazodone for Reside receiving Klonopin an the same effects. An interview was come 2/14/19 at 11:54 AM. Physician #2 respond recommendations. S | hs they were brought back office and she received donce she got the form mpleted the required action . Resident #57 ' s 10/24/18 dation that was signed by 6/18 was reviewed with UM he had not noticed that this over 2 months for nd to when she reviewed hued Resident #57 ' s 18. She verified that d Trazodone daily through ed she was not aware of the he use of PRN psychotropic not known that these PRN o date. UM #1 confirmed rder for Resident #57 was through 12/27/18. ducted with the Pharmacy 0 at 2:49 PM. Resident #57 ' recommendation that was t2 on 12/26/18 was reviewed onsultant. He revealed that cy recommendation took e a response from the red the discontinuation of nt #57. He indicated that in e was an unnecessary of the the the DON on The DON stated that | F | 758 | | | | |

Facility ID: 923099

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| DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I | | | | | | FORM | D: 04/10/2019 MAPPROVED D. 0938-0391 |
|---|--|--------------------|-----|--|--|-------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , <i>i</i> | | E CONSTRUCTION | | (X3) DATE COMF | SURVEY PLETED |
| | 345421 | B. WING | | | _ | | C 14/2019 |
| NAME OF PROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAURELS OF CHATHAM | | | | 72 CHATHAM BUSINESS P PITTSBORO, NC 27312 | | | |
| PREFIX (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| pharmacy recommendacknowledged that a pharmacy recommendication. The DON the regulations to be a of PRN psychotropic orders for all PRN psy a stop date. F 761 Label/Store Drugs an SS=E CFR(s): 483.45(g)(h)() §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the eapplicable. §483.45(h) Storage of \$483.45(h)(1) In according federal laws, the facibiologicals in locked of temperature controls, personnel to have according of controlled of the Comprehensive D Control Act of 1976 an abuse, except when t package drug distributes appropriate accession of the comprehensive D Control Act of 1976 an abuse, except when t package drug distributes appropriate accession of the comprehensive D Control Act of 1976 an abuse, except when t package drug distributes appropriate accession of the comprehensive D Control Act of 1976 an abuse, except when t package drug distributes appropriate accession of the comprehensive D Control Act of 1976 an abuse, except when t package drug distributes appropriate accession of the comprehensive D Control Act of 1976 an abuse, except when t package drug distributes appropriate accession of the comprehensive D Control Act of 1976 an abuse, except when t package drug distributes appropriates accession of the comprehensive D Control Act of 1976 and abuse, except when t package drug distributes appropriates accession of the comprehensive D Control Act of 1976 and abuse, except when t package drug distributes appropriates accession of the comprehensive D Control Act of 1976 and abuse, except when t package drug distributes appropriates accession of the comprehensive D Control Act of 1976 and abuse, except when t package drug distributes appropriates accession of the comprehensive D Control Act of 1976 and abuse, except when t package drug distributes appropriates accession of the comprehensive D Control Act of 1976 and abuse, except when t package drug distributes approp | ON reported that her he physician to respond to dations within a month. She delayed response to dations had the potential to on of an unnecessary I stated that she expected followed regarding the use medications by ensuring ychotropic medications had d Biologicals (1)(2) of Drugs and Biologicals a used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized | | 758 | | | | 3/29/19 |

Facility ID: 923099

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DAT | NO. 0938-0391 TE SURVEY |
|--|----------------------------|
| | |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COL | MPLETED |
| | С |
| | 2/14/2019 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK | |
| THE LAURELS OF CHATHAM PITTSBORO, NC 27312 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE | COMPLETION DATE |
| DEFICIENCY) | |
| | |
| F 761 Continued From page 102 F 761 | |
| be readily detected. This REQUIREMENT is not met as evidenced | |
| by: | |
| Based on observation and staff interview, the F761 Label/Store Drugs and Biologicals | |
| facility failed to discard expired stock nutritional | |
| supplements in 1 of 2 medication storage rooms Corrective Action: reviewed. The 7 bottles of Cholecalciferol D-3-5 | |
| 5000 were discarded during the survey | |
| Findings included: when discovered. | |
| On 02/14/19 at 9:00 am an observation and Identification of others potentially at risk: | |
| interview were conducted with Nurse #4 of At the time of survey when notified of the | |
| Station #2's medication storage room and 7 expired supplements, the DON and nurse | |
| unopened bottles of Cholecalciferol D3-5 5000 managers checked each area of | |
| units dietary supplement had a manufacturer'smedication storage and did not find anyexpiration date of 11/2018 for all bottles. Nurseother expired items. | |
| #4 stated that the Supply Clerk and Unit Manager | |
| were responsible to check the stock medication Systematic Changes: | |
| for expiration date each week and discard as As the nurse managers, the DON, central | |
| appropriate. Nurse #4 also stated that nursingsupply clerk, and Administrator routinelystaff would also discard if identified at the time ofcheck daily for expired supplements in 6 | |
| retrieval from storage. | |
| two medication rooms, and we have | |
| On 2/14/19 at 9:30 am an interview was added the pharmacy nurse to review | |
| conducted with the Unit Manager who stated thatthese areas as well during their visit. Ifthe Unit Managers, Supply Clerk, and Pharmacyitems are going to expire within the next | |
| were responsible to check for expired date 15 days, we will pull that item and discard | |
| medication and supplements each week and to it. The Central Supply coordinator has | |
| discard accordingly. been educated the week of March 11th, to | |
| rotate stock each time new stock in put in | |
| On 2/14/19 at 2:10 pm an interview was and to pull any items that will expire in the conducted with the Director of Nursing who stated next 15 days. | |
| she expected staff to check medication storage | |
| weekly and as needed for expired medication and Monitoring | |
| supplements and to discard them and reorder. The Director of Nurses, using a QA | |
| auditing tool, will review each area of | |
| storage weekly for the next 4 weeks, and then monthly for the next quarter to | |
| determine how any expired supplement | |

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| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | NO. 0938-039 |
|--------------------------|--|---|---------------------|--|---|---------------------------|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | | TE SURVEY MPLETED |
| | | 345421 | B. WING | | 0 | C 12/14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK | | |
| | | | | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| F 761 F 867 SS=E | Continued From page QAPI/QAA Improvem CFR(s): 483.75(g)(2) | ent Activities | F 76 | could end up in a storage area discarded. The results will be re the DON, to the monthly QAPI Assurance and Performance Improvement) meeting for any recommendations. The DON w responsible to follow-up on any recommendation from the QA of with additional training to be pro- the Clinical Resource Specialis indicated. | eported by (Quality further ill be committee ovided by | 3/29/19 |
| | §483.75(g)(2) The qu assurance committee (ii) Develop and imple action to correct iden | - | | | | |
| | Based on observatio record reviews, the fa and Assurance Comm maintain implemented interventions that the following the annual r 12/14/17. This was fo the areas of Care Pla F657- not reviewing a falls previously cited of Unnecessary Psycho F758-not placing time | ns, staff interviews and ncility's Quality Assessment nittee (QAA) failed to d procedures and monitor committee put into place recertification survey dated or two recited deficiencies in n Timing and Revision at and revising the care plan in on 12/14/17 and Free from tropic Meds/PRN use at e duration on as needed nedications previously cited | | F867 Improvement Activities Corrective Action Resident #88 is currently out of Resident #28 s care plan has updated to reflect no wandergu being used. Resident #270 s of has been updated to include re and the careplan for Resident # been updated to include behav updates have been completed Minimum Data Set (MDS) care nurse, during the week of Febri Corrections were transmitted F through the 15th. | been ard is careplan cent falls ¢9 has iors. These by the plan uary 18. | |

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| CENTER STATEMENT (| | D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · · | E CONSTRUCTION | FORM OMB NC (X3) DATE | LETED |
|--------------------------|---|--|---------------------|---|---|----------------------------|
| | | 345421 | B. WING | | 02/ | 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | : | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| TAG F 867 | Continued From page This citation is cross r F657- Based on obse staff interview, the fac revise care plans in th (Residents #28 and # and behaviors (Resid residents. F758- Based on recor and Physician, Nurse Consultant interviews that as needed (PRN) were time limited in di #10, #74 and #57) for medications. An interview was com Administrator 2/14/19 the repeat citations in to the size of the build time Minimum Data S time MDS nurse, until part time MDS positio | e 104 referenced to: rvation record review and bility failed to review and be areas of wandering 88), falls (Resident #270) ent #9) for 4 of 27 sampled rd reviews, staff interviews Practitioner, Pharmacy , the facility failed to ensure) psychotropic medications uration (Residents #81. #9, 5 of 8 residents reviewed pleted with the at 12:40pm. He stated that care plans, could be related ding, there was only one full et (MDS) nurse and a part January 2019 when the n became a full-time at he was uncertain why titions for the PRN | F 867 | DEFICIENCY) Residents #81, #9, #10, #74 and #57 PRN (as needed) psychotropic drug orders were reviewed by physician an either discontinued or rewritten to pro both an appropriate rationale and duration. Resident #57's medical record was reviewed by pharmacy for any further recommended dose reduction or identification of duplicative medication therapy. Corrective Action for those having the potential to be affected At the time of the survey, all residents had an assessment in the past three months were reviewed by the Minimu Data Set (MDS) assessment care plan nurse, and/or the nurse managers, to determine if comprehensive care plan have been updated for all recent falls, wandering behaviors, and behaviors i general. No other resident was found not have timely updated care plans or care cards. Residents who have orders for PRN psychotropic drugs are potentially at r and residents who receive psychotrop medications are potentially at risk for having a gradual dose reduction or duplicate therapy. Our pharmacy has completed a monthly medication revie on 2-28-2019, to determine if there ar | is d vide that m n s n to isk ic not we | |
| | | | | any other PRN psychotropic medication that are not time limited and to determ if there are any gradual dose reduction that should be attempted or any duplicative therapy (these are identified through the monthly pharmacy review | ons iine ns ed | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 04/10/2019 MAPPROVED D. 0938-0391 |
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| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| THELAU | RELS OF CHATHAM | | | | CHATHAM BUSINESS PARK | | |
| | | | | Pľ | TTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | K | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 867 | Continued From page | € 105 | F8 | 367 | Recommendations from these findings have been completed on Medication Recommendations to Physician and forwarded to physician for response. Based on the physician response to ear recommendation, orders have been carried out by the Unit Managers. Systemic changes The QAPI committee includes the Med Director, Administrator, Director of Nurses, Assistant Director of Nurses, Housekeeping Director, Social Worker Pharmacist on a Quarterly Basis, and Maintenance Director has been in-serviced by the Administrator the we of March 11th, on the procedure for developing and implementing appropri plans of action to correct identified qua concerns. Education will include 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. The MDS/Care Plan Nurse an administrative nurses will have been re-educated on 3-15-19, by our Clinica Resource Specialist regarding coding accuracy of the MDS. ADON/staff development coordinator has inservice nurses regarding the requirement that PRN psychotropic medications are tim limited in duration not to exceed 14 da unless the provider believes that it is appropriate for the PRN order to be extended beyond 14 days, and he or s documents their rationale in the resident and indicate | ach lical , the eek ate ality nd l ed e ys | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 |
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| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
| | | 345421 | B. WING | | | | _ 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | 1 | | ST | IREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PARK | | |
| | | | | P | ITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 867 | Continued From page | e 106 | F | 867 | the duration for the PRN order. The pharmacist has been re-educated by the Director of Clinical Services of the pharmacy on March 6th. Monitoring The Director of Nurses, and/or her nur manager, will perform audits bi-weekly one month and then monthly for one quarter, to determine if there are any residents who have had wandering episodes, falls, and/or behaviors. Rest of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendation The Administrator will be responsible t ensure any further recommendations a carried out. Medication reconciliation chart checks done on newly admitted residents□ ch and a check to ensure that any PRN psychotropic medication has an appropriate duration and rationale will a part of this check for ongoing monitoring. Also, orders are reviewed daily at clinical operations meetings ar any orders for PRN psychotropic medication will be reviewed for duratio time limit and rationale. Orders will be corrected as identified for ongoing monitoring. An independent consultant pharmacist will provide the monthly drug regimen review, for at least one quarter as abo The results will be reported to the Dire of Clinical Services of the provider pharmacy and to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further | se for ults ons. o are are arts be nd n | |

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Facility ID: 923099

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 04/10/20 FORM APPROV OMB NO. 0938-03 | |
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| TATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED | |
| | | 345421 | B. WING | C 02/14/2019 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAU | RELS OF CHATHAM | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE COMPLETIC | |
| F 867 | Continued From pag | e 107 | F 867 | recommendations. The Administra be responsible to follow-up on any recommendation from the QA com with additional training to be provid the Clinical Resource Specialist, a indicated | / nmittee ded by | |
| F 881 SS=E | Antibiotic Stewardshi CFR(s): 483.80(a)(3) | | F 881 | | 3/29/19 | |
| | program. The facility must esta and control program a minimum, the follow §483.80(a)(3) An ant that includes antibiot system to monitor an | ibiotic stewardship program ic use protocols and a | | | | |
| | Based on observation Practitioner and Con- and record review, the the continued use of or re-evaluation in the symptoms of infection Resident #72 and Re- reviewed for antibioti included: Review of the Antibiot 5/2016 read as follow was to preserve the e- use. The procedures McGeer's Criteria (m for infection control s Care. The procedure | ons, staff, Physician, Nurse sultant Pharmacist interviews a facility failed to address antibiotics with no stop date e absence of signs or n for 3 (Resident #71, esident #74) of 3 residents c stewardship. The findings thic Stewardship Policy dated ws: The purpose of the policy effectiveness of antibiotic included the use of inimum criteria for infections) urveillance in Long Term reads the Physician must piotics to include the dose, | | F881 Antibiotic Stewardship Prog Corrective Action: Residents number 71, 72, and 74 been reviewed by the pharmacist recommendations sent to the mer director to review. Recommendat have been reviewed the week of 3 and orders written if any changes be made. Resident #71 did have h Infectious Disease appointment or 9-11-18, and we do have the office documentation. Corrective action for those who has potential to be affected Any resident that requires an antik has the potential to be affected by | have with dical ions 3-4-19 were to her n e ave the piotic | |

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| | | MEDICAID SERVICES | | | | 3-039 |
|--------------------------|---|---|---------------------|---|--|---------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | 1 |
| | | | | | C | |
| | | 345421 | B. WING | | 02/14/201 | 9 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z | IP CODE | |
| THE LAU | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI | ACTION SHOULD BE COMPL TO THE APPROPRIATE DA | (5) LETIO ATE |
| F 881 | Continued From page | e 108 | F 88 | 31 | | |
| | duration and indication collaborate with the p antibiotic use and eduresidents and resider resistance and opport antibiotic use. 1. Resident #71 was cumulative diagnoses Osteomyelitis. Review of an General note dated 8/14/18 w through 8/20/18 read (antibiotic) and Metro hospital discharge an Diseases on 9/6/18. The facility was not a | on for use. The facility would oharmacy to improve ucate the staff, Physician, nt families about antibiotics tunities for improving admitted 10/21/15 with s of pressure ulcers and al Infectious Disease Consult thile hospitalized from 8/9/18 to restart the Cefdinir onidazole (antibiotic) on ad follow up with Infectious able to provide any evidence intment with Infectious | | alleged deficient practice identified by reviewing the antibiotic reports general pharmacy. The Director preformed and audit dur 2-18-19, of all residents antibiotics. No other res be on indefinite antibioti appropriate documentate attending physician. Systemic Changes The pharmacist has bee 3-16-2019, by the Direct Services of the provider include reviewing of stop antibiotics. An independ pharmacist(s) will provide services for at least one March 2019. The consu will address the above is monthly drug regimen res | ne weekly ated from our of Nurses ing the week of that were on ident was found to c therapy without ion from the en re-educated on tor of Clinical pharmacy to o orders for ent consultant le consulting quarter starting in ltant pharmacist ssues during the | |
| | dated 9/16/18 read R the hospital with Sep- life-threatening respo result if multiple orga tract infection (UTI). read she was to contr intravenously through benefit from UTI prop Resident #71 was dis Cefdinir and Metronic date. Resident #71's quarte (MDS) dated 9/23/18 cognitively intact and | onse to infection which may n damage) due to a urinary The discharge summary inue with Invaz (antibiotic) n 9/20/18 and she may ohylaxis (preventive). scharged on 9/16/18 taking dazole, both with no stop | | Monitoring The Director of Nurses/ utilizing a QA auditing to weekly antibiotic reports our pharmacy, to ensure orders in place or to det is not a stop order, wee months, and then month months. The results wi the DON, to the monthly any further recommenda cause analysis. The DO responsible to follow-up recommendation from th additional training is indi | Unit Managers, bol, will review the generated from the there are stop ermine why there only for the next 2 have reported by y QAPI meeting for ations or root N will be on any ne committee and | |

Facility ID: 923099

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 |
|--------------------------|--|--|---------------------|---|--|-------------------|--|
| STATEMENT | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | _ | (02/ | _ 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | 5 | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAU | RELS OF CHATHAM | | | 2 CHATHAM BUSINESS P PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE) CROSS-REFEREI | S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 881 | coded for 2 stage 4 pr catheter and a coloste days of antibiotic use The MDS was coded Review of the Treatm (TAR) for October 202 of her second of her to Review of Nurse Prace read Infectious Diseas Resident #71's Cefdir her hospital discharge she developed a feve hospital and diagnose (potentially fatal cond low blood pressure) d the facility on 10/6/18 Nurse Practitioner res Metronidazole after he completed on 10/16/1 reviewed by the Phys Resident #71's quarte (MDS) dated 10/13/18 cognitively intact and was coded for total as of daily living except e coded for 2 stage 4 pr catheter and a coloste days of antibiotic use The MDS was coded Review of lab work da Resident #71's white with normal ranges fro | eating. Resident #71 was ressure ulcers, a urinary omy. She was coded for 3 for the 7 days look back. for a UTI. ent Administration Record 18 revealed multiple refusals wo daily dressing changes. etitioner note dated 10/8/18 ses did not want to restart hir and Metronidazole after e on 9/16/18 and on 9/30/18, r and sent back to the ed with Septic Shock ition when Sepsis leads to a ue to a UTI. She returned to . The note indicated the started the Cefdinir and er other antibiotics were 8. The note was initialed as ician. erly Minimum Data Set 3 indicated she was exhibited no behaviors. She saistance for all her activities eating. Resident #71 was ressure ulcers, a urinary omy. She was coded for 7 for the 7 days look back. | F 881 | | | | |

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| CENTERS FOR MEDICARE | & MEDICAID SERVICES | | | FORI | D: 04/10/2019 MAPPROVED D. 0938-0391 |
|--|---|---------------------------------|---|------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | | (X3) DATE COMF | E SURVEY PLETED |
| | 345421 | B. WING | | | C / 14/2019 |
| NAME OF PROVIDER OR SUPPLIER | | STR | EET ADDRESS, CITY, STATE, ZIP COI | DE | |
| THE LAURELS OF CHATHAM | | | HATHAM BUSINESS PARK TSBORO, NC 27312 | | |
| PREFIX (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 881 Continued From p | age 110 | F 881 | | | |
| Physician Orders daily for osteomyet initiated 10/18/18 also an order for M for osteomyelitis m date of 10/19/19 a Review of lab wor Resident #71's wh with normal range Review of Residen Physician Orders daily for osteomyet initiated 10/18/18 also an order for M for osteomyelitis m date of 10/19/19 a Review of the TAF multiple refusals of dressing changes Review of lab wor Resident #71's wh with normal range Review of Residen Physician Orders daily for osteomyet initiated 10/18/18 also an order for M for osteomyet initiated 10/18/18 also an order for M for osteomyet initiated 10/18/19 a | k dated 10/24/18 indicated nite blood cell count was 6.9 s from 4.0 to 11.0. Int #71's November 2018 read Cefdinir twice by mouth elitis. This order was dated as with no stop date. There was Metronidazole three times daily naintenance with an initiation and no stop date. R for November 2018 revealed of her second of her two daily k dated 11/20/18 indicated nite blood cell count was 7.3 s from 4.0 to 11.0. Int #71's December 2018 read Cefdinir twice by mouth elitis. This order was dated as with no stop date. There was Metronidazole three times daily naintenance with an initiation | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | 0: 04/10/2019 1 APPROVED 0. 0938-0391 |
|--------------------------|--|--|---------------------|--|--|------|---|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | E CONSTRUCTION | | | LETED |
| | | 345421 | B. WING | | _ | | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS P PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE) CROSS-REFEREI | PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 881 | Continued From page dressing changes. | : 111 | F 88′ | | | | |
| | Resident #71's urinaly Escherichia Coli (bact environment, foods an Spectrum B-lactamas produced by bacteria resistance to commor Resident #71's Physic started in Invanz (anti 12/3/18 and this was (antibiotic) by mouth f Review of a Physician 12/5/18 read staff rep noncompliant sometir and changing position ulcers were a source she was on chronic an history of multiple UT be her chronic suprap inserted below the na | teria found in the nd intestines) and Extended ses (ESBL-enzymes that have an increased nly used antibiotics). cian orders read she was ibiotic) intramuscularly on changed to Augmentin for 7 days for a UTI. In progress note dated ort that Resident #71 was nes with her medications ns. Resident #71's pressure of multiple infections and ntibiotic. Resident #71 has a l's with the culprit thought to public catheter (a tube vel into the bladder to drain s were prophylactics and she | | | | | |
| | the electronic record f | • | | | | | |
| | Orders read Cefdinir to osteomyelitis. This or 10/18/18 with no stop order for Metronidazo | 71's January 2019 Physician twice by mouth daily for der was dated as initiated date. There was also an le three times daily for nance with an initiation date op date. | | | | | |

Facility ID: 923099

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | : 04/10/2019 APPROVED . 0938-0391 |
|--------------------------|--|--|---------------------|--|--|-----------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | _ | (02/ [,] | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | TATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS F PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE) CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 881 | Continued From page | 112 | F 88 | 1 | | | |
| | | January 2019 revealed r second of her two daily | | | | | |
| | (MDS) dated 1/11/19 cognitively intact and was coded for total as of daily living except e coded for 2 stage 4 pi catheter and a colosted | exhibited no behaviors. She ssistance for all her activities eating. Resident #71 was ressure ulcers, a urinary omy. She was coded for 7 for the 7 days look back. | | | | | |
| | only allowing one pre- day and for choosing by wound physician. ⁻ giving Resident #71 h prevention of osteomy | e planned on 9/17/18 for ssure ulcer treatment per not to reposition as advised The interventions included er antibiotic as ordered for yelitis dated initiated an was dated last revised on | | | | | |
| | mouth daily for osteor dated as initiated 10/1 There was also an or | d Cefdinir by mouth twice nyelitis. This order was 18/18 with no stop date. der for Metronidazole three nyelitis maintenance with an | | | | | |
| | to 2/13/19 revealed m second of her two dai | ly dressing changes. | | | | | |
| | Set (MDS) dated 2/1/ | cant change Minimum Data 19 indicated she was exhibited no behaviors. She | | | | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | 0: 04/10/2019 1 APPROVED 0. 0938-0391 |
|--------------------------|---|---|---------------------|---|--|-------------------|---|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | (X3) DATE COMP | LETED |
| | | 345421 | B. WING | | _ | | _ 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | | | |
| THE LAU | RELS OF CHATHAM | | | 2 CHATHAM BUSINESS F PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE) CROSS-REFEREI | S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 881 | of daily living except e coded for 2 stage 4 p catheter and a coloste days of antibiotic use The MDS was coded During an observation 10:18 AM, Resident # bariatric bed. She voi confirmed the present She stated one of the #71 stated she did no bed. During an interview of Infection Control Prev was aware that antibio indication for use and some residents who w indefinitely. The ICP of the McGeer's Criteria infections. She stated the Physician maintai #71's antibiotic use. During an interview of Director of Nursing (D pharmacy recommend date for Resident #71 have expected one. During an interview of Nurse Practitioner (NI left about a week ago around to meet her re- was unusual to see a | esistance for all her activities eating. Resident #71 was ressure ulcers, a urinary omy. She was coded for 7 for the 7 days look back. for no infection. In and interview on 2/11/19 at t71 was sitting up in a ced no discomfort and ce of one pressure ulcer. area was healed. Resident t get up preferring to stay in In 2/12/19 at 2:30 PM, the rentionist (ICP) stated she otic should have an a stop date but there were vere prescribed antibiotics confirmed the facility utilized | F 881 | | | | |

Facility ID: 923099

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| | - | D HUMAN SERVICES | | | | FORM | D: 04/10/2019 |
|--------------------------|---|--|---------------------|-----------------------------|--|-----------|----------------------------------|
| STATEMENT (| S FOR MEDICARE & I OF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | LE CONSTRUCTION | | (X3) DATE | D. 0938-0391 SURVEY PLETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, S | TATE, ZIP CODE | · · · · | |
| | | | | 72 CHATHAM BUSINESS I | PARK | | |
| THE LAUF | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | 2 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| | | | | | DEFICIENCE) | | |
| F 881 | Continued From page | 9 114 | F 88 | 1 | | | |
| | During a wound care | observation on 2/13/19 at | | | | | |
| | | hial Stage 4 wound was | | | | | |
| | | ion and the right ischial area | | | | | |
| | | | | | | | |
| | . . | terview on 2/13/19 at 11:23 | | | | | |
| | Resident #71 was not | ted the use of antibiotics for | | | | | |
| | | hospitalizations due to | | | | | |
| | | ids. He stated he was not | | | | | |
| | - | chial wound was healed but | | | | | |
| | | re also indicated for the | | | | | |
| | | ted with Resident #71's | | | | | |
| | | Physician #3 stated when | | | | | |
| | | l signs of an infection, she Id ended up on a ventilator | | | | | |
| | - | enefits outweigh the risk. He | | | | | |
| | | Disease Department was | | | | | |
| | | 1, but he was unsure when | | | | | |
| | she was last evaluate | d. He stated it would be his | | | | | |
| | - | be re-evaluated for the | | | | | |
| | continued use of the a | antibiotics. | | | | | |
| | The facility was upabl | a to provide ovidence of any | | | | | |
| | - | e to provide evidence of any us Disease since Resident | | | | | |
| | #71 was hospitalized | | | | | | |
| | During an interview o | n 2/13/19 at 1:20 PM, the | | | | | |
| | | st stated he read that the | | | | | |
| | | of the open-ended use of | | | | | |
| | Resident #71's antibio | | | | | | |
| | | nfectious Disease from the | | | | | |
| | | d the continued use of her | | | | | |
| | antibiotic. He stated h | - | | | | | |
| | Cefdinir or Metronida | jarding Resident #71's zole. | | | | | |
| | | | | | | | |
| | During an interview of | n 2/14/18 at 11:54 AM, the | | | | | |

| | - | ID HUMAN SERVICES | | | | FORM | / APPROVED |
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| | S FOR MEDICARE & | MEDICAID SERVICES | (X2) MUL | | E CONSTRUCTION | (X3) DATE | 0. 0938-0391 SURVEY |
| | CORRECTION | IDENTIFICATION NUMBER: | ` ´ | | | | LETED |
| | | | | | | (| C |
| | | 345421 | B. WING | | ······ | 02/ | 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | | | |
| | SI IMMARY ST | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREF | | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | COMPLETION DATE |
| | 1 | | | | DEHOLENOTY | | |
| F 881 | Continued From page | 115 | | 881 | | | |
| 1 001 | | cal Director (MD) was | | 001 | | | |
| | | iew and that the other | | | | | |
| | Physicians and MD a | - | | | | | |
| | | the Infectious Disease | | | | | |
| | - | stated she was not aware on who restarted Resident | | | | | |
| | | etronidazole in October 2018 | | | | | |
| | | re of any follow up with | | | | | |
| | | nce her hospitalization | | | | | |
| | were not in accordance | ated the use of prophylactics ce with the antibiotic | | | | | |
| | | nd that the policy should be | | | | | |
| | | #71 reassessed for the | | | | | |
| | continued need of he | r antibiotics. | | | | | |
| | 2. Resident # 72 was | admitted on 10/6/18 with | | | | | |
| | | s of Chronic Obstructive | | | | | |
| | Pulmonary Disease a | ind Diabetes. | | | | | |
| | Review of Resident # | 72's hospital discharge | | | | | |
| | orders read she was | to receive Nitrofurantoin | | | | | |
| | | ms (mg) four times daily for | | | | | |
| | tract infections (UTIs) | reafter to prevent urinary). | | | | | |
| | Review of Resident # | 72's October 2018 | | | | | |
| | | d an order for Nitrofurantoin | | | | | |
| | daily prophylactic. Th | e order did not include an | | | | | |
| | indication or a stop da | ate. | | | | | |
| | Resident #72 was car | re planned on 10/19/18 for a | | | | | |
| | risk of urinary tract in | fection (UTI's) related to a | | | | | |
| | | equent incontinence of bowel | | | | | |
| | retention. Interventior | ory of recent UTI and urinary | | | | | |
| | administer her medica | | | | | | |
| | | ess/side effects and report | | | | | |
| | abnormal findings to | physician. | | | | | |
| | | | | | | | |

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| | - | D HUMAN SERVICES | | | | | FORM |): 04/10/2019 // APPROVED |
|--------------------------|--|---|---------------------|----|------------------------------|---|-----------|---------------------------------|
| STATEMENT | S FOR MEDICARE & I | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | | (X3) DATE | 0. 0938-0391 SURVEY LETED |
| | | 345421 | B. WING | | | _ | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | T | ST | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| | | | | 72 | 2 CHATHAM BUSINESS P | ARK | | |
| THE LAU | RELS OF CHATHAM | | | P | ITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| (EACH CORREC CROSS-REFERE | PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 881 | Review of Resident # Physician Orders read daily prophylactic. The indication or a stop da Review of Resident # Physician Orders read daily prophylactic. The indication or a stop da Review of a urinalysis Resident #72 was neg Review of Resident # Orders read an order prophylactic. The order indication or a stop da Review of Resident # Physician Orders read daily prophylactic. The indication or a stop da Resident #72 quarter 1/11/19 indicated mod with no behaviors. Sh assistance with perso assistance with perso assistance with toileti as frequently incontin having no infections a days of antibiotics du period. Review of a urinalysis #72 was negative for During an observation 9:00 AM, Resident #7 | 72's November 2018 d an order for Nitrofurantoin e order did not include an ate. 72's December 2018 d an order for Nitrofurantoin e order did not include an ate. 6 dated 12/13/18 read gative for an UTI. 72's January 2019 Physician for Nitrofurantoin daily er did not include an ate. 72's February 2019 d an order for Nitrofurantoin e order did not include an ate. 72's February 2019 d an order for Nitrofurantoin e order did not include an ate. 9 Minimum Data Set dated derate cognitive impairment e was coded for extensive nal hygiene and total ng. Resident #72 was coded ent of bladder and bowel, as and as having received 7 ring the 7 days look back | F 8 | 81 | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 |
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| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, S | TATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | 72 CHATHAM BUSINESS I PITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 881 | Continued From page discomfort. | 9 117 | F 88 | 1 | | | |
| | Infection Control Prev was aware that antibi- indication for use and some residents who w indefinitely. The ICP of the McGeer's Criteria | a stop date but there were vere prescribed antibiotics confirmed the facility utilized for the treatment of esident #72 did not meet the | | | | | |
| | Director of Nursing (D pharmacy recommend indication or stop date | n 2/13/19 at 8:30 AM, the OON) stated she had no dations related to the clinical e for Resident #72's puld have expected one. | | | | | |
| | Nurse Practitioner (NI left about a week ago around to meet her re was unusual to see a antibiotics for UTIs ar commonly used anym with the Responsible about the risk associa the absence of clinica agreed to discontinue During a telephone in AM, Physician #3 stat | the antibiotic. terview on 2/13/19 at 11:23 | | | | | |
| | Physician and that if h Resident #72, he wou Resident #72 was res During an interview of | ne ordered the antibiotic for Ild not discontinue it while | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|---|---------------------|----------------|--|--------|----------------------------|
| | | ``` | | E CONSTRUCTION | | PLETED | |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | S | TREET ADDRESS, CITY, STATE, ZIP CODE | · | |
| THE LAU | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIZ TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 881 | Resident #72's antibio daily upon discharge During an interview o DON stated the Mediu unavailable for intervi Physician and MD alw recommendations of Resident #72. The DO prophylactics were no | ut the continued use of otic since it was ordered from the hospital. n 2/14/18 at 11:54 AM, the cal Director (MD) was ew and that the other ways followed the the primary Physician for DN stated the use of ot in accordance with the policy and that the policy | F | 381 | | | |
| | 10/8/18 with multiple dementia. Review of Resident # revealed he had a ph 10/9/18 for Nitrofuran milligrams (mgs) - 1 c Chronic Urinary Tract The antibiotic order d The quarterly Minimu assessment dated 1/7 Resident #74 had sev and she had received 7 days during the ass Review of Resident # Medication Administra | 74's medical record ysician's order dated toin (an antibiotic) 100 capsule by mouth daily for Infection (UTI) prevention. id not contain a stop date. m Data Set (MDS) 14/19 indicated that vere cognitive impairment I an antibiotic medication for essment period. 74's February 2019 ation Record (MAR) continued to receive use of | | | | | |

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| | | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 |
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| STATEMENT (| DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| THE LAUF | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 881 F 883 SS=E | On 2/12/19 at 2:26 Pf Nurse (IC) was intervi was aware of the facil program that physicia should have a stop da stated that she was a several residents on p she didn't know the re- should only be ordered should be time limited On 2/12/19 at 3:20 Pf was interviewed. She that the facility had ar program but she did r about. The UM indica not have an acute uril since admission. She was admitted on Nitro prevention. An interview with the was conducted on 2/1 stated that she expect stewardship program orders for antibiotic ha Influenza and Pneum CFR(s): 483.80(d)(1)(1) §483.80(d) Influenza immunizations §483.80(d)(1) Influenza immunizations | M, the Infection Control iewed. She stated that she lity's antibiotic stewardship n's order for antibiotic ate. The IC Nurse further ware that the facility had prophylactic antibiotic but egulation that antibiotic d for active infection and d in duration. M, the Unit Manager (UM) e stated that she was aware ntibiotic stewardship not know what this was all ated that Resident #74 did nary tract infection (UTI) e verified that Resident #74 ofurantoin for UTI Director of Nursing (DON) 14/19 at 11:52 AM. The DON ted the facility's antibiotic to be followed by ensuring ave a stop date. ococccal Immunizations (2) and pneumococcal za. The facility must develop es to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; | | 881 | | | 3/29/19 |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 04/10/2019 MAPPROVED). 0938-0391 | |
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| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
| | | 345421 | B. WING | | | _ | | C 14/2019 | |
| NAME OF PR | ROVIDER OR SUPPLIER | | • | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | | |
| | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS P | | | | |
| | | | | P | PITTSBORO, NC 27312 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 883 | contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident of was provided education and potential side effec- immunization; and (B) That the resident of immunization or did n- immunization or did n- immunization due to r refusal. §483.80(d)(2) Pneum must develop policies that- (i) Before offering the immunization, each re- representative receive benefits and potential immunization; (ii) Each resident is of immunization, unless medically contraindica already been immuniz (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident of | r 1 through March 31 mmunization is medically resident has already been a time period; e resident's representative orfuse immunization; and dicat record includes dicates, at a minimum, the or resident's representative on regarding the benefits ects of influenza either received the influenza nedical contraindications or ococccal disease. The facility and procedures to ensure pneumococcal esident or the resident's es education regarding the side effects of the fered a pneumococcal the immunization is ated or the resident has zed; e resident's representative or fuse immunization; and dicat record includes dicates, at a minimum, the or resident's representative on regarding the benefits | F | 8883 | | DEFICIENCY) | | | |
| | following: (A) That the resident of | or resident's representative on regarding the benefits | | | | | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 04/10/2019 FORM APPROVED OMB NO. 0938-0391 |
|--------------------------|---|--|---------------------|--|--|
| STATEMENT O | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 345421 | B. WING | | C 02/14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | • | - - | STREET ADDRESS, CITY, STATE, ZIP CODE | • |
| | | | | 72 CHATHAM BUSINESS PARK | |
| | RELS OF CHATHAM | | | PITTSBORO, NC 27312 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE COMPLETION |
| F 883 | the pneumococcal im contraindication or re This REQUIREMENT by: Based on staff interv facility failed to admir Immunization Series admission for 6 (Resi Resident #64, Reside Resident #74) of 6 re Pneumonia Immuniza included: Review of the facility Pneumococcal Immu 2/5/16 read in adults residents of a long-te administered both the the Pneumovax23 (P series. 1. Resident #92 was cumulative diagnoses and Seizures. The mo signed consent on ad Immunization. A review of Resident | either received the nization or did not receive imunization due to medical fusal. T is not met as evidenced iew and record review, the nister the Pneumonia as consented to on dent #92, Resident #98, ent #61, Resident #118 and sidents reviewed for ations. The findings provided policy titled nization dated revised age 65 or older as well as rm care facility should be e Prevnar 13 (PCV13) and PSV23) routinely as a admitted 3/3/16 with s of Paraplegia, Diabetes edical record revealed a lmission for the Pneumonia | F 883 | | d #74 ation sent (PCV13 anager, unit based ccine cion under ne t Risk: ally at pleted er Unit ived those |
| | whether the resident pneumococcal vaccir A review of Resident | received or refused either of nes. #92's most recent quarterly | | nursing will go through the process re-issuing VIS (vaccine information statements) and immunization cons forms for pneumococcal vaccines (and PPSV23) and identified resider | s of sent (PCV13 nts will |
| | - | IDS) assessment dated d. Section O of the MDS | | be given the appropriate vaccine be on response. Administration of vac | |
| | | | | | |

Event ID: PVRD11

Facility ID: 923099

If continuation sheet Page 122 of 132

| | | ND HUMAN SERVICES MEDICAID SERVICES | | | | F | NTED: 04/10/2019 ORM APPROVED NO: 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|--|---|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | CONSTRUCTION | (X3) | DATE SURVEY COMPLETED |
| | | 345421 | B. WING | | | C 02/14/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | • | | ST | IREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAU | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 883 | assessment indicated pneumococcal vaccin declined. During an interview of Director of Nursing (I expectation that resid that have consented Immunization receive ordered. She was un as to why the Pneum administered for Res it was ultimately resp Managers and Unit O the Infection Control the Infection Control the immunizations we During an interview of Infection Control Prev there was no informa medical record that re PPSV23 was adminis offer any explanation Pneumonia Immuniza administered. She state behind the Unit Mana ensure the immunization series consented. She state behind the Unit Mana ensure the immunization series consented, and she we that the PPSV23 imm | d the resident's hation was offered and an 2/12/19 at 1:50 PM, the DON) stated it was her dents residing at the facility to the Pneumonia the immunization series as able to offer any explanation onia Immunizations were not ident # 92. The DON stated onsibility of the Unit coordinator with oversight by Preventioist (ICP) to ensure ere administered. an 2/12/19 at 2:30 PM, the ventionist (ICP) confirmed tion in Resident #92's effected that the PCV13 or stered. She was unable to as to why the consented ations were not ated on admission, the Unit hit Coordinator were | F | 883 | will be documented on the Medicatio Administration Record (MAR) and ut the Immun (Immunization) tab of the electronic medical record by the char nurse who is giving the immunization Systemic Changes: During the admission process reside will be given the VIS (vaccine inform statements). Immunization consent for pneumococcal vaccines (PCV13 PPSV23) and identified residents wi given the appropriate vaccine based response. Administration of vaccine be documented on the Medication Administration Record (MAR) and ut the Immun (Immunization) tab of the electronic medical record. This information is reviewed at Clinical operations meeting and scheduled if needed if not already completed. The ADON/staff development coord will inservice nursing on the two pneumococcal vaccines (PCV13 and PPSV23) to include documentation, frequency and time intervals of these vaccinations. The inservices have be given at various times by over the w of February 25th and March 4th. All inservcies for all licensed staff, to inter- full time, part time, and as necessary will be completed by 3-22-19, or will be scheduled to work. Monitoring: The Director of Nurses, using a QA auditing tool, will review immunization weekly for 3 months to determine compliance. The results will be reported in the results will be reported. | nder errge n. ents hation forms and ll be l on e will nder e f linator d e een eeks clude y staff, not | |

Facility ID: 923099

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | FOR | D: 04/10/2019 M APPROVED D. 0938-0391 |
|--------------------------|--|---|------------------------------|---|-------------------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | (X3) DATE COM | (X3) DATE SURVEY COMPLETED | |
| | | 345421 | B. WING | | | C / 14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | 7 | 2 CHATHAM BUSINESS PARK | | |
| THE LAUP | RELS OF CHATHAM | | P | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| TAG F 883 | Continued From page stated she learned on could be administered She was unable to ex the missing PCV13 in completed. During another intervit the DON stated it was Resident #92's receiv Immunization as orde 2. Resident #98 was a cumulative diagnoses damage) and Alcohol medical record reveal admission for the Pne A review of Resident revealed there was no whether the resident of pneumococcal vaccin A review of Resident cumulative diagnoses damage) and Alcohol medical record reveal admission for the Pne A review of Resident pneumococcal vaccin A review of Resident pneumococcal vaccin Data Set (MDS) asse reviewed. Section O indicated the resident vaccination was offered During an interview of Director of Nursing (D expectation that resid that have consented the | a 123 a 2/11/19 that the PPSV23 d 8 weeks after the PCV13. cplain why the initial doses of munizations was not iew on 2/14/19 at 11:54 AM, a her expectation that the Pneumonia ared and done timely. admitted 8/13/18 with a of Encephalopathy (brain Abuse. Resident of the led a signed consent on eumonia Immunization. #98's medical record the of documentation to indicate received or refused either of the les. #98's most recent Minimum ssment dated 1/22/19 was of the MDS assessment 's pneumococcal ed and declined. m 2/12/19 at 1:50 PM, the DON) stated it was her ents residing at the facility | F 883 | DEFICIENCY) | Quality er hittee | |
| | as to why the Pneumo administered for Resi | able to offer any explanation onia Immunizations were not dent #98. The DON stated it isibility of the Unit Managers with oversight by the | | | | |

If continuation sheet Page 124 of 132

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|--------------------------|--|---|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | LE CONSTRUCTION | (X3) DATE COMI | E SURVEY PLETED |
| | | 345421 | B. WING | | | | /14/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | L | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| THE LAUF | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 883 | immunizations were a During an interview o Infection Control Prev there was no informa medical record that re PPSV23 was adminis offer any explanation Pneumonia Immuniza administered. She stat Managers and the Ur responsible for initiati Immunization series o consented. She state behind the Unit Mana ensure the immunizat During an interview o Coordinator (UC) stat Pneumonia Immunizat consented, and she v that the PPSV23 immuniti 1 year after the i stated she learned or could be administered She was unable to ex- the missing PCV13 in completed. | ventioist (ICP) to ensure the administered. In 2/12/19 at 2:30 PM, the ventionist (ICP) confirmed tion in Resident #98's effected that the PCV13 or stered. She was unable to as to why the consented ations were not ated on admission, the Unit nit Coordinator were ng the Pneumonia on residents who have d she did not routinely go ogers or Unit Coordinator to tions were completed. In 2/12/19 at 5:04 PM, Unit ted she administered the ations to residents who had was under the impression nunization could not be given nitial PCV13 dose. She n 2/11/19 that the PPSV23 d 8 weeks after the PCV13. cplain why the initial doses of nmunizations was not | F | 883 | | | |
| | and Diabetes. Review | admitted 2/17/18 with of Congestive Heart Failure v of the medical record nsent on admission for the | | | | | |

Facility ID: 923099

If continuation sheet Page 125 of 132

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 APPROVED 0. 0938-0391 | |
|--------------------------|---|--|---------------------|-------------------------------|--|-------------------------------|---|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
| | | 345421 | B. WING | | _ | | C 14/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | | |
| | | | 7 | 2 CHATHAM BUSINESS P | ARK | | | |
| THE LAUF | RELS OF CHATHAM | | P | ITTSBORO, NC 27312 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 883 | | ation. #64's medical record o documentation to indicate received or refused either of | F 883 | | | | | |
| | Minimum Data Set (M 11/14/18 was reviewed assessment indicated pneumococcal vaccin During an interview o Director of Nursing (E expectation that resid that have consented t Immunization receive ordered. She was una as to why the Pneumo administered for Resi was ultimately respon and Unit Coordinator | ation was up to date. n 2/12/19 at 1:50 PM, the OON) stated it was her ents residing at the facility to the Pneumonia the immunization series as able to offer any explanation onia Immunizations were not dent #64. The DON stated it isibility of the Unit Managers with oversight by the ventioist (ICP) to ensure the | | | | | | |
| | Infection Control Prev there was no information medical record that re PPSV23 was administ offer any explanation Pneumonia Immunization Administered. She state Managers and the Ur responsible for initiation Immunization series of | effected that the PCV13 or tered. She was unable to as to why the consented ations were not ated on admission, the Unit it Coordinator were | | | | | | |

Facility ID: 923099

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DA | IO. 0938-0391 FE SURVEY MPLETED | | |
|--|---------------------------------------|--|--|
| A. BUILDING | • | | |
| 345421 B. WING 0 | C 2/14/2019 | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| THE LAURELS OF CHATHAM 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY) DEFICIENCY) DEFICIENCY) | (X5) COMPLETION DATE | | |
| F 883 Continued From page 126 F 883 behind the Unit Managers or Unit Coordinator to ensure the immunizations were completed. During an interview on 2/12/19 at 5:04 PM, Unit Coordinator (UC) stated she administered the Pneumonia Immunizations to residents who had consented, and she was under the impression that the PPSV23 immunization could not be given until 1 year after the initial PCV13 does. She stated she learned on 2/11/19 that the PPSV23 could be administered 4 weeks after the PCV13. She was unable to explain why the initial doese of the missing PCV13 immunizations was not completed. During another interview on 2/14/19 at 11:54 AM, the DON stated it was her expectation that Resident #64's receive the Pneumonia Immunization as ordered and done timely. 4. Resident #61's medical record revealed a signed consent on admission for the Pneumonia Immunization. A review of Resident #61's medical record revealed there was no documentation to indicate whether the resident #61's medical record revealed there was no documentation to indicate whether the resident #61's medical record revealed a signed consent on admission for the Pneumonia Immunization. A review of Resident #61's medical record revealed a signed consent on admission for the Pneumonia Immunization. A review of Resident #61's most recent quarterly Minimum Data Set (MDS) assessment dated 1/18/19 was reviewed. Section O of the MDS assessment indicated the resident's pneumococcal vaccination was up to date. During an interview on 2/12/19 at 1:50 PM, the | | | |

Facility ID: 923099

If continuation sheet Page 127 of 132

| | | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 04/10/2019 APPROVED 0. 0938-0391 | |
|--------------------------|--|--|-------------------|-----|--|---|-------------------------------|---|--|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · | | | | (X3) DATE SURVEY COMPLETED | | |
| | | 345421 | B. WING | | | _ | (02/ | C 14/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | | |
| THE LAUF | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS P ITTSBORO, NC 27312 | | | | |
| | | | | F | - | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORREC CROSS-REFERE | EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 883 | Continued From page Director of Nursing (D expectation that resid that have consented t Immunization receive ordered. She was una as to why the Pneumo administered for Resid was ultimately respon and Unit Coordinator Infection Control Prev immunizations were a During an interview of Infection Control Prev there was no informat medical record that re PPSV23 was adminis offer any explanation Pneumonia Immuniza administered. She stated Managers and the Un responsible for initiatii Immunization series of consented. She stated behind the Unit Mana ensure the immunizat During an interview of Coordinator (UC) stat Pneumonia Immunizat consented, and she w that the PPSV23 immunit 1 year after the in stated she learned on | 127 ON) stated it was her ents residing at the facility o the Pneumonia the immunization series as able to offer any explanation onia Immunizations were not dent #61. The DON stated it sibility of the Unit Managers with oversight by the entioist (ICP) to ensure the dministered. n 2/12/19 at 2:30 PM, the entionist (ICP) confirmed ion in Resident #61's flected that the PCV13 or tered. She was unable to as to why the consented tions were not ted on admission, the Unit it Coordinator were ng the Pneumonia n residents who have d she did not routinely go gers or Unit Coordinator to | | 883 | | | | | |
| | She was unable to ex the missing PCV13 in completed. | plain why the initial doses of imunizations was not | | | | | | | |

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| DEPARTMENT OF HEALTH | | | | | | | FORM | 0: 04/10/2019 APPROVED |
|---|--|---|---------|-------------------------------|---|---------------|----------------------------|----------------------------------|
| CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDE | R/SUPPLIER/CLIA ATION NUMBER: | · / | | E CONSTRUCTION | | (X3) DATE | D. 0938-0391 SURVEY PLETED |
| | | 345421 | B. WING | | | - | | C 14/2019 |
| NAME OF PROVIDER OR SUPPLIEF | | | | 5 | STREET ADDRESS, CITY, STA | ATE, ZIP CODE | • | |
| | | | | 7 | 72 CHATHAM BUSINESS PA | ARK | | |
| THE LAURELS OF CHATHAM | | | | F | PITTSBORO, NC 27312 | | | |
| PREFIX (EACH DEFIC | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG | | | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY) | | (X5) COMPLETION DATE | |
| F 883 Continued From During another in the DON stated in Resident #61's re Immunization as 5. Resident #118 cumulative diagn blood platelet con Infection. Review a signed consent Pneumonia Immu A review of Resid revealed there w whether the resid pneumococcal va A review of Resid reviewed. Section indicated the resi vaccination was During an intervie Director of Nursin expectation that in that have consent Immunization reco ordered. She was as to why the Pn administered for it was ultimately in Managers and U the Infection Con the immunization | terview on 2/14/ twas her expecta eceive the Pneum ordered and don was admitted 1// oses of Thrombo unt) and a Urinar of the medical re on admission fo unization. lent #118's medical as no documenta lent received or re accines. lent #118's admis assessment date n O of the MDS a dent's pneumoco up to date. ew on 2/12/19 at residents residing ted to the Pneum eve the immuniz sunable to offer accines and the muni- section of | ation that nonia e timely. 24/19 with ccytopenia (low y Tract ecord revealed r the cal record ation to indicate efused either of ssion Minimum d 1/31/19 was assessment occal 1:50 PM, the it was her g at the facility nonia cation series as any explanation zations were not the DON stated he Unit ith oversight by (ICP) to ensure ered. 2:30 PM, the | F | 883 | | | | |

Facility ID: 923099

If continuation sheet Page 129 of 132

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 |
|--------------------------|---|---|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 345421 | B. WING | | | | C 14/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | ę | STREET ADDRESS, CITY, STATE, ZIP CODE | · | |
| THE LAU | RELS OF CHATHAM | | | | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 883 | there was no informal medical record that re PPSV23 was adminis offer any explanation Pneumonia Immuniza administered. She stat Managers and the Ur responsible for initiati Immunization series of consented. She state behind the Unit Mana ensure the immunizat During an interview of Coordinator (UC) stat Pneumonia Immunizat consented, and she w that the PPSV23 immuniti stated she learned or could be administered She was unable to ex- the missing PCV13 in completed. During another intervi- the DON stated it was Resident #118's recei Immunization as order 6. Resident #74 was a cumulative diagnoses and Hypertension. Re- revealed a signed cor Pneumonia Immunizat A review of Resident revealed there was no | tion in Resident #118's effected that the PCV13 or stered. She was unable to as to why the consented attions were not ated on admission, the Unit hit Coordinator were ing the Pneumonia on residents who have d she did not routinely go gers or Unit Coordinator to tions were completed. In 2/12/19 at 5:04 PM, Unit ted she administered the ations to residents who had was under the impression funization could not be given initial PCV13 dose. She 0 2/11/19 that the PPSV23 d 8 weeks after the PCV13. cplain why the initial doses of immunizations was not see on 2/14/19 at 11:54 AM, is her expectation that we the Pneumonia ared and done timely. admitted 10/8/18 with of Dementia, weakness eview of the medical record heation. | F | 883 | | | |

Facility ID: 923099

If continuation sheet Page 130 of 132

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 04/10/2019 MAPPROVED D. 0938-0391 | |
|--------------------------|--|---|---------------------|----|---|-------------------|--|--|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | CONSTRUCTION | (X3) DATE COMP | (X3) DATE SURVEY COMPLETED | |
| | | 345421 | B. WING _ | | | | C 14/2019 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | - - | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | - | | |
| | RELS OF CHATHAM | | | 72 | 2 CHATHAM BUSINESS PARK | | | |
| | | | | PI | ITTSBORO, NC 27312 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE | |
| F 883 | Continued From page pneumococcal vaccin | | F٤ | 83 | | | | |
| | Minimum Data Set (M 1/14/19 was reviewed assessment indicated pneumococcal vaccin During an interview of Director of Nursing (D expectation that resid that have consented t Immunization receive ordered. She was una as to why the Pneuma administered for Resi was ultimately respon and Unit Coordinator Infection Control Prev immunizations were a During an interview of Infection Control Prev there was no informat medical record that re PPSV23 was adminis offer any explanation Pneumonia Immuniza administered. She stat Managers and the Un responsible for initiati Immunization series of consented. She state | ation was up to date. n 2/12/19 at 1:50 PM, the DON) stated it was her ents residing at the facility to the Pneumonia the immunization series as able to offer any explanation onia Immunizations were not dent #74. The DON stated it isibility of the Unit Managers with oversight by the ventionist (ICP) to ensure the administered. n 2/12/19 at 2:30 PM, the ventionist (ICP) confirmed tion in Resident #74's effected that the PCV13 or stered. She was unable to as to why the consented ations were not ated on admission, the Unit hit Coordinator were ng the Pneumonia on residents who have d she did not routinely go gers or Unit Coordinator to | | | | | | |
| | During an interview o | n 2/12/19 at 5:04 PM, Unit ed she administered the | | | | | | |

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 04/10/2019 APPROVED). 0938-0391 |
|--------------------------|--|---|--|-----|--|------------------------------------|---|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | |
| | | 345421 | B. WING | | | | 14/2019 |
| NAME OF PF | ROVIDER OR SUPPLIER | | • | S | TREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| | RELS OF CHATHAM | | | | 2 CHATHAM BUSINESS PARK | | |
| | | | | P | PITTSBORO, NC 27312 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 883 | consented, and she w that the PPSV23 imm until 1 year after the in stated she learned on could be administered She was unable to ex the missing PCV13 in completed. | ations to residents who had vas under the impression nunization could not be given nitial PCV13 dose. She of 2/11/19 that the PPSV23 d 8 weeks after the PCV13. Explain why the initial doses of nmunizations was not sew on 2/14/19 at 11:54 AM, s her expectation that re the Pneumonia | F | 883 | | | |
| FORM CMS-256 | 7(02-99) Previous Versions Obs | olete Event ID: PVR | D11 | Fa | cility ID: 923099 If continual | ion sheet P | age 132 of 132 |