| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| THE LAURELS OF CHATHAM | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 4/14/24 through 4/17/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #TE6U11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 4/14/24 through 4/17/24 Event ID#TE6U11. The following intakes were investigated NC00215701, NC00214347, NC00212613, NC00210701, NC00210483, NC00210047, NC00208516, NC00204138, and NC00203104.<br><br>14 of the 21 complaint allegation(s) resulted in deficiency. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, | F 550 | | 5/8/24 |

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

Electronically Signed | 05/08/2024

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| F 550 | Continued From page 1<br>severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff and resident interviews, the facility failed to provide stool incontinence care on night shift for a dependent resident which caused him to feel angry (Resident #59) and failed to communicate with a resident. A reasonable person expects to be provided communication during care and understand what to expect (Resident #15). This deficient practice affected 2 of 3 residents reviewed for dignity.<br><br>Findings included:<br><br>1. | F 550 | The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is May 8, 2024. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.<br><br>F550: | |

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| F 550 | Continued From page 2<br>Resident #59 was admitted to the facility on 9/1/23 with the diagnosis of liver failure.<br><br>Resident #59's Minimum Data Set dated 3/29/24 documented the resident had an intact cognition, was understood and understands others. The resident required staff assistance of one with all activities of daily living. The resident was incontinent of stool.<br><br>Resident #59's care plan dated 3/29/24 documented he had an activity of daily living deficit. The resident was incontinent of stool and the interventions were to check during routine rounds and as needed for incontinence.<br><br>On 4/15/24 at 11:47 am an interview was conducted with Resident #59. Resident #59 stated that the Nursing Assistants (NA) on night shift do not always round until the morning about 5:00 am or 6:00 am. The staff on night shift do not answer the call light or take hours to come when the sun is coming up. "This happened just last night" (4/14/24). "I put the call light on and was sitting in stool for more than 2 hours because staff never rounded every 2 hours and had not answered the call light; this made me feel angry." The NA (NA #11) finally came about 5:00 am (was watching TV and could see the time) and helped me. Resident #59 also commented that he was receiving medication for his liver that caused frequent lose stools, and he had to have incontinence care regularly. The Resident stated his skin was fine, but "I can smell stool. Sitting in stool that long caused the smell to remain."<br><br>On 4/16/24 at 2:30 pm contact with NA #11 who was on staff assigned night shift 4/15/24 to Resident #59 was unsuccessful. | F 550 | The facility will continue to provide timely incontinence care on night shift for dependent residents. The facility will continue to communicate with residents during care so that they understand what to expect.<br><br>Resident #59 will continue to have timely staff assistance with incontinence care on night shift as evidenced by DON and C N A Preceptor observation of being odor free on night shift 5.1.24. No negative ongoing psychosocial outcome was identified relating to this observation.<br><br>Resident #15 will continue to have staff communicate with her during care so that she understands what to expect as evidenced by Regional Clinical Nurse observation of care on 5.1.24. No negative ongoing psychosocial outcome was identified relating to this observation.<br><br>Current residents that require assistance with incontinence care on night shift have the potential to be affected. Current residents that require assistance with incontinence care on night shift were observed during night shift rounds on 5.1.24 by the DON and C N A Preceptor, to ensure that they were being provided with timely incontinence care. No negative psychosocial outcome was identified relating to these observations.<br><br>Current residents that are rarely understood/rarely understand have the potential to be affected. Current residents that are rarely understood/rarely | |

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| F 550 | Continued From page 3<br><br>On 4/17/24 at 12:15 pm an interview was conducted with the Director of Nursing (DON). The DON stated the facility has had a problem with night shift staff answering call lights and providing care. This was reported by residents individually and during the resident council meeting in March 2024. The DON stated, "I thought this was addressed." We provided staff education.<br><br>2.<br>Resident #15 was admitted to the facility on 8/24/19 with the diagnosis of seizure.<br><br>Resident #15's quarterly Minimum Data Set documented the resident was unable to participate in the brief interview for mental status due to confusion. The resident was rarely understood and rarely understands. The resident had behaviors of yelling and screaming during the 7-day look back period. The active diagnosis was psychotic disorder with delusions.<br><br>Resident # 15's care plan had a need for crying spells and yelling out. The interventions were to approach in a quiet, calm manner, encourage participation in activities of daily living, report changes in mood or behavior to include anger and harm to others and self, agitation, and feeling threatened by others. The resident was to have consistency in timing of care and caregivers.<br><br>On 4/14/24 at 11:05 am an observation was done of Resident #15. The resident was receiving care from NA #5. NA #5 was observed to be attempting to place the resident's left arm into her sleeve and the resident was locking her elbow and yelled loud, non-intelligible words while | F 550 | understand were observed during care by the DON, ADON, Unit Managers, C N A Preceptor, and Regional Clinical Nurse between 4.30.24 and 5.3.24, to ensure that staff were communicating during care so that they understand what to expect.<br><br>100% of all nursing assistants and licensed nurses will be inserviced by the ADON as of 5.7.24 on the facility policy for ensuring that residents that require assistance with incontinence care on night shift are provided with timely incontinence care.<br><br>100% of all nursing assistants and licensed nurses will be inserviced by the ADON as of 5.7.24 on the facility expectation that staff will communicate with residents during care so that they understand what to expect.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will randomly observe 3 residents on night shift 3x/week x 4 weeks then 3x/week x 4 weeks then weekly x 4 weeks, then bi-weekly x 4 weeks, to ensure that staff are providing timely incontinence care. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will randomly observe | |

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| F 550 | Continued From page 4<br>looking at the NA. The resident appeared angry by facial expression and wide eyes. NA #5 had not talked to the resident to inform the resident what care was taking place during this time. The resident was yelling unintelligible words and slapped NA #5 with her hand on her arm after repeated attempts by the NA to place the arm in the sleeve. NA #5 continued to remain silent and had not informed the resident of what care was being provided and what to expect. The surveyor talked to the resident to distract, guide, and redirect. The resident stopped yelling and looked at the surveyor with softer eyes.<br><br>On 4/14/24 at 12:55 pm an interview was conducted with NA #5. NA #5 stated she spoke to Resident #15 this morning at the start of care to direct her. NA #5 stated the resident talked to her "normal." NA #5 stated when she tried to place the resident's left arm in the sleeve the resident resisted by locking her arm/elbow and hit her with that same arm/hand. NA #5 stated she had not further directed the resident at this time to cooperate, she had already let the resident know the care that was taking place and the resident talked to her but was not talking now, she was yelling.<br><br>On 4/17/24 at 11:55 am an interview was conducted with the Director of Nursing (DON). The DON was informed of Resident #15's behavior and NA #5's lack of communication during care on 4/14/24. The DON stated that she was aware of Resident #15's behaviors and staff should direct the resident during care and if the resident resisted to stop providing care at that time. | F 550 | communication between staff and 3 residents 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then bi-weekly x 4 weeks to ensure that staff are communicating with residents during care so that they understand what to expect. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>Observation results will be reported to the Administrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through the facility's Quality Assurance Program and through random observations.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |
| F 561 SS=D | Self-Determination | F 561 | | 5/8/24 |

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| F 561 | Continued From page 5<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff interview, the facility failed to honor a resident's right to refuse care when Nursing Assistant (NA) #5 attempted to dress the resident in a gown despite the resident's (Resident #15) physical and verbal behaviors resisting this care. This deficient practice affected 1 of 2 residents reviewed for | F 561 | F561:<br>The facility will continue to honor resident rights to refuse care.<br><br>Resident #15 will continue to have her rights to refuse care honored by staff as evidenced by Regional Clinical Nurse | |

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| F 561 | Continued From page 6<br>choices.<br><br>Findings included:<br>Resident #15 was admitted to the facility on 8/24/19 with the diagnoses of seizure disorder and psychotic disorder with delusions.<br><br>Resident #15's quarterly Minimum Data Set dated 3/15/24 indicated the resident had severely impaired cognition. The resident had verbal behaviors 1 to 6 times per week during the 7-day look back period. The resident required assistance of one staff member for dressing. The resident was coded for refusal of care.<br><br>Resident # 15's care plan had a need for crying spells and yelling out. The interventions were to approach in a quiet, calm manner, encourage participation in activities of daily living, report changes in mood or behavior to include anger and harm to others and self, agitation, and feeling threatened by others. The resident was to have consistency in timing of care and caregivers.<br><br>On 4/14/24 at 11:05 am an observation was done of Resident #15 in her room during morning care. NA #5 was observed to be attempting to place the resident's left arm into her sleeve and the resident was locking her elbow and yelled loud, non-intelligible words while looking at the NA with wide eyes. The resident also appeared angry by facial expression. The resident was yelling unintelligible words and slapped NA #5 with an open hand on her right upper arm after repeated attempts by the NA to place the arm in the sleeve. NA #5 quickly placed the resident's arm in the gown. The resident looked at the NA with an angry stare and started yelling again. NA #5 then placed the sheet on the resident's bare legs and | F 561 | observation of care on 4.30.24. No negative psychosocial outcome was identified relating to this observation.<br><br>Current residents have the potential to be affected. Current residents were observed during care by the DON, ADON, Unit Managers, C N A Preceptor, and Regional Clinical Nurse between 4.30.24 and 5.4.24 to ensure that resident rights to refuse care were being honored. No negative outcome was identified relating to these observations.<br><br>100% of nursing assistants and licensed nurses will be inserviced by the ADON as of 5.7.24 on ensuring that residents rights to refuse care are being honored by staff.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will randomly observe 3 staff to resident interactions 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then bi-weekly x 4 weeks to ensure that staff are honoring resident rights to refuse care. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>Observation results will be reported to the Administrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quality Assurance Committee during monthly meetings. | |

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| F 561 | Continued From page 7<br>the resident kicked it off with her right leg. The NA placed the sheet again to cover the resident's bare legs and the resident kicked the sheet off her legs.<br><br>On 4/14/24 at 12:00 pm an interview was conducted with Unit Supervisor #2. Unit Supervisor #2 was informed of the incident with Resident #15 regarding resisting care and verbal and physical behavior. Unit Supervisor #2 stated if the resident resisted care NA #5 should have waited and not dressed the resident at the time. From the incident, it sounded like the resident had not wanted care at the time.<br><br>On 4/14/24 at 12:55 pm an interview was conducted with NA #5. NA #5 stated when she tried to place the resident's left arm in the sleeve the resident resisted by locking her arm/elbow and hit her with that same arm/hand. NA #5 stated the resident had resisted by body language and had not cooperated by refusing to bend her arm and slapped her. NA #5 stated she placed the sheet over the resident's bare legs and the resident kicked it off. NA #5 stated she attempted to place the sheet again for dignity. NA #5 stated once the care was done, the resident stopped hitting and yelling. NA #5 stated she continued with care because the resident was exposed, and visitors frequently came in the room. NA #5 stated the resident was resisting care and had not wanted to place her arm in the gown or have sheets on her legs. This was a form of communication that the resident had not wanted this care at the time. NA #5 stated the resident had the right to refuse care, but in NA #5's thinking, "the resident had to be covered to prevent exposure and provide privacy." | F 561 | Continued compliance will be monitored through the facility's Quality Assurance Program and through random observations.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |

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| F 561 | Continued From page 8<br>On 4/17/24 at 11:55 am an interview was conducted with the Director of Nursing (DON). The DON was informed of Resident #15's behavior and NA #5's response to the behavior during care on 4/14/24. The DON stated if any resident resisted care with resulting behaviors and hit staff, the staff member were expected to stop providing care and address why the behavior was occurring. | F 561 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. | F 565 | | 5/8/24 |

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| F 565 | Continued From page 9<br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and resident interviews, the facility failed to resolve resident council concerns regarding call bell responses on night shift. (Resident #s 23, 41, 77), and failed to provide the residents a private resident council meeting without staff interference for 2 of 4 months reviewed (March 2024 and April 2024). Findings included:<br><br>1.<br>Resident council meeting minutes/concern form dated 3/5/24 documented by the Activity Coordinator for new business revealed residents had to wait a long time on night shift for staff to answer call lights. The facility response was call bells were to be answered within 3 to 5 minutes. It was everyone's responsibility to answer call bells. If you cannot assist a guest, leave the light on.<br>Resident council meeting minutes/concern form dated 4/2/24 documented by the Activity Coordinator for new business (brought forward from the month before) revealed the Nursing Assistants (NA) on night shift 11:00 pm to 7:00 am do not provide care and round regularly. Old business from last month's minutes: residents are waiting a long time for care on night shift. There was no documented response to the concern reported. | F 565 | F565:<br>The facility will continue to resolve resident council concerns related to timely response to call bells on night shift.<br>The facility will continue to provide residents with a private resident council meeting without staff interference.<br><br>Residents #23, #41, and #77 will continue to have timely staff response to call bells on night shift as evidenced by DON and C N A Preceptor observations on 4.30.24 to 5.1.24. No negative psychosocial outcome was identified relating to this observation.<br><br>Residents #23, #41, and #77 will continue to have private resident council meetings without staff interference as evidenced by Resident Council meeting held on 5.2.24 by the Administrator and Activity Director.<br><br>Current residents have the potential to be affected. Current residents were observed during the night shift on 4.30.24 to 5.2.24 by the DON and C N A Preceptor to ensure that call bells were responded to timely. No negative outcome was identified relating to these observations. | |

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| F 565 | Continued From page 10<br><br>On 4/16/23 at 2:15 pm during the resident council meeting, Resident #s 23, 41, and 77 voiced that night shift nursing assistants were not rounding and providing care and it was taking hours for staff to answer the call light. This had been going on since before March 2024. It had gotten better for a little while but was an ongoing problem at this time and discussed again at the 4/2/24 resident council meeting.<br><br>On 4/16/24 at 2:55 pm an interview was conducted with the Activity Coordinator. The Activity Coordinator stated the concern during the resident council meeting that night shift nursing assistants were not rounding and providing care and taking hours to answer the call light was an ongoing issue. It was reported at the March 2024 meeting and was still reported as a problem at the April 2024 meeting. The Activity Coordinator stated that management was aware.<br><br>On 4/17/24 at 12:15 pm an interview was conducted with the Director of Nursing (DON). The DON stated the facility has had a problem with night shift staff answering call lights and providing care/rounding. This was reported by residents and during the resident council meeting. The DON stated, "I thought this was addressed." We provided staff education last month. The DON stated she was not aware this remained a problem and she was not informed this problem remained after the 4/2/24 resident council meeting.<br><br>2.<br>On 4/16/24 at 2:15 pm a resident council meeting was held in the activity room. There were 4 residents in attendance and a sign was posted on | F 565 | Current residents were observed by the Administrator during a Resident Council meeting on 5.2.24 , to ensure the residents were allowed to have a private resident council meeting without staff interference. No negative outcome was identified relating to these observations.<br><br>100% of nursing assistants and licensed nurses will be inserviced by the ADON as of 5.7.24 on ensuring that call bells are responded to timely. 100% of all staff will be inserviced by the ADON as of 5.7.24 on ensuring that residents are allowed to have private resident council meetings without staff interference.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will randomly observe call bell response time on night shift 3x/week x 4 weeks then weekly x 4 weeks then bi-weekly x 4 weeks to ensure that staff are responding to call bells on night shift timely. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the Administrator/designee beginning on 5.8.24. The Administrator/designee will observe Resident Council meetings monthly x 3 months to ensure that staff are allowing residents to have private resident council meetings without staff interference. | |

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|---|---|---|---|---|
| F 565 | Continued From page 11<br>the door announcing the meeting and not to disturb. NA #8 entered the activity room while the meeting was in progress, interrupted without asking, and asked for the Activity Coordinator.<br><br>On 4/17/24 at 9:20 am an interview was conducted with NA #8. NA #8 stated she entered the resident council meeting unannounced when the sign was observed on the door in error. "I know better not to enter and did not know what I was thinking and went ahead and interrupted to look for the Activity Coordinator."<br><br>On 4/16/23 at 2:15 pm during the resident council meeting when NA #8 entered the activity room unannounced, Resident #s 23, 41, and 77 voiced that the meeting was private, and she was not supposed to do that. "This was wrong."<br><br>On 4/15/24 at 2:55 pm an interview was conducted with the Activity Coordinator. The Activity Coordinator stated the resident council meeting sign was posted not to enter and staff should not have entered during this time.<br><br>On 4/17/24 at 11:55 am an interview was conducted with the Director of Nursing (DON). The DON was informed of NA #8's entry into the resident council meeting. The DON stated the meeting was private and no staff should enter while the meeting was in progress. | F 565 | Observation results will be reported to the Administrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through the facility's Quality Assurance Program and through random observations.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident | F 580 | | 5/8/24 |

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|---|---|---|---|---|
| F 580 | Continued From page 12 | F 580 | | |

representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(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

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|---|---|---|---|---|
| F 580 | Continued From page 13<br>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).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations, and interviews with the Orthopedic nurse, Orthopedic Physician Assistant, Responsible Party (RP) , and staff, the facility failed to notify the orthopedic provider of a newly acquired pressure ulcer caused by a knee immobilizer and that the knee immobilizer was not being worn as ordered for Resident #102's fractured distal femur (the area of the leg just above the knee joint). The facility also failed to notify the RP of the addition and increase of medication prescribed for Resident #173. This was for 2 of 2 residents reviewed for notification.<br><br>The findings included:<br><br>1) Resident #102 was admitted to the facility on 3/2/24 with diagnoses that included fracture of the right femur, bullous pemphigoid (an autoimmune disorder that causes itchy raised rashes and large blisters) and psoriasis.<br><br>The hospital discharge summary dated 3/2/24 indicated Resident #102 was to wear the well-padded knee immobilizer which could be removed for hygiene.<br><br>A review of Resident #102's physician orders included an order dated 3/2/24 to 3/19/24 for right knee immobilizer to be worn at all times. Remove for hygiene, replace padding if removed every shift. | F 580 | F580:<br>The facility will continue to ensure that resident physicians and responsible parties are notified when there is a new pressure ulcer identified and/or a medication change.<br><br>Resident # 102□s orthopedic provider was notified of the newly acquired pressure ulcer by the facility nurse on 4.17.24. No negative outcome was identified relating to this observation. Resident #173 no longer resides in the facility. No negative outcome was identified relating to this observation.<br><br>Current residents have the potential to be affected. An audit was conducted between 5.1.24 □ 5.3.24 by the DON, ADON, and Unit Managers to ensure that resident physicians and responsible parties were notified of any new pressure ulcers and/or medication changes. No negative outcomes were identified relating to these observations.<br><br>100% of licensed nurses were inserviced by the ADON as of 5.7.24 on the facility policy for ensuring that resident physicians and responsible parties are notified of any new pressure ulcers and/or medication changes. | |

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|---|---|---|---|---|
| F 580 | Continued From page 14<br><br>An orthopedic provider progress note dated 3/14/24 indicated Resident #102 was to wear the right knee immobilizer which could be removed for hygiene purposes.<br><br>A review of Resident #102's physician orders included an order dated 3/19/24 for right knee immobilizer to be worn at all times. Remove for hygiene, check skin integrity. Replace padding if removed every shift.<br><br>A nursing progress note dated 4/3/24, timed 2:43 PM, and completed by Nurse #3 read that Resident #102 had a new unstageable wound to the ankle area. The wound care nurse and hospice were notified.<br><br>A skin/wound progress note dated 4/3/24, timed 6:01 PM and completed by the wound nurse indicated there was a sudden onset of a new unstageable wound to the right inner ankle. The area measured 3 centimeters (cm) in length, 2.3 cm in width and 0.3 cm in depth. There was 90% slough tissue and periwound was red. The hall nurse is to notify the family, hospice, and physician and would have the wound provider evaluate on 4/4/24.<br><br>A wound provider progress note dated 4/4/24 indicated Resident #102 had an orthopedic prescribed leg brace that went down to her right ankle. A right inner ankle wound came on rapidly over the last few days and the facility had been treating the wound. The right inner ankle wound was an unstageable pressure ulcer due to the medical device brace. There was no odor to the wound, however there was drainage and necrotic tissue present. The area measured 4.5 cm in | F 580 | A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will audit 5 charts 3x/week x 4 weeks, then 3 charts 3x/week x 4 weeks, then 3 charts weekly x 4 weeks to ensure that resident physicians and responsible parties are notified of any new pressure ulcers and/or medication changes. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated.<br><br>Observation results will be reported to the Administrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |

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|---|---|---|---|---|
| F 580 | Continued From page 15 | F 580 | | |

length, 3 cm in width and 0.2 cm in depth. 80% necrotic tissue was present to the wound.

An orthopedic progress note dated 4/4/24 read that Resident #102 had a postop hinged knee brace that was to be removed for skin checks and hygiene purposes. There was no mention of a pressure ulcer to the right inner ankle.

A nursing progress note dated 4/4/24 indicated that Resident #102 had been seen at the orthopedic clinic with recommendations for the knee immobilizer to stay on and only removed for hygiene and skin checks. The note read "resident has new wound to right inner ankle so knee brace will not be worn. This is to encourage and maintain skin integrity". The note made no reference of contacting the orthopedic provider regarding the new wound or asking if the brace could be discontinued.

A review of the April 2024 Treatment Administration Record (TAR) indicated the right knee immobilizer was not used on 4/3/24, 4/4/24, 4/9/24, 4/10/24, 4/11/24 and 4/12/24.

A review of the nursing progress notes for Resident #102 from 4/1/24 to 4/15/24 indicated that the right knee immobilizer was not in use 4/3/24, 4/4/24, 4/9/24, 4/10/24, 4/11/24 and 4/12/24 for the following reasons:
" Held per management
" Held to maintain skin integrity
" Not in place per Director of Nursing (DON)
" Off per management due to wound

An interview occurred with Nurse Aide (NA) #1 on 4/16/24 at 9:52 AM, who was assigned to care for Resident #102 on the 7:00 AM to 3:00 PM shift.

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|---|---|---|---|---|
| F 580 | Continued From page 16 | F 580 | | |

She stated that the right knee immobilizer was not being used due to the pressure area on the right inner ankle and had been told by management to leave the brace off.

An interview occurred with the wound nurse on 4/16/24 at 10:50 AM who stated that she had not called the orthopedic provider regarding the wound that was identified on 4/3/24 or the decision not to use the right knee immobilizer but had gotten the wound care provider involved. The wound nurse stated management decided it was in Resident #102's best interest not to wear the knee immobilizer due to the wound on her right ankle and the increased pressure it may have caused. She thought a note had been sent with Resident #102 to her orthopedic appointment on 4/4/24 by the floor nurse letting them know of the new wound caused by the right knee immobilizer.

A phone interview occurred with UNC Orthopedic Nurse on 4/16/24 at 3:00 PM. She stated she had received a call from the facility today reporting Resident #102 had a pressure ulcer to her right inner ankle from the knee immobilizer and that the immobilizer was not being used. She added the clinic was unaware she had developed a pressure ulcer to the ankle on 4/3/24 or that the immobilizer was not being used consistently.

On 4/17/24 at 9:25 AM, an interview occurred with Unit Manager #1 who stated she spoke with the orthopedic clinic on 4/16/24 regarding the new wound and decision not to place the immobilizer on the right leg. She was unable to state if the orthopedic provider had been notified verbally prior to 4/16/24.

Nurse #3 was interviewed on 4/17/24 at 9:50 AM.

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| F 580 | Continued From page 17 | F 580 | | |

She was the nurse on duty when the right inner ankle wound was identified on 4/3/24. She stated she notified the medical director, family, and hospice of the new wound. Resident #102 had a follow-up with the orthopedic provider on 4/4/24 and she sent a note about the new wound to her right ankle but did not call the provider to let him know. She further stated when Resident #102 returned from her appointment, the right knee immobilizer was in place, but the DON and wound nurse thought it was best for Resident #102 not to wear the splint due to the new pressure area on her ankle.

The DON and Regional Nurse Consultant were interviewed on 4/17/24 at 10:03 AM and explained the orthopedic provider was notified on 4/16/24 regarding the new wound identified on 4/3/24 and that the right knee immobilizer was not being used. They were unable to state why the orthopedic provider had not been notified prior to 4/16/24, however the hospice nurse and wound care provider had been made aware when the area was first identified. The DON stated a decision was made not to use the knee immobilizer to prevent further pressure areas to the right leg and they should have inquired further with the orthopedic provider.

On 4/17/24 at 5:00 PM, a phone interview occurred with the Orthopedic PA who was familiar with Resident #102. Stated he saw her last in the clinic on 4/4/24, assessed her skin where the brace would have been on the right leg and didn't see any open wounds, but she did have several areas with bandages present. He further stated that Resident #102 had a bad fracture to the right femur but due to her age and fragility conservative management with a knee

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|---|---|
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|---|---|---|---|---|
| F 580 | Continued From page 18 | F 580 | | |

immobilizer was chosen. He could not recall any communication from the facility regarding the pressure wound to Resident #102's right ankle nor the decision not to put the immobilizer prior to 4/16/24.
2. Resident #173 was admitted on 8/13/23 with cumulative diagnoses of Alzheimer's Disease, dementia with behaviors, and Bipolar Disease.

The Quarterly Minimum Data Set dated 9/18/23 indicated Resident #173 had severe cognitive Impairment and exhibited physical and wandering behaviors.

Review of a Physician order dated 9/6/23 for Depakote (anticonvulsant) 125 mg I capsule twice daily for bipolar disorder and a current manic episode. There was no documentation in Resident #173's medical record by nursing or the Physician that Resident #173's RP was notified.

Review of another Physician order dated 9/28 /23 for Depakote Extended Release 24 hour 250mg 1 tablet twice daily for bipolar disorder and a current manic episode. There was no documentation in Resident #173's medical record by nursing or the Physician that Resident #173's RP was notified of the increase in the Depakote dose.

An interview was completed on 4/15/24 at 3:45 PM with Unit Manager #1. She recalled the incident involving a nurse not notifying Resident #173's RP of the addition of Depakote to her medications causing the RP to become upset and not allowing Resident #173 to return to the facility. She stated the nurse was re-educated at the time along with all the nurses on notification.

An interview was completed on 4/16/24 at 11:45

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|---|---|---|---|
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|---|---|---|---|---|
| F 580 | Continued From page 19<br>AM with the Physician. He stated he did not recall speaking the Resident #173's RP but expected someone from the facility to have notified her RP of the addition of the Depakote.<br><br>A telephone interview was completed on 4/16/24 at 2:45 PM with Resident #173's RP. She stated Resident #173 was diagnosed with drug induced delirium at the hospital when she went to the hospital for a fall on 10/8/23 and that was how she discovered the addition of the Depakote to Resident #173's medication regimen. The RP stated nobody from the facility notified her so she went to discuss her concerns with the Director of Nursing (DON) when she picked up Resident #173's belongings. The RP stated the DON would complete an investigation to see what failed and it was determined that the nurse did not follow procedure by letting her know of the addition of Depakote or the increase of the Depakote. The RP stated had she known about the new order for Depakote, she would have asked questions about the side effects along with her recently prescribed Seroquel (antipsychotic).<br><br>An interview was completed on 4/17/24 at 11:00 AM with the Director of Nursing (DON) and the Regional Nurse Consultant. The Regional Nurse Consultant stated it was the expectation of the facility management that the floor nurses notify the RP anytime there was a new or change in a resident medication and then to ensure that it was documented in the residents medical record. | F 580 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary | F 677 | | 5/8/24 |

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|---|---|---|---|---|
| F 677 | Continued From page 20<br>services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff and resident interviews, the facility failed to provide dependent residents nail care (Resident #s 59 and 92) and failed to provide hair care and facial hair shaving (Resident #59) for 2 of 7 residents reviewed for activities of daily living.<br><br>Findings included:<br>1. Resident #59 was admitted to the facility on 9/1/23 with the diagnoses of post-traumatic stress disorder and depression.<br><br>Resident #59's Minimum Data Set dated 3/29/24 documented an intact cognition and no behaviors or rejection of care. The resident required staff assistance of one for bathing and personal care.<br><br>Resident #59's care plan dated 3/29/24 documented he had an activity of daily living deficit and could refuse care, needs assistance with all activities of daily living, and to keep his nails trimmed.<br><br>A review of Resident #59's Nursing Assistant (NA) documentation for personal care, including facial and nail care, were documented "yes" for each day for 4/1/24 through 4/16/24.<br><br>On 04/15/24 at 11:47am Resident #59 was observed to be in his bed wearing a hospital gown. He had greasy, matted hair, long nails with black soil underneath, and long facial hair (approximately an inch).<br><br>On 4/15/24 at 11:47 am an interview was | F 677 | F677:<br>The facility will continue to ensure that dependent residents nails are trimmed and clean, and assistance is provided with shaving facial hair and washing hair.<br><br>Residents #59 and #92 received assistance with trimming/cleaning nails on 4.17.24 per c n a as directed by DON. Resident #59 received assistance with hair care and facial hair shaving on 4.17.24, per c n a as directed by DON. No negative outcome was identified relating to these observations.<br><br>Current residents that require assistance with trimming/cleaning nails, shaving facial hair, and washing hair have the potential to be affected. All current residents that require assistance with trimming/cleaning nails, shaving facial hair, and washing hair were observed by the DON, ADON, Unit Managers, and C N A Preceptor during ADL care by c n a's to ensure that each received assistance as needed. These observations were made between 4.30.24 & 5.1.24. No negative outcome was identified relating to these observations.<br><br>100% of nursing assistants and licensed nurses were inserviced by the ADON as of 5.7.24 on facility policy for providing assistance to residents that require assistance with trimming/cleaning nails, | |

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| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 677 | Continued From page 21<br>conducted with Resident #59. Resident #59 stated he would like to have his hair washed, face shaved, and nail care. He commented he would rather stay in his bed for care. "They can wash my hair in bed but had not offered ever in bed or were supposed to come back after morning care." Resident #59 stated it had been weeks since he had nail care. He had refused to take a shower in the past, so a bed bath was offered, and a partial bed bath was provided. His hair was not washed. The NA had no comment about the resident's hair or nails. NA #5 indicated the resident usually refused a shower but accepted all care in his bed.<br><br>On 4/15/24 at 12:05 pm Unit Supervisor #2 was interviewed and informed of Resident #59's hair, nails, and facial hair and that the resident agreed to receive care in his bed. The Unit Supervisor stated she would have the NA assigned assist the resident with hair wash, nail care, and facial hair trim in his bed. The resident had depression and declined to leave his room. The Unit Supervisor had not observed the resident's hair, facial hair, or nails.<br><br>On 4/16/24 at 9:30 am Resident #56 was lying in his bed and his hair appeared greasy and clumped. The resident stated he had not had his hair washed in the bed and his facial hair and nails remained the same. The resident stated he would accept care in his bed, he did not want a shower. Resident #56 stated he had not declined care in his bed, but he had asked staff to come back after breakfast.<br><br>On 4/16/24 at 9:40 am Unit Supervisor #2 was interviewed. She stated Resident #59 had his hair washed by an NA in his bed yesterday. The | F 677 | shaving facial hair, and washing hair.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will randomly observe 5 residents 5x/weekly x 4 weeks, then 3x/weekly x 4 weeks, then weekly x 4 weeks to ensure that assistance is being provided to residents that require assistance with trimming/cleaning nails, shaving facial hair, and washing hair. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>Observation results will be reported to the Administrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through the facility's Quality Assurance Program and random observations.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.<br><br>Date of compliance: 5.8.24 | |

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|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 677 | Continued From page 22 | F 677 | | |

Supervisor was not aware if staff offered facial hair or nail care. She stated the resident refused a shower but usually accepted care in his bed.

On 4/16/24 at 9:55 am NA #7 was interviewed. NA #7 stated Resident #59 refused a shower but accepted care in his bed. NA #7 stated she noticed the resident's hair was greasy appearing today, but the resident had not wanted a shower. NA #7 stated the resident's hair could have been washed in the bed, but she had not offered. The NA did not comment why hair care was not offered. NA #7 stated the resident had not refused nail care or facial hair care before and she would ask him this morning. NA #7 was not sure why his facial hair was long, and his nails were long and had black soil underneath.

On 4/17/24 at 9:30 am an observation was done of Resident #59. His hair was washed, but his facial hair and nails remained the same.

On 4/17/24 at 9:50 am an interview was conducted with NA #6. NA #6 stated Resident #59 always accepted care. She explained it was about the approach and the resident's needs. NA #6 had not worked with the resident recently and was not aware of his hair and nails needing care.

On 4/17/24 at 11:55 am an interview was conducted with the Director of Nursing (DON). The DON was not aware Resident #59 had not received nail care, facial shaving, and hair care. The DON stated residents that do not get out of their bed can have their care provided in the bed, including hair wash.

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

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|---|---|---|---|---|
| F 677 | Continued From page 23 | F 677 | | |

2. Resident #92 was admitted to the facility on 02/15/24 with diagnosis that moderate protein-calorie malnutrition (inadequate intake of food).

The admission Minimum Data Set (MDS) assessment dated 02/21/24 indicated Resident #92 ' s cognition was moderately impaired with no behaviors or rejection of care. He required maximum assistance of 1 for toileting hygiene, shower/bath, and dressing and moderate assistance of 1 for personal hygiene. He had functional limitations with range of motion to both upper extremities.

Resident #92 ' s active care plan, last reviewed 02/23/24, revealed a focus that read Resident #92 had a functional ability deficit and required assistance with self-care/mobility related to deconditioning, decline in mobility, blindness, cognition, and wounds. The interventions included that staff were to keep fingernails trimmed and clean.

A review of Resident #92's nursing progress notes from 02/15/24 to 04/15/24 revealed no refusals of nail care documented.

An observation was conducted on 04/14/24 at 12:49 PM. Resident #92 ' s fingernails on his left hand were discolored (yellowish), thick, jagged, and long. His pointer and pinky nails extended 1/4 of an inch past the tip of finger. The fingernails on his right hand were discolored (yellowish), thick, jagged, and long. His thumb, pointer and pinky

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|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 677 | Continued From page 24 | F 677 | | |

fingernails extended 1/4 of an inch past the tip of finger.

An observation was conducted on 04/15/24 at 3:42 PM of Resident #92. He was observed in his room in his wheelchair with his bedside table pulled beside him. There were no observed changes in the resident ' s fingernails. The fingernails continued to appear untrimmed, jagged, thick, and discolored.

An observation and interview were conducted on 04/16/24 at 10:20 AM with Resident #92. He was observed in his room in his wheelchair. He stated he would like his fingernails to be cut but no one had offered to do so. He stated if someone would offer to cut his fingernails, he would let them.

An interview and observation were conducted on 04/16/24 at 10:25 AM with Unit Manager #2. She stated the Nursing Assistants (NAs) were responsible for cleaning and cutting residents nails during showers/baths and/or when they see nails needed to be trimmed. No one had reported

Resident #92 ' s fingernails were long or that they needed to be trimmed. She verified Resident #92's nails were discolored (yellowish), thick, jagged, long, and needed to be cut.

An interview was conducted on 04/16/24 at 12:11 PM with Nursing Assistant (NA) #4. She indicated she was the NA assigned to Resident #92 for that day and stated she did nail care daily with her residents. The protocol was to do nail care during baths and as needed. She also stated she reported to nursing that Resident #92's nails were too thick to cut on several occasions.

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|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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| F 677 | Continued From page 25<br>An interview was conducted on 04/17/24 at 10:46 AM with the Director of Nursing (DON) and the Regional Nurse Consultant. The DON stated she was unaware Resident #92 ' s nail care had not been performed. She indicated Nursing Assistants (NAs), and Nurses were to perform nail care during showers and as needed. If they are uncomfortable in doing nail care they are to report it to the unit manager. | F 677 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations and interviews with the Medical Director, Orthopedic nurse, Orthopedic Physician Assistant and staff, the facility failed to apply a right knee immobilizer for a resident with a fractured distal femur (the area of the leg just above the knee joint) as ordered (Resident #102). In addition, the facility transferred a resident with an obvious deformity and pain to the right hip/leg after a fall. (Resident #30). This was for 2 of 3 residents reviewed for well-being.<br><br>The findings included:<br><br>1) Resident #102 was admitted to the facility on | F 684 | F684:<br>The facility will continue to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident□s choices.<br><br>Resident #102 received a new order on 4.15.24 to discontinue the right knee immobilizer. This order was carried out by the Unit Manager on the same date. No ongoing negative outcome was identified relating to this observation. Resident #30 was treated in the hospital | 5/8/24 |

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

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|---|---|---|---|---|
| F 684 | Continued From page 26<br>3/2/24 with diagnoses that included fracture of the right femur.<br><br>The hospital discharge summary dated 3/2/24 indicated Resident #102 was to wear the well-padded knee immobilizer which could be removed for hygiene purposes.<br><br>A review of Resident #102's physician orders included an order dated 3/2/24 to 3/19/24 for right knee immobilizer to be worn at all times. Remove for hygiene, replace padding if removed every shift.<br><br>The admission Minimum Data Set (MDS) assessment dated 3/8/24 indicated Resident #102 had severe cognitive impairment and limited range of motion to one lower extremity. She required maximum assistance with toileting hygiene, bathing, and bed mobility.<br><br>An orthopedic provider progress note dated 3/14/24 indicated Resident #102 was to wear the right knee immobilizer which could be removed for hygiene purposes.<br><br>A review of Resident #102's physician orders included an order dated 3/19/24 for right knee immobilizer to be worn at all times. Remove for hygiene, check skin integrity. Replace padding if removed every shift.<br><br>An orthopedic progress note dated 4/4/24 read that Resident #102 had a postop hinged knee brace that was to be removed for skin checks and hygiene purposes.<br><br>A nursing progress note dated 4/4/24 indicated that Resident #102 had been seen at the | F 684 | on 10.18.23 and returned to the facility on 10.23.23. No ongoing negative outcome was identified relating to this observation.<br><br>Current residents with splints or braces have the potential to be affected. All residents with orders for splints or braces were audited by the Regional Clinical Nurse on 5.1.24 to ensure that each was applied per physician□s order. No negative outcomes were identified relating to these observations.<br><br>Current residents that fall in the facility have the potential to be affected. Current residents that have fallen in the facility in the past 90 days were audited by the Regional Clinical Nurse on 5.1.24 to ensure that post fall measures were carried out per physician orders. No negative outcomes were identified relating to these observations.<br><br>100% of licensed nurses were inserviced by the ADON as of 5.7.24 on ensuring that splints and braces are applied per physician orders and post fall measures are carried out per physician orders.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will audit 3 residents with splints or braces 5x/week x 4 weeks then 3x/week x 4 weeks then weekly x 4 weeks to ensure that splints or braces are applied per physician orders. Variances will be corrected at the time of observation and additional education or corrective | |

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|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 684 | Continued From page 27<br>orthopedic clinic with recommendations for the knee immobilizer to stay on and only removed for hygiene and skin checks. The note read "resident has new wound to right inner ankle so knee brace will not be worn. This is to encourage and maintain skin integrity".<br><br>A review of the April 2024 Treatment Administration Record (TAR) indicated the right knee immobilizer was not used on 4/3/24, 4/4/24, 4/9/24, 4/10/24, 4/11/24 and 4/12/24.<br><br>A review of the nursing progress notes for Resident #102 from 4/1/24 to 4/15/24 indicated that the right knee immobilizer was not in use 4/3/24, 4/4/24, 4/9/24, 4/10/24, 4/11/24 and 4/12/24 for the following reasons:<br>" Held per management<br>" Held to maintain skin integrity<br>" Not in place per Director of Nursing (DON)<br>" Off per management due to wound<br><br>An interview occurred with Nurse Aide (NA) #1 on 4/16/24 at 9:52 AM, who was assigned to care for Resident #102 on the 7:00 AM to 3:00 PM shift, stated that the right knee immobilizer was not being used due to the pressure area on the right inner ankle and had been told by management to leave the brace off.<br><br>An interview occurred with the wound nurse on 4/16/24 at 10:50 AM who stated that she had not called the orthopedic provider regarding the decision not to use the right knee immobilizer due to a new wound on Resident #102's right inner ankle. The wound nurse stated management decided it was in Resident #102's best interest not to wear the knee immobilizer due to the wound on her right ankle and the increased | F 684 | action provided when indicated.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will audit 3 residents that have fallen in the facility weekly x 12 weeks to ensure that post fall measures are carried out per physician orders. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated.<br><br>Observation results will be reported to the Administrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |

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

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|---|---|---|---|---|
| F 684 | Continued From page 28 | F 684 | | |

pressure it may have caused. She thought a note had been sent with Resident #102 to her orthopedic appointment on 4/4/24 by the floor nurse letting them know of the new wound caused by the right knee immobilizer.

A phone interview occurred with UNC Orthopedic Nurse on 4/16/24 at 3:00 PM. She stated she had received a call from the facility today (4/16/24) reporting Resident #102 had a pressure ulcer to her right inner ankle from the knee immobilizer and that the immobilizer was not being used. She added the clinic was unaware she had developed a pressure ulcer to the ankle on 4/3/24 or that the immobilizer was not being used consistently.

On 4/17/24 at 9:25 AM, an interview occurred with Unit Manager #1 who stated she spoke with the orthopedic clinic on 4/16/24 regarding the new wound and decision not to place the immobilizer on the right leg. She was unable to state if the orthopedic provider had been notified verbally prior to 4/16/24.

Nurse #3 was interviewed on 4/17/24 at 9:50 AM. She was the nurse on duty when the right inner ankle wound was identified on 4/3/24. She stated she notified the medical director, family, and hospice of the new wound. Resident #102 had a follow-up with the orthopedic provider on 4/4/24 and she sent a note about the new wound to her right ankle but did not call the provider to let him know. She further stated when Resident #102 returned from her appointment, the right knee immobilizer was in place, but the DON and wound nurse thought it was best for Resident #102 not to wear the splint due to the new pressure area on her ankle. She was unaware if

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 684 | Continued From page 29 | F 684 | | |

the orthopedic provider had been made aware.

The DON and Regional Nurse Consultant were interviewed on 4/17/24 at 10:03 AM and explained the orthopedic provider was notified on 4/16/24 regarding the right knee immobilizer not being used due to a wound on the right inner ankle. The DON stated a decision was made not to use the knee immobilizer to prevent further pressure areas to the right leg and they should have inquired further with the orthopedic provider.

On 4/17/24 at 5:00 PM, a phone interview occurred with the Orthopedic PA who was familiar with Resident #102, and stated he saw her last in the clinic on 4/4/24. He further stated that Resident #102 had a bad fracture to the right femur but due to her age and fragility, conservative management with a knee immobilizer was chosen. He was made aware 4/16/24 that the facility was not applying the knee immobilizer to Resident #102 due to the pressure area on her right ankle. The Orthopedic PA stated the facility was notified today (4/17/24) the if Resident #102 was not getting out of bed it would be ok to leave the knee immobilizer to the right leg off but careful attention needed to be made when moving her right leg.

2. Resident #30 was admitted to the facility on 05/26/21 with diagnoses that included Alzheimer's Disease, Dementia, history of stroke, osteoporosis, and falls.

The quarterly Minimum Data Set (MDS) assessment dated 03/29/24 indicated Resident #30 ' s cognition was severely Impaired. She was dependent on staff for eating, bed mobility, transfers, toilet hygiene, shower/bath, dressing, personal hygiene, and had limited range of

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|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 684 | Continued From page 30 | F 684 | | |

motion impairment to both sides of upper and lower extremities. She was coded for having two or more falls with injury. She was always incontinent of bowel and bladder.

Progress note dated 10/18/23 revealed Resident #30 was observed on the floor at 2:15 AM lying on her back. She was lifted back to bed by two staff members with noted pain in her right hip. They noticed Resident #30 ' s right hip was "unlike the other hip and was misshaped". The physician was notified, and new orders received to obtain x-ray, administer Tylenol, and apply ice to area.

Incident Report dated 10/18/23 revealed Resident #30 was observed on the floor at 2:15 AM lying on her back. Nurse #10 noted pain to right hip and the right hip appeared to be out of alignment and different from the other hip. Resident #30 was lifted back to bed, ice applied, and Tylenol given 650 milligrams (mg) was given. The physician was notified, and new orders received.

The eInteract Situation, Background, Assessment, Recommendation (SBAR) dated 10/18/23 revealed Resident #30 was sent to the emergency room on 10/18/23 at 4:20 AM due to pain rated at a level 5 on a 1-10 scale with 10 being the worst pain to the right trochanter (hip) area. The physician stated that if Resident #30 was having a lot of pain to send out to the emergency department (ED) and if not much pain, then do hip x-ray stat. Hip x-ray ordered.

A Post Falls Evaluation Form, dated 10/18/23, was completed by Nurse #10 indicated Resident #30 was found on the floor beside bed, lying on her back with arms by her side on 10/18/23. The

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 31 | F 684 | | |

report indicated Resident #30 had been provided incontinence care at 2:00 AM and was observed on the floor at 2:15 AM. It also indicated that she was turning or changing position in bed prior to the fall.

An interview was conducted on 04/16/24 at 12:05 PM with the Medical Director (MD). He stated if a resident falls the nurse was to assess them on the floor and if there was pain voiced and/or deformity the resident was to be transferred to the hospital and not moved.

A phone interview was conducted on 04/17/24 at 7:48 AM with Nurse #10. She stated she remembers Resident #30's fall on 10/18/23. She explained that the Nursing Assistant had changed the resident at approximately 2:15 AM. Nurse #10 then stated she came up the hall approximately 15 minutes later when she heard a noise coming from Resident #30's room. Upon entering Resident #30 ' s room she observed her lying on the floor on the left side of the bed in a supine position and voiced pain to her right hip area. She also stated she assessed the resident on the floor and noticed her right hip appeared to be out of alignment and looked different from the other hip. She then had the Nursing Assistant (NA) assist her in transferring Resident #30 back into the bed, each had one side of her body lifting her to the bed. Nurse #10 stated she was aware that moving the resident with a possible hip fracture could cause additional damage and pain. She further stated, "I didn't want to leave her on the floor with a fractured hip". The physician stated if resident was having a lot of pain to send her to the emergency department (ED) and if not in much pain, then do hip x-ray STAT (order should be prioritized first as it's needed urgently). Nurse

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|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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|---|---|
| THE LAURELS OF CHATHAM | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 |

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|---|---|---|---|---|
| F 684 | Continued From page 32<br>#10 indicated she ordered the STAT x-ray, although she did not know why she chose to do so considering the residents pain and hip/leg deformity. The x-ray company was not able to perform the x-ray STAT, so she was transferred to the hospital by emergency medical services (EMS).<br><br>An interview was conducted on 04/17/24 at 10:46 AM with the Director of Nursing (DON) and the Regional Nurse Consultant. The DON stated If a resident falls the nurse was to assess the resident prior to moving them from the floor. If the resident complains of pain or has obvious deformity the nurse is to contact the Medical Director (MD) and call 911 for transfer and evaluation to the hospital. She was unaware Nurse #10 moved Resident #30 after she noted pain and deformity to the right hip.<br><br>Multiple attempts were made to contact Nursing Assistant #3 (NA) on 04/16/24 and 04/17/24 with no success. NA #3 was on duty at the time of Resident #30 ' s fall on 3/18/23. | F 684 | | |
| F 686 SS=G | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent | F 686 | | 5/8/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 686 | Continued From page 33<br>with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations and interviews with the Orthopedic Physician Assistant, Orthopedic Nurse, Wound Physician Assistant, Medical Director, Hospice Aide, and staff, the facility failed to assess Resident #102's skin under an immobilizer used following a fractured distal femur (the area of the leg just above the knee joint). This resulted in the development of an unstageable (full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by eschar (dry, dark scab of dead skin), slough (yellow tissue that is stringy and thick) and granulation tissue (part of the healing process in which lumpy, pink tissue containing new connective tissue and capillaries form around the edges of the wound) pressure ulcer to the right inner ankle. The facility also failed to transcribe and provide protective skin care to a recently healed pressure ulcer (Resident #92). This deficient practice affected 2 of 7 residents reviewed for pressure ulcers.<br><br>The findings included:<br><br>1) Resident #102 was admitted to the facility on 3/2/24 with diagnoses that included fracture of the right femur, bullous pemphigoid (an autoimmune disorder that causes itchy raised rashes and large blisters) and psoriasis. She was admitted to the facility on hospice services.<br><br>The hospital discharge summary dated 3/2/24 | F 686 | F686:<br>The facility will continue to ensure that skin integrity underneath splints or braces is assessed.<br><br>The facility will continue to ensure that protective skin care orders are transcribed per physician orders.<br><br>Resident #102 received a new physicians order to discontinue the right knee immobilizer on 4.15.24. This order was carried out on the same day by the Unit Manager.<br>Resident #92 had protective skin care order per wound care consultant recommendation transcribed by the Unit Manager on 4.16.24.<br><br>Current residents with splints or braces have the potential to be affected. Current residents with splints or braces had audits completed by the Regional Clinical Nurse on 5.1.24 to ensure that residents with splints or braces had orders to check skin integrity underneath the devices. No negative outcomes were identified relating to these assessments.<br><br>Current residents followed by the wound care consultant have the potential to be affected. Current residents followed by the wound care consultant were audited by the Regional Clinical Nurse on 5.1.24. | |

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| THE LAURELS OF CHATHAM | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 |

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|---|---|---|---|---|
| F 686 | Continued From page 34<br>indicated Resident #102 was to wear the well-padded knee immobilizer which could be removed for hygiene.<br><br>A review of Resident #102's physician orders included an order dated 3/2/24 to 3/19/24 for right knee immobilizer to be worn at all times. Remove for hygiene, replace padding if removed every shift.<br><br>The baseline care plan included a focus area initiated on 3/2/24 for being at risk for impaired skin integrity/pressure injury related to deconditioning, decline in mobility, incontinence, malnutrition, fragile skin, and end of life.<br><br>A nursing progress note dated 3/8/24 revealed Resident #102's personal care was provided by the hospice aide and right knee immobilizer was present.<br><br>The admission Minimum Data Set (MDS) assessment dated 3/8/24 indicated Resident #102 had severe cognitive impairment and limited range of motion to one lower extremity. She required maximum assistance with toileting hygiene, bathing, and bed mobility. There were no pressure ulcers, but she was coded for pressure reducing device to the bed, nutrition/hydration intervention to manage skin problems, application of nonsurgical dressing other than to feet and application of ointments/medications other than to feet.<br><br>A review of the weekly skin assessment dated 3/10/24 and completed by Nurse #1 indicated that Resident #102 had no new wounds.<br><br>An orthopedic provider progress note dated | F 686 | to ensure that all wound care consultant recommendations were transcribed per physician orders. No negative outcomes were identified relating to. these audits.<br><br>100% of licensed nurses will be inserviced by the ADON as of 5.7.24 on the facility expectation that routine skin integrity checks underneath splints and braces will be conducted and all wound care consultant recommendations will be transcribed per physician orders.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will audit 3 residents with splints or braces 5x/week x 4 weeks then 3x/week x 4 weeks then weekly x 4 weeks to ensure that routine skin integrity checks underneath splints and braces are conducted. Variances will be corrected at the time of audit and additional education provided when indicated.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will audit 3 residents followed by the wound care consultant 5x/week x 4 weeks then 3x/week x 4 weeks then weekly x 4 weeks to ensure that recommendations are transcribed per physician orders. Variances will be corrected at the time of audit and additional education provided when indicated.<br><br>Audit results will be reported to the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 686 | Continued From page 35<br>3/14/24 indicated Resident #102 was to wear the right knee immobilizer and was okay to remove for hygiene.<br><br>A review of the weekly skin assessments dated 3/16/24 and 3/25/24 and completed by the wound nurse indicated that Resident #102 had no new wounds identified.<br><br>A review of Resident #102's physician orders included an order dated 3/19/24 for right knee immobilizer to be worn at all times. Remove for hygiene, check skin integrity, replace padding if removed every shift.<br><br>A review of the weekly skin assessment dated 3/27/24 and completed by Nurse #2 read that Resident #102 had no new wounds identified.<br><br>A physician progress note dated 4/3/24 and timed 11:26 AM stated Resident #102 was seen for her chronic conditions. He referenced that per nursing Resident #102 had recently completed an antibiotic for the treatment of bullous pemphigoid. It was noted she had sores to her chest and upper extremities but there was no mention of a new pressure ulcer to her right inner ankle.<br><br>A nursing progress noted dated 4/3/24, timed 2:43 PM, and completed by Nurse #3 read that Resident #102 had a new unstageable wound to the ankle area. The wound care nurse and hospice were notified.<br><br>A review of the weekly skin assessment dated 4/3/24 and completed by Nurse #3 read that Resident #102 had one new wound present.<br><br>A skin/wound progress note dated 4/3/24, timed | F 686 | Administrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |

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|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 686 | Continued From page 36 | F 686 | | |

6:01 PM and completed by the wound nurse indicated there was a sudden onset of a new unstageable wound to the right inner ankle. The area measured 3 centimeters (cm) in length, 2.3 cm in width and 0.3 cm in depth. There was 90% slough tissue and periwound was red. The hall nurse is to notify the family, hospice, and physician. Will have wound provider evaluate on 4/4/24.

A wound provider progress note dated 4/4/24 indicated Resident #102 had an orthopedic prescribed leg brace that went down to her right ankle. A right inner ankle wound came on rapidly over the last few days and the facility had been treating the wound. The right inner ankle wound was an unstageable pressure ulcer due to the medical device brace. There was no odor to the wound, however there was drainage and necrotic tissue present. The area measured 4.5 cm in length, 3 cm in width and 0.2 cm in depth. 80% necrotic tissue was present to the wound.

A review of the physician orders included an order dated 4/4/24 to clean the unstageable wound to the right inner ankle, pat dry, skin prep to the periwound, apply Medihoney, calcium alginate ( a dressing used for moderately draining wounds) and cover with a foam dressing every day and as needed if soiled.

An orthopedic progress note dated 4/4/24 read that Resident #102 had a postop hinged knee brace that was to be removed for skin checks and hygiene purposes. There was no mention of a pressure ulcer to the right inner ankle.

Resident #102's care plan included a focus area initiated on 4/6/24 for having actual impaired skin

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 686 | Continued From page 37 | F 686 | | |

integrity related to unstageable to right medial ankle.

A skin and wound evaluation dated 4/10/24 read that Resident #102 had an unstageable pressure ulcer to the right inner ankle that was acquired in-house. The area measured 4.6 cm in length and 2.2 cm in width.

A wound provider progress note dated 4/11/24 indicated Resident #102's right inner ankle pressure wound measured 4 cm in length, 2.7 cm in width and 0.2 cm in depth. There was 60% necrotic tissue present. Resident being seen for right inner ankle wound (medical device related pressure) that had improved from last visit.

On 4/16/24 at 9:52 AM, an interview occurred with Nurse #4 who explained that when Resident #102 was wearing the right knee immobilizer it was removed by the aide or hospice aide during her personal care tasks. They would have alerted her to any changes to the skin or pressure areas.

Nurse Aide (NA) #1 was interviewed on 4/16/24 at 9:56 AM and stated that when she provided personal care to Resident #102, she loosened the right knee immobilizer to make sure her skin was clean and dry and that there were no open areas. She went onto explain she was caring for Resident #102 on 4/3/24 and noticed the open area to her right inner ankle. She notified the nurse duty of her findings.

On 4/16/24 at 10:35 AM, a wound care observation occurred of Resident #102 with the wound care nurse. Resident #102 had been premedicated for pain prior to the dressing change. Yellow slough was present to the center

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|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 686 | Continued From page 38 | F 686 | | |

of the right inner ankle pressure area with pink wound bed visible slightly. There was moderate drainage present and no odor to the wound. Wound care was completed as ordered without signs or symptoms of discomfort. Protective boots were present and alternating air mattress was functioning correctly.

The wound care nurse was interviewed on 4/16/24 at 10:45 AM and stated she assessed the wound when it was first identified on 4/3/24 and saw where the right knee immobilizer ended at the ankle. Wound care was provided, and she was to be seen by the wound provider the following day. She stated the aides would have loosened the brace to look under it during personal care tasks. Any open areas would have been reported to the nurse on duty. The wound care nurse added the pressure area developed very fast on Resident #102.

The Medical Director was interviewed on 4/16/24 at 11:39 AM and stated that Resident #102 had multiple co-morbidities that placed her at risk for pressure ulcers such as her age, fragile skin, pemphigus bullous diagnosis, and her hospice status. He felt the right knee immobilizer causing the pressure ulcer to the right inner ankle was avoidable.

On 4/16/24 at 1:51 PM, a phone interview occurred with the wound care Physician Assistant (PA). She explained she had seen Resident #102 twice. The first time she assessed her right inner ankle wound was on 4/4/24. The immobilizer was off, but staff applied it which was observed to touch the ankle area. She felt the pressure ulcer came from the pressure of the right knee immobilizer. She couldn't say whether the area

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 686 | Continued From page 39 | F 686 | | |

was avoidable or unavoidable, only that the pressure ulcer came from wearing the brace. She added that Resident #102 had risk for pressure ulcers due to her age, hospice status and diagnosis of bullous pemphigus.

A phone interview occurred with UNC Orthopedic Nurse on 4/16/24 at 3:00 PM. She stated she had received a call from the facility today reporting Resident #102 had a pressure ulcer to her right inner ankle from the knee immobilizer. She added the clinic was unaware she had developed a pressure ulcer to the ankle on 4/3/24. She stated she asked the facility if the immobilizer was being taken off for hygiene and was told "they were doing the best they could".

An interview occurred with Nurse #5 on 4/16/24 at 3:42 PM who cared for Resident #102 on the second shift (3:00 PM to 11:00 PM). She stated she had never removed the right knee immobilizer to look at the skin under the brace but that would have bene done by the NAs and treatment nurse.

A phone call was placed to Nurse #2 on 4/17/24 at 8:36 AM. She had completed a skin assessment on Resident #102 on 3/27/24. A message was left for a return call that was not received during the survey.

A phone interview was completed with Nurse #1 on 4/17/24 at 8:37 AM who cared for Resident #102 on the night shift (11:00 PM to 7:00 AM). He completed the skin assessment on 3/10/24. Stated he "believed" he removed the knee immobilizer to complete the skin assessment but would not have removed it any other time. The NA's that provided her bath during the day and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|
| THE LAURELS OF CHATHAM | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 |

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|---|---|---|---|---|
| F 686 | Continued From page 40 | F 686 | | |

the treatment nurse would have removed the immobilizer any other time.

An observation occurred with Unit Manager #1 of the application of the right knee immobilizer to Resident #102. Once the immobilizer was placed on correctly the end of the brace rested on the right ankle.

On 4/17/24 at 9:50 AM, an interview occurred with Nurse #3 and stated that when the right knee immobilizer was loosened for personal care from the NA Resident #102's skin would be red around the closures of the brace. She explained that on 4/3/24 the NA came to her and told her about the new open area to the right inner ankle. It was reported to the wound nurse and to the hospice nurse.

On 4/17/24 at 11:00 AM, an interview was completed with the hospice aide who comes into provide personal care assistance to Resident #102 on Monday and Wednesdays. She explained that she provided a bath, personal and oral care and assesses her skin condition. She added that she didn't remove or loosen the immobilizer to the right leg when she provided her care so was unable to assess her skin condition to that area.

A phone interview occurred with NA #2 on 4/17/24 at 11:13 AM who provided scheduled baths and personal care to Resident #102 on the 7:00 AM to 3:00 PM shift. She stated she had not removed or loosened the right knee immobilizer when providing personal care or bathing assistance to Resident #102.

On 4/17/24 at 5:00 PM, a phone interview

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| F 686 | Continued From page 41 | F 686 | | |

occurred with the Orthopedic PA who was familiar with Resident #102. Stated he saw her last in the clinic on 4/4/24, assessed her skin where the brace would have been on the right leg and didn't see any open wounds, but she did have several areas with bandages present. He further stated that Resident #102 had a bad fracture to the right femur but due to her age and fragility conservative management with a knee immobilizer was chosen. She was at a high risk for pressure ulcers and had asked that the splint be removed for hygiene purposes as well as skin checks.
2. Resident #92 was admitted to the facility on 02/15/24 with diagnosis that included proteus mirabilis (a species of bacteria that infects the urinary tract of the human body) as the cause of diseases and moderate protein-calorie malnutrition (inadequate intake of food).

The admission Minimum Data Set (MDS) assessment dated 02/21/24 indicated Resident #92 ' s cognition was moderately impaired with no behaviors or rejection of care. He required maximum assistance of 1 for toileting hygiene, shower/bath, and dressing and moderate assistance of 1 for personal hygiene. He had functional limitations with range of motion to both upper extremities. Residents #92 was coded for having two stage 2 and one stage 3 pressure ulcers that were present on admission that required treatment.

Resident #92 ' s active care plan, last reviewed 02/23/24, revealed a that Resident #92 was at risk for further impaired skin integrity/pressure injury related to deconditioning, decline in mobility, fragile skin, incontinence, current wounds, and malnutrition. The interventions

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE LAURELS OF CHATHAM | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 |

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|---|---|---|---|---|
| F 686 | Continued From page 42 | F 686 | | |

included for staff to follow facility policies/protocols for the prevention/treatment of impaired skin integrity.

A wound provider progress note dated 04/11/24 revealed an open area to Resident #92 ' s right heel was healed and a recommendation for skin prep every shift for protection for at least 7 days was noted.

A nursing progress note dated 04/11/24 written by the Wound Nurse revealed Resident #92 was seen by wound care provider. Per wound care provider, stage 4 wound to right heel has healed, and wound has been resolved. No further follow up or treatments needed at this time.

A review of Resident #92's physician orders from 04/11/24 to 04/16/24 revealed no order for skin prep to right heel.

An interview was conducted on 04/16/24 at 10:20 AM with Resident #92. He stated his pressure ulcers had healed as of last week and refused to allow observation of his right heel. He stated there was nothing there to look. He denied staff applying anything to it.

An interview was conducted on 04/16/24 at 2:33 PM with the Wound Nurse. She verified the wound consultation note had a recommendation for skin prep every shift for protection for at least 7 days was noted. She also verified all new orders are noted on the wound care consult note, however, she stated she must have missed the order. She verified there was no active or discontinued order for skin prep to Resident #92 ' s right heel and she had not been applying it.

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| F 686 | Continued From page 43<br>An interview was conducted on 04/17/24 at 10:46 AM with the Director of Nursing (DON). She stated the Wound Nurse was responsible for transcribing all orders/recommendations noted by the Wound Care Physician Assistant (PA). She was unaware the order had not been transcribed. | F 686 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. | F 756 | | 5/8/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F 756 | Continued From page 44<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:<br>Based on staff, Physician and Consultant Pharmacist interviews and record review, the Consultant Pharmacist failed to identify the lack of documentation for the monitoring of side effects for a resident prescribed antipsychotic medications. This was for 1 (Resident #173) of 7 residents reviewed for unnecessary medications. The findings included:<br><br>Resident #173 was admitted on 8/13/23 with cumulative diagnoses of Alzheimer's Disease, dementia with behaviors, and Bipolar Disease.<br><br>Review of Resident #173's admission Physician orders included an order dated 8/13/23 for Zyprexa (antipsychotic) 2.5 milligrams (mg) every 6 hours as needed for psychotic disorder x 14 days until 8/27/23.<br><br>Resident #173 was care planned on 8/14/23 for a risk for adverse reactions and side effects related to receiving multiple psychotropic medications which included an antipsychotic. Interventions for the antipsychotic included to observed for sedation, headaches, dizziness, diarrhea, anxiety, tremors, orthostatic hypotension, blurred vision, extrapyramidal (impaired motor control) side effects to include akathisia (inability to stay still) restlessness, dystonia (involuntary muscle | F 756 | F756:<br>The Consultant Pharmacist will continue to identify the need for monitoring of side effects for residents prescribed antipsychotic medications.<br><br>Resident #173 no longer resides in the facility. No negative outcome was identified relating to this observation.<br><br>Current residents prescribed antipsychotic medications have the potential to be affected. All current residents prescribed antipsychotic medications were audited to ensure that orders for monitoring for side effects are in place. No negative outcomes were identified relating to these observations.<br><br>The Consultant Pharmacist was educated as of 5.2.24 by the clinical manager on ensuring that residents prescribed antipsychotic medications have orders for monitoring for side effects in place.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will audit 3 guests | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 756 | Continued From page 45 | F 756 | | |

contractions) and tardive dyskinesia (chronic condition that results in involuntary, sudden, irregular movement of the face body or both).

Review of a Consultant Pharmacist medication review note dated 8/15/23 read there was nothing "inconsistent with customary, accepted clinical approaches to providing pharmaceutical products or services or that could reasonably be expected to impede or interfere with the achievement of the intended or reasonably expected outcomes."

Review of another Physician order dated 8/16/23 for Seroquel (antipsychotic) 25 mg twice a day for bipolar disorder and a current manic episode. There were no orders or adverse side effect monitoring.

Review of Resident #173's behaviors monitoring documentation read she had the following behaviors on the follow days for August 2023:
8/13/23-aggressive behavior
8/15/23-wandering
8/17/23 inappropriate language
8/19/23-wandering
8/22/23-wandering x 2
8/23/23-wandering and aggressive behavior
8/24/23-aggressive behavior
8/26/23-wandering
8/28/23-wandering and aggressive behaviors
8/29/23-aggressive behavior x 2
8/31/23-aggressive behavior

Review of Resident #173's nursing notes and medication administration record (MAR) for August 2023 did not include any documentation of monitoring of adverse side effects.

prescribed antipsychotic medication weekly x 12 weeks to ensure that orders for monitoring for side effects are in place. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated.

Observation results will be reported to the Administrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quality Assurance Committee during monthly meetings.

Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program.

Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 756 | Continued From page 46 | F 756 | | |

Review of Resident #173's September 2023 Physician orders included an order dated 9/5/23 to add Seroquel 100 mg at bedtime.

Review of a Consultant Pharmacist medication review note dated 9/7/23 read there was nothing "inconsistent with customary, accepted clinical approaches to providing pharmaceutical products or services or that could reasonably be expected to impede or interfere with the achievement of the intended or reasonably expected outcomes."

Review of Resident #173's aide behavior monitoring documentation read she had the following behaviors on the follow days for September 2023:

9/1/23-aggressive behavior, rejection of care, wandering
9/5/23-aggressive behavior
9/7/23-rejection of care
9/12/23-aggressive behavior
9/14/23-rejection of care
9/16/23-wandering
9/18/23-rejection of care x 2
9/26/23-wandering
9/27/23-rejection of care
9/29/23-wandering
9/30/23-wandering

Review of Resident #173's nursing notes and MAR for September 2023 did not include any documentation of monitoring of adverse side effects.

The Quarterly Minimum Data Set dated 9/18/23 indicated Resident #173 had severe cognitive Impairment and exhibited physical and wandering

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F 756 | Continued From page 47 | F 756 | | |

behaviors.

Review of Resident #173's behaviors monitoring documentation read she had the following behaviors on the follow days for October 2023:
10/4/23-rejection of care
10/5/23-wandering

Review of Resident #173's nursing notes and MAR for October 2023 did not include any documentation of monitoring of adverse side effects.

Review of a Consultant Pharmacist medication review note dated 10/5/23 read there was nothing "inconsistent with customary, accepted clinical approaches to providing pharmaceutical products or services or that could reasonably be expected to impede or interfere with the achievement of the intended or reasonably expected outcomes."

Review of Resident #173's nursing notes from 8/13/23 to 10/8/23 did not include any documentation regarding any observations of her presenting over sedated or difficult to arouse.

An interview was completed on 4/15/24 at 3:45 PM with Unit Manager #1. She recalled Resident #173 stating she was admitted from a sister facility. Unit Manager #1 stated while she resided at the facility, Resident #173 was combative, wandered into other residents rooms and frequently refused her medications with resulted in worsening of her behaviors. She did not recall any occasion where Resident #173 was difficult to arouse or appeared over sedated.

An interview was completed on 4/16/24 at 8:30 AM with Nurse #11. She stated she was not

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 756 | Continued From page 48 | F 756 | | |

working at the facility at the time Resident #173 resided there. She stated whenever a resident was admitted, readmitted or newly prescribed a psychotropic medication, there had to be an order for target behaviors monitoring and side effect monitoring.

An interview was completed on 4/16/24 at 11:45 AM with the Physician. He stated when Resident #173 was admitted, her behaviors were impeding her care so he prescribed Seroquel, made an increase to the Seroquel and added an anticonvulsant. The Physician stated anytime a resident was prescribed an antipsychotic medication, it was imperative for staff to monitor for adverse side effects such as tardive dyskinesia and over sedation.

An interview was completed on 4/16/24 at 9:10 AM with Nurse #12. She stated she did not recall Resident #173. She stated anytime a resident was prescribed an antipsychotic, there should be monitoring of adverse side effects like tremors, sedation and symptoms of tardive dyskinesia.

An interview was completed on 4/16/24 at 2:10 PM with Nursing Assistant (NA) #10. She stated Resident #173 refused her medications and was combative during care. NA #10 did not recall any occasion where Resident #173 appeared over sedated or difficult to arouse.

A telephone interview was completed on 4/16/24 at 3:55 PM with the Consultant Pharmacist. He stated he should have noted there were no orders or documentation of monitoring for adverse side effects related to Resident #173's antipsychotic medications. He stated it was an oversight due to the efforts of the facility attempts to regulate

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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| F 756 | Continued From page 49<br>Resident #173's behaviors.<br><br>An interview was completed on 4/17/24 at 11:00 AM with the Director of Nursing (DON) and the Regional Nurse Consultant. The Regional Nurse Consultant stated the Consultant Pharmacist should have identified the need for observation to ensure Resident #173 was not experiencing any adverse side effects associated with taking antipsychotic medications. | F 756 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; | F 758 | | 5/8/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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| F 758 | Continued From page 50<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and Physician interviews and record review, the facility failed to identify the lack of documentation for the monitoring of side effects for a resident prescribed antipsychotic medications. This was for 1 (Resident #173) of 7 residents reviewed for unnecessary medications. The findings included:<br><br>Resident #173 was admitted on 8/13/23 with cumulative diagnoses of Alzheimer's Disease, dementia with behaviors, and Bipolar Disease.<br><br>Review of Resident #173's admission Physician orders included an order dated 8/13/23 for Zyprexa (antipsychotic) 2.5 milligrams (mg) every 6 hours as needed for psychotic disorder x 14 | F 758 | F758:<br>The facility will continue to ensure that residents prescribed antipsychotic medications are monitored for side effects.<br><br>Resident #173 no longer resides in the facility. No negative outcome was identified relating to this observation.<br><br>Current residents prescribed antipsychotic medications have the potential to be affected. All current residents prescribed antipsychotic medications were audited to ensure that orders for monitoring for side effects are in place. No negative | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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| F 758 | Continued From page 51<br>days until 8/27/23.<br><br>Resident #173 was care planned on 8/14/23 for a risk for adverse reactions and side effects related to receiving multiple psychotropic medications which included an antipsychotic. Interventions included to observed for sedation, headaches, dizziness, diarrhea, anxiety, tremors, orthostatic hypotension, blurred vision, extrapyramidal (impaired motor control) side effects to include akathisia (inability to stay still) restlessness, dystonia (involuntary muscle contractions) and tardive dyskinesia (chronic condition that results in involuntary, sudden, irregular movement of the face body or both).<br><br>Review of another Physician order dated 8/16/23 for Seroquel (antipsychotic) 25 mg twice a day for bipolar disorder and a current manic episode. There were no orders or adverse side effect monitoring.<br><br>Review of Resident #173's behaviors monitoring documentation read she had the following behaviors on the follow days for August 2023:<br>8/13/23-aggressive behavior<br>8/15/23-wandering<br>8/17/23 inappropriate language<br>8/19/23-wandering<br>8/22/23-wandering x 2<br>8/23/23-wandering and aggressive behavior<br>8/24/23-aggressive behavior<br>8/26/23-wandering<br>8/28/23-wandering and aggressive behaviors<br>8/29/23-aggressive behavior x 2<br>8/31/23-aggressive behavior | F 758 | outcomes were identified relating to these observations.<br><br>100% of licensed nurses were educated as of 5.7.24 on ensuring that residents prescribed antipsychotic medications have orders for monitoring for side effects in place.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will audit 3 guests prescribed antipsychotic medication weekly x 12 weeks to ensure that orders for monitoring for side effects are in place. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated.<br><br>Observation results will be reported to the Administrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through random observations and through the facility□s Quality Assurance Program.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 758 | Continued From page 52 | F 758 | | |

Review of Resident #173's nursing notes and medication administration record (MAR) for August 2023 did not include any documentation of monitoring of adverse side effects.

Review of Resident #173's September 2023 Physician orders included an order dated 9/5/23 to add Seroquel 100 mg at bedtime.

Review of Resident #173's aide behavior monitoring documentation read she had the following behaviors on the follow days for September 2023:

9/1/23-aggressive behavior, rejection of care, wandering
9/5/23-aggressive behavior
9/7/23-rejection of care
9/12/23-aggressive behavior
9/14/23-rejection of care
9/16/23-wandering
9/18/23-rejection of care x 2
9/26/23-wandering
9/27/23-rejection of care
9/29/23-wandering
9/30/23-wandering

Review of Resident #173's nursing notes and MAR for September 2023 did not include any documentation of monitoring of adverse side effects.

The Quarterly Minimum Data Set dated 9/18/23 indicated Resident #173 had severe cognitive Impairment and exhibited physical and wandering behaviors.

Review of Resident #173's behaviors monitoring documentation read she had the following

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 758 | Continued From page 53 | F 758 | | |

behaviors on the follow days for October 2023:
10/4/23-rejection of care
10/5/23-wandering

Review of Resident #173's nursing notes and MAR for October 2023 did not include any documentation of monitoring of adverse side effects.

Review of Resident #173's nursing notes from 8/13/23 to 10/8/23 did not include any documentation regarding any observations of her presenting over sedated or difficult to arouse.

An interview was completed on 4/15/24 at 3:45 PM with Unit Manager #1. She recalled Resident #173 stating she was admitted from a sister facility. Unit Manager #1 stated while she resided at the facility, Resident #173 was combative, wandered into other residents rooms and frequently refused her medications with resulted in worsening of her behaviors. She did not recall any occasion where Resident #173 was difficult to arouse or appeared over sedated.

An interview was completed on 4/16/24 at 8:30 AM with Nurse #11. She stated she was not working at the facility at the time Resident #173 resided there. She stated whenever a resident was admitted, readmitted or newly prescribed a psychotropic medication, there had to be an order for target behaviors monitoring and side effect monitoring.

An interview was completed on 4/16/24 at 11:45 AM with the Physician. He stated when Resident #173 was admitted, her behaviors were impeding her care so he prescribed Seroquel, made an increase to the Seroquel and added an

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 758 | Continued From page 54<br>anticonvulsant. The Physician stated anytime a resident was prescribed an antipsychotic medication, it was imperative for staff to monitor for adverse side effects such as tardive dyskinesia and over sedation.<br><br>An interview was completed on 4/16/24 at 9:10 AM with Nurse #12. She stated she did not recall Resident #173. She stated anytime a resident was prescribed an antipsychotic, there should be monitoring of adverse side effects like tremors, sedation and symptoms of tardive dyskinesia.<br><br>An interview was completed on 4/17/24 at 11:00 AM with the Director of Nursing (DON) and the Regional Nurse Consultant. The Regional Nurse Consultant stated the facility should have identified the need for observation to ensure Resident #173 was not experiencing any adverse side effects associated with taking antipsychotic medications. | F 758 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident | F 842 | | 5/8/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 842 | Continued From page 55 | F 842 | | |

that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE LAURELS OF CHATHAM | 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 |

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|---|---|---|---|---|
| F 842 | Continued From page 56<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to have complete and accurate medical records in the areas of wound care (Residents #273 and #274). This was for 2 of 7 closed records reviewed.<br><br>The findings included:<br><br>1) A review of Resident #273's February 2024 Treatment Administration Record (TAR) revealed wound care to the left great toe amputation site was not signed as completed or refused by the resident on 2/8/24 and 2/15/24.<br><br>A phone interview was completed with Nurse #6 on 4/16/24 at 2:51PM. She was assigned to care for Resident #273 on 2/8/24. Nurse #6 stated she recalled completing wound care as ordered for Resident #273 but must have gotten busy and forgot to sign off as completed.<br><br>A phone interview occurred with Nurse #7 on 4/16/24 at 9:11 AM, who was assigned to care for Resident #273 on 2/15/24. Nurse #7 stated she completed wound care to her left great toe area as ordered but must have forgotten to sign off as | F 842 | F842:<br>The facility will continue to maintain complete and accurate medical records in the areas of wound care.<br><br>Residents #273 and #274 no longer reside in the facility. No negative outcome was identified relating to these observations.<br><br>Current residents with orders for wound care have the potential to be affected. Medical records for current residents with orders for wound care were reviewed by the Unit Managers between on 5.6.24 to ensure that wound care was documented appropriately. No negative outcomes were identified relating to these observations.<br><br>100% of licensed nurses were inserviced by the ADON as of 5.7.24 on the facility policy for ensuring that medical records for wound care are accurate.<br><br>A QA monitoring tool will be utilized to | |

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|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 842 | Continued From page 57<br>complete.<br><br>On 4/17/24 at 10:03 AM, an interview was conducted with the Director of Nursing (DON) who stated she expected documentation to be complete and accurate.<br><br>2) A review of the April 2023 to July 2023 Treatment Administration Records (TARs) revealed the wound care to the left lower extremity pin sites was not signed off as completed or refused by Resident #274 on 4/11/23, 4/12/24, 4/13/24, 4/15/24, 4/21/23, 6/19/23, 6/25/23, 7/14/23 and 7/17/23.<br><br>A phone interview occurred with Nurse #6 on 4/16/24 at 2:51 PM. She was the nurse assigned to provide wound care to Resident #274 on 7/14/23. She recalled providing wound care to Resident #274's pin sites on her leg but must have forgotten to sign it off as completed.<br><br>On 4/17/24 at 9:43 AM, an interview was completed with the wound nurse. She had been assigned to care for Resident #274 on 4/12/23 and 4/21/23. She stated she always made sure to do wound care but must have gotten busy and forgot to sign it off as completed.<br><br>Multiple phone calls were made to Nurse #9 during the survey with no return call received. She was the nurse assigned to provide wound care to Resident #274 on 4/13/23 and 6/25/23.<br><br>Multiple phone calls were made to Nurse #8 during the survey to no avail. She was the nurse assigned to provide wound care to Resident #274 on 4/11/23, 4/15/23, 6/19/23 and 7/17/23. | F 842 | ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will randomly audit wound care documentation for 5 residents 5x/week x 2 weeks, then 5 residents 3x/week x 2 weeks, then 5 residents weekly x 4 weeks, then 5 residents biweekly x 4 weeks to ensure that documentation for wound care is accurate. Variances will be corrected at the time of audit and additional education or corrective action provided when indicated.<br><br>Audit results will be reported to the Administrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through random medical records audits and through the facility□s Quality Assurance Program.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |

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|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 842 | Continued From page 58<br><br>On 4/17/24 at 10:03 AM, an interview was conducted with the Director of Nursing (DON) who stated she expected documentation to be complete and accurate | F 842 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. | F 867 | | 5/8/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 867 | Continued From page 59<br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.<br><br>§483.75(d) Program systematic analysis and systemic action.<br><br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, | F 867 | | |

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|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 867 | Continued From page 60 | F 867 | | |

resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 867 | Continued From page 61<br>available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification survey dated 2/9/23 in order to achieve and sustain compliance. This was for recited deficiencies on a recertification survey on 4/14/24. The deficiencies were in the areas of dignity (550), activities of daily living, pressure ulcer, and accurate medical records. The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective quality assurance program.<br><br>The findings included:<br><br>This tag is cross-referenced to:<br><br>F550: Based on record review, observation, and staff and resident interviews, the facility failed to provide stool incontinence care on night shift for a dependent resident which caused him to feel angry (Resident #59) and failed to communicate with a resident. A reasonable person expects to be provided communication during care and understand what to expect (Resident #15). This deficient practice affected 2 of 3 residents reviewed for dignity.<br><br>During the previous recertification survey on 2/9/23, the facility failed to provide a dignified dining experience by providing residents with disposable food containers and plastic utensils during three observed meals and referring to a resident who needed assistance with meals as a "feeder". This was for 3 of 9 residents reviewed | F 867 | F867<br><br>The facility will continue to ensure that the QAPI Committee implements, monitors, and revises action plans as needed in order to achieve and sustain compliance.<br><br>The facility will continue to provide timely incontinence care on night shift for dependent residents.<br><br>The facility will continue to communicate with residents during care so that they understand what to expect.<br><br>The facility will continue to provide a dignified dining experience by providing residents with regular plates and utensils.<br><br>The facility will refrain from referring to residents as feeders.<br><br>The facility will continue to ensure that dependent residents nails are trimmed and clean, and assistance is provided with shaving facial hair and washing hair.<br><br>The facility will continue to ensure that assistance is provided with bathing.<br><br>The facility will continue to ensure that skin integrity underneath splints or braces is assessed.<br><br>The facility will continue to ensure that protective skin care orders are transcribed | |

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|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

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|---|---|---|---|---|
| F 867 | Continued From page 62<br>for dignity. Based on the reasonable person concept residents would expect to utilize regular plates and utensils regardless of how fast they eat and would not expect to be identified as a "feeder." Requiring a resident to utilize disposable food containers and plastic utensils while other residents were not or being labeled a "feeder" has the potential for a reasonable person to experience a negative psychosocial outcome.<br><br>F677: Based on record review, observation, and staff and resident interviews, the facility failed to provide dependent residents nail care (Resident #s 59 and 92) and failed to provide hair care and facial hair shaving (Resident #59) for 2 of 7 residents reviewed for activities of daily living.<br><br>During the previous recertification survey on 2/9/23, the facility failed to trim and clean dependent residents' nails (Residents #66, #28, #114, #40, #116 and #58) and failed to assist with shaving (Resident #84). In addition, the facility failed to assist a resident with bathing (Resident #33). This was for 8 of 12 residents reviewed for Activities of Daily Living (ADLs).<br><br>F686: Based on record reviews, observations and interviews with the Orthopedic Physician Assistant, Orthopedic Nurse, Wound Physician Assistant, Medical Director, Hospice Aide, and staff, the facility failed to assess Resident #102's skin under an immobilizer used following a fractured distal femur (the area of the leg just above the knee joint). This resulted in the development of an unstageable (full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by eschar (dry, dark scab of dead skin), slough (yellow | F 867 | per physician orders.<br><br>The facility will continue to ensure that alternating pressure reducing air mattresses are set according to resident□s weight.<br><br>The facility will continue to maintain complete and accurate medical records in the areas of wound care.<br><br>Current residents have the potential to be affected. See specific plans of correction under F550, F677, F686, and F842.<br><br>The Administrator and DON consulted with Alliant QIO on 4.30.24.<br><br>The QAPI Committee completed a root cause analysis for each repeat deficiency on 5.1.24.<br><br>The facility's quality assurance committee was inserviced by the Regional Clinical Coordinator on the procedures for developing and implementing appropriate plans of action to correct identified quality concerns on 5.1.24. Education included determining the root cause of the identified concerns, and identifying, implementing, and monitoring the corrective action plan and recognizing when an action plan may need to be revised.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance for by the Administrator/designee beginning on 5.8.24. The Administrator/designee will | |

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

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|---|---|---|---|---|
| F 867 | Continued From page 63<br>tissue that is stringy and thick) and granulation tissue (part of the healing process in which lumpy, pink tissue containing new connective tissue and capillaries form around the edges of the wound) pressure ulcer to the right inner ankle. The facility also failed to transcribe and provide protective skin care to a recently healed pressure ulcer (Resident #92). This deficient practice affected 2 of 7 residents reviewed for pressure ulcers.<br><br>During the previous recertification survey on 2/9/23, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 3 of 12 residents reviewed for pressure ulcers.<br><br>F842: Based on record review and staff interviews, the facility failed to have complete and accurate medical records in the areas of wound care (Residents #273 and #274). This was for 2 of 7 closed records reviewed.<br><br>During the previous recertification survey on 2/9/23, the facility failed to provide a dignified dining experience by providing disposable food containers and referring to a resident as a feeder, failed to provide nail care, facial hair shaving, and bathing, failed to assure the pressure reduction mattress was correctly set, and failed to maintain accurate medical records for wound care.<br><br>On 4/17/24 at 12:30 pm an interview was conducted with the Administrator. The Administrator stated the facility had hired more staff to address the need for activities of daily living which affected the resident's dignity and care and the resident that acquired the pressure ulcer from the splint has had an improvement in | F 867 | randomly observe 5 staff to resident interactions weekly x 12 weeks to ensure that the facility is in compliance with the elements of F550. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will randomly observe 5 residents weekly x 12 weeks to ensure that the facility is in compliance with the elements of F677. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will randomly audit 5 resident records and observe skin condition weekly x 12 weeks to ensure that the facility is in compliance with the elements of F686. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will randomly observe 5 resident medical records weekly x 12 weeks to ensure that the facility is in compliance with the elements of F842. Variances will be corrected at the time of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345421 | A. BUILDING _____ B. WING _____ | C 04/17/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 867 | Continued From page 64<br>her wound. The facility had hired a new wound care company to manage the facility's wounds and a new medical staff management firm to manage the medical care and would provide a nurse practitioner 5 weekdays. The Administrator had no comment regarding the inaccurate medical records. The Administrator had no comment regarding the inaccurate medical records. The facility has a quality assurance/performance improvement committee that meets once a month and as needed. The members include the Administrator, Medical Director, Director of Nursing, and all department heads. Plans of correction are presented at the monthly meetings by the Director of Nursing. | F 867 | audit and additional education provided when indicated.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Nurse beginning on 5.8.24. The Regional Clinical Coordinator will attend the facility quality assurance committee meeting monthly x 3 months to ensure committee is developing and implementing appropriate plans of action to correct quality concerns. Variances will be corrected and/or additional education provided when indicated.<br><br>Audit results will be reported to the Regional Clinical Nurse monthly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through random audits and through the facility's Quality Assurance Program.<br><br>Compliance will be monitored by the QA Committee and the Regional Clinical Nurse for 3 months or until resolved and additional education/training will be provided for any issues identified. | |