

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345421	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/05/2015
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF CHATHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted on 03/05/2015. Event ID # 236411.	F 000			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to cover a urinary drainage bag to provide privacy 1 of 4 sampled residents (Resident#144). Findings included: Resident # 144 was admitted on 10/28/14 with diagnoses that included urinary retention secondary to bilateral prostatic hypertrophy requiring an indwelling urinary catheter. The resident's care plan, last reviewed on 2/11/15, did not address covering the urinary drainage bag to provide privacy. Review of a Report of Consultation, dated 2/20/15, revealed the resident had seen the urologist and during the appointment, his catheter had been changed. An observation was made on 3/2/15 at 3:06 PM. The resident was in his room. The catheter	F 241	The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is November 26, 2014 Preparation and/or execution of this plan does not constitute admission to nor agreement with either the existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. F241 The privacy bag for #144 was provided and installed. All other residents with urinary drainage bags were audited by the Administrator and found to have privacy bags in place. Urinary privacy bags will be in stock, and nursing staff will be inserviced on the importance of having these in place for residents requiring them. Each week for four weeks all residents	3/23/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/18/2015

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

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F 241	<p>Continued From page 1</p> <p>drainage bag for Resident #144 was visualized from the hall and was observed not to be covered with a privacy bag.</p> <p>Resident #144 was observed in the hallway on 3/3/15 at 3:17 PM. The catheter drainage bag had been covered.</p> <p>At 2:05 PM on 3/4/15, an observation was made of Resident #144 lying in bed. His urinary catheter bag was uncovered and easily visualized from the hall.</p> <p>An interview was held with Nursing Assistant (NA)#1 on 3/4/15 at 2:16 PM. NA #1 stated she had cared for Resident #144 that day. She stated she had been taught to cover the urinary drainage bag for privacy and to maintain the resident's dignity. NA #1 added privacy covers were available in the facility. She stated she had not reported the lack of a urinary drainage bag privacy cover to the nurse.</p> <p>Nurse #1 was interviewed on 3/4/15 at 2:20 PM. Nurse #1 stated it was the facility policy to cover urinary drainage bags to maintain a resident's dignity and privacy. The nurse added she was unaware Resident #144's drainage bag did not have a cover. Nurse #1 stated the resident had a urology appointment at the end of February. At that time, the urologist changed his catheter and used a bag without a privacy cover. The nurse added that typically, when a resident returned from an appointment, the drainage bag would be immediately changed. The nurse observed and acknowledged Resident #144's urinary drainage bag was not covered and stated it was an oversight.</p>	F 241	<p>with urinary catheter bags will be audited by the Administrator to ensure the privacy bag is in place. Corrections will be made immediately if warranted.</p> <p>The results of these audits (in the survey audit book) will be presented at the next quality assurance meeting by the Administrator, which meets monthly.</p>		

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F 241	Continued From page 2 An interview was held with the Staff Development Coordinator (SDC) on 3/4/15 at 4:09 PM. She stated staff were taught to use the facility provided urinary drainage bags that provided privacy and maintained the dignity of the resident. The SDC added if a clear urinary drainage bag had been received during an appointment, the expectation was for the bag to be changed within 24 hours after returning to the facility. The Director of Nursing (DON) was interviewed on 3/5/15 at 7:34 AM. The DON stated her expectation was for all urinary drainage bags to be covered to maintain the privacy and dignity of the resident. The DON added the facility provided bags that provided privacy and she expected nurses to use those drainage bags when a resident returned from an appointment.	F 241			
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff and responsible party interviews and record review, the facility failed to provide activities of interest as care planned for 1 of 2 sampled residents (Resident #54) reviewed for activities. Findings included:	F 248	F248 Resident #144's care plan was reviewed and his needs were accommodated. All other resident's care plans were reviewed by the Activities Director and compared to the activities provided. Changes were made where warranted by the Activities Director.	3/23/15	

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F 248	<p>Continued From page 3</p> <p>Resident #54 was admitted on 5/24/13 with diagnoses that included dementia and hypertension.</p> <p>The resident's care plan, last reviewed on 11/20/14, indicated the care plan had been reviewed with the Responsible Party (RP). The care plan identified the resident would participate in activities of choice. The goal was Resident # 54 would attend in activities of interest as tolerated at least 2 times per week. Interventions to attain the goal included assist the resident to activities during the time of most energy, modify activities as needed and post a list of activities. The care plan did not indicate the RP refused to allow Resident #54 to participate in facility activities.</p> <p>Review of a 2/10/15 Activity Progress Note indicated Resident #54 participated in in-room and out of room activities of choice. The care plan indicated the resident participated passively during group and social activities. The care plan also listed as an intervention that activity staff would continue to provide activities and encourage involvement.</p> <p>An observation on 3/2/15 at 4:00 PM revealed the resident was in bed. There was no music playing and the television was not on.</p> <p>On 3/3/15 at 8:34 AM Resident #54 was observed sitting upright in bed with his breakfast tray on the over bed table. The resident was sitting with his eyes shut and his fork in mid air. There was no television or radio on in the room.</p> <p>A telephone interview was held with the RP on 3/3/15 at 10:45 AM. She stated she staff did not</p>	F 248	<p>The activities director was inserviced by the Administrator 3/17 on care plans, comparing them to provided activities, and the regulation surrounding provision of activities.</p> <p>For 4 weeks, 10% of the active population will be audited by the Activities Director to ensure the provided activities match the care plan. Immediate intervention will occur if there is an error.</p> <p>The Activities Director will present the results of these audits (in the survey audit book) will be presented to the next available quality assurance committee meeting, which meets monthly.</p>		

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F 248	<p>Continued From page 4</p> <p>encourage the resident to attend activities. The RP added at times Resident #54 was too sick, but at times he was not too sick to attend.</p> <p>An interview was held with Nursing Assistant (NA) #2 on 3/4/15 at 1:39 PM. She stated Resident # 54 was out of her room for at least one meal per day. Other than dining, the NA stated she had not seen the resident attend any out of room activities and could not recall anyone from the activity department providing in room activities. NA #2 stated there was a television and a radio in the resident's room, but no one had instructed her to keep either the television or the radio on when the resident was in the room.</p> <p>On 3/4/15 at 2:47 PM, Nurse #2 was interviewed. Nurse #2 stated the RP refused to let the resident attend activities. She stated activities of television programs and music were provided in the room.</p> <p>The nurse manager (NM) for the resident's unit was interviewed on 3/4/15 at 3:20 PM. She stated the resident did not attend any out of room activities. The NM stated in room activities consisted of listening to the radio or watching television.</p> <p>The Activity Director (AD) was interviewed on 3/5/15 at 9:39 AM. She stated in room activities were provided for residents that were not out of bed by choice or were bed bound because of health reasons. Types of activities provided to residents were determined by the choices identified during the activity assessment and stated interests. The AD stated when Resident # 54 was out of bed he attended singing groups and television classics. She added when he was in his room, the television or radio played to</p>	F 248			

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F 248	Continued From page 5 provide stimulation. She added Resident #54 was provided in room activities at least once a week and attended out of room activities 1 to 2 times per week. She stated this week, the resident had not been out of his room. The AD stated she kept participation logs for both in room and out of room activity participation. Additionally, she stated the NAs kept the television or the radio on in the resident's room. Review of the Individual Activity Log revealed the resident had participated in one activity on 11/5/14, 12/9/14, 12/31/14, 2/5/15 and 3/4/15 for a total of 5 in room activities over the past 4 months. Review of the Recreation Participation Logs, that represented out of room activities, indicated the resident attended out of room activities on 11/17/14, 11/26/14, 12/29/14 and 2/14/15 for a total of 4 out of room activities for a 4 month period. The AD stated all attendance logs were inaccurate.	F 248			
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide a barrier between bare	F 371	F371 Specific residents were not identified in	3/23/15	

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F 371	<p>Continued From page 6</p> <p>hands and ready to eat food during 2 of 2 meal observations in the memory care unit.</p> <p>Findings included:</p> <p>An observation was made on 3/2/15 at 11:44 AM. Nursing Assistant (NA) # 3 and NA #4 were serving the residents. NA # 3 and NA #4 were observed to take the rolls and sandwiches out of the protective bags with their bare hands. The NAs were observed to hold the rolls with their hands while cutting and buttering the bread. .</p> <p>Another observation was made on 3/3/15 at 11:45 AM. Lunch was served to the residents by NA #4 and NA #5. Both NAs were seen to consistently touch the rolls and sandwiches with their bare hands as the bread was removed from the protective bags served in locked unit.</p> <p>NA # 4 and NA #5 were interviewed on 3/3/15 at 1:49 PM. The NAs stated they had been taught not to touch resident's food with their bare hands. NA #4 and NA#5 acknowledged they had touched the rolls and the sandwiches with their bare hands while serving the residents. The NAs stated they just did not think.</p> <p>An interview was held with NA #3 on 3/4/15 at 11:42 AM. The NA stated she had been taught not to touch resident's food with her bare hands. The NA stated she remembered touching the rolls and sandwiches as she served residents. She stated she had just forgotten.</p> <p>An interview was held with the Director of Nursing on 3/5/15 at 7:55 AM. The DON stated she expected the resident's food not to be touched with bare hands as it was served.</p>	F 371	<p>this deficiency.</p> <p>All residents have the potential to be affected by this practice, so all staff who prepares or serves food (dietary and nursing) will be inserviced by the Administrator or Director of Nursing on providing a barrier between food and hands while preparing or serving food. Weekly for four weeks, the administrator will audit at least two meals per week at varying times and varying dining rooms. The results of these audits (in the survey audit book) will be presented by the Administrator to the next available quality assurance committee meeting, which meets monthly.</p>		

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F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the</p>	F 431	F431	3/23/15	

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F 431	<p>Continued From page 8</p> <p>facility failed to dispose of expired insulin medication for 1 of 7 medication carts (200 hall medication cart) checked for expired medications. Findings included:</p> <p>Observations of the facility's medication storage units were conducted on 3/5/15 at 1:00 PM. An inspection of the medication cart for the 200 hallway revealed one vial of Humalog insulin that was dated as opened on 1/21/15.</p> <p>The manufacturer's instructions (Humalog.com) state to "Throw away opened vials 28 days after first use, even if there is insulin left in the vial." As a result, the expiration date for this particular Humalog vial would have been 2/17/15.</p> <p>The Unit Manager for nurses' station 1 was interviewed at 1:10 PM on 3/5/15, she stated that she checks the carts periodically and pharmacy checks the carts monthly. She also stated that the nurse who works on the cart should also be checking the dates. She did not know how the insulin vial got missed during inspections.</p> <p>The Director of Nursing was interviewed at 1:20 PM on 3/5/15. She stated that "Every nurse at every shift is instructed to check the medications before administering it to a resident. Unit coordinators check the carts routinely, and I do random audits of the carts as well. We changed pharmacies this month, but the pharmacist also checks the carts. This should not have happened."</p> <p>Nurse #3, who regularly utilizes the medication cart, was interviewed at 2:00 PM on 3/5/15. She stated that "I should check the expiration dates prior to administering insulin but I cannot say for</p>	F 431	<p>No specific residents were identified in this deficiency. The discovered expired medications were immediately removed. All residents who utilize insulin could be affected; therefore an audit of all carts and medication storage spaces was done to ensure there were no expired insulin vials (or any other expired medication). All licensed staff was inserviced in writing to the policy and practice of expired meds not being available for use, and how to dispose of them, so this does not reoccur. For four weeks, the Director of Nursing will at least 4 carts each week for expired medication vials and immediately correct, and also provide immediate education to the nurse if warranted.</p> <p>The results of these audits will be presented by the director of nursing to the next available quality assurance committee meeting, which meets monthly, for suggestions if warranted</p>		

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F 431	Continued From page 9 sure that I did. I was not aware that there was expired insulin in my medication cart."	F 431			