	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345421	B. WING			/09/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 -	
THE LAUF	RELS OF CHATHAM			72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	investigation survey v through 2/9/23. The fa compliance with the r	equirement CFR 483.73, ness. Event ID# HZHR11.	F 000			
	was conducted from 2 ID# HZHR11. The following intakes NC00189390, NC001 NC00195448, NC001 NC00190831, NC001	omplaint investigation survey 2/6/23 through 2/9/23. Event were investigated 91909, NC00191905, 95560, NC00189304, 97736 and NC00197870. allegations resulted in				
F 550 SS=D	Ū	8	F 550			3/3/23
	self-determination, ar access to persons an	ht to a dignified existence, ad communication with and				
	with respect and dign resident in a manner promotes maintenance	and in an environment that e or enhancement of his or ognizing each resident's ity must protect and				
	access to quality care	cility must provide equal regardless of diagnosis, or payment source. A facility				
		SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					02/24/2023

Electronically Signed

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

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/28/2023 APPROVED . 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMPI	SURVEY LETED	
		345421	B. WING			C 02/09/2023		
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE	ZIP CODE	02/0	572025	
				2 CHATHAM BUSINESS PAR				
THE LAUF	RELS OF CHATHAM			PITTSBORO, NC 27312				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE	
F 550	practices regarding traprovision of services of residents regardless of \$483.10(b) Exercise of The resident has the prights as a resident of or resident of the Unit \$483.10(b)(1) The factor resident can exercise interference, coercion from the facility. \$483.10(b)(2) The resident can exercise of interference, coercion from the facility. \$483.10(b)(2) The resident can exercise of interference, coercion from the facility. \$483.10(b)(2) The resident can exercise of his or her subpart. This REQUIREMENT by: Based on observation interviews, the facility dining experience by disposable food contact during three observed Resident #31) and reference wit (Resident #75). This with the facility is and would not a "feeder." Requiring disposable food contact while other residents of the resi	aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her the facility and as a citizen ted States. cility must ensure that the his or her rights without a, discrimination, or reprisal sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this is not met as evidenced ms, record reviews, and staff failed to provide a dignified providing residents with ainers and plastic utensils d meals (Resident #89 and ferring to a resident who th meals as a "feeder" was for 3 of 9 residents Based on the reasonable ents would expect to utilize ensils regardless of how fast of expect to be identified as a resident to utilize ainers and plastic utensils were not or being labeled a	F 550	The Laurels of Chath this submitted plan of its written allegation o alleged compliance is Preparation and/or ex of correction does not admission to, nor agre the existence of or the of any of the cited def conclusions set forth i deficiencies. This pla executed to ensure co with regulatory require F550 Resident Right	correction stand a f compliance. Ou March 3, 2023. ecution of this pla constitute eement with, either scope and seven iciencies, or n the statement of n is prepared and ontinuing complian ements.	as r n r ity f /or		
		ntial for a reasonable person		Rights:				

Facility ID: 923099

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	0: 02/28/2023 APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\` <i>`</i>	LE CONSTRUCTION		LETED
		345421	B. WING			C 09/2023
NAME OF PI	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				72 CHATHAM BUSINESS PARK		
	RELS OF CHATHAM			PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 550		ive psychosocial outcome.	F 55	The facility will continue to ensure that residents are provided a dignified dinir		
	03/06/2020 with diagr unspecified dementia The quarterly Minimur assessment dated 01 #89's cognition was c understood and requi by one person. A record review revea Resident #89 needed containers or plastic u On 02/06/23 at 11:53 observed to be utilizin containers and plastic while her other 3 table plates and utensils. On 02/07/23 at 11:47 observed to be utilizin containers and plastic while her other 2 table plates and utensils.	admitted to the facility on hoses which included and hypertension. m Data Set (MDS) /27/23 indicated Resident oded as rarely/never red supervision with eating to det no order indicating to utilize disposable food itensils. AM Resident #89 was g disposable food e utensils in the dining room emates were utilizing regular AM Resident #89 was g disposable food e utensils in the dining room emates were utilizing regular		 experience. Corrective Action: Residents #89, #31, and #75 will continue to be provided w dignified dining experience as evidence by staff providing meals using standard dishes and silverware and not using lat to describe the level of assistance required with eating. No negative psychosocial outcome was identified relating to these observations. How the facility will identify those who have the potential to be affected: Current residents that require assistan with eating have the potential to be affected and are identified through the careplan process Current residents the require assistance with eating were observed during mealtime on 2.21.221 the Director of Nurses (DON) and Unit Manager to ensure that they are being provided with a dignified dining experience. No negative psychosocial outcome was identified relating to these observations. 	ith a ed bels ce hat by	
	while her other 2 table plates and utensils. During an interview w 02/08/23 at 12:00 PM "eats slowly" so the fa	ng disposable food e utensils in the dining room emates were utilizing regular		Systemic changes: 100% of all nursin assistants will be inserviced by the Assistant Director of Nurses (ADON) a 2.28.23 on ensuring that residents that require assistance with eating are provided with a dignified dining experience. Newly hired staff Certified Nursing Assistants (c n a)'s and agence n a 's that are hired after 2.28.23 will b educated by the ADON on the facility	sof t yc	

Facility ID: 923099

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/28/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345421	B. WING				C 09/2023
	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	09/2023
					2 CHATHAM BUSINESS PARK		
THE LAUF	RELS OF CHATHAM				ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)					(X5) COMPLETION DATE
F 550	Continued From page	3	F	550			
	not have to keep the			550	policy on ensuring that residents that		
					require assistance with eating are		
	On 02/08/23 at 12:05	PM the Dietary Manager			provided with a dignified dining		
		stated he was told by facility			experience.		
	staff Resident #89 wa	is a "late riser" and was					
		provide her with disposable			Monitoring: A Quality Assurance (QA)		
	-	lastic utensils for all meals.			monitoring tool will be utilized to ensure		
		ested speech therapy to			ongoing compliance by the Unit Manag		
	obtain an order for the	ese items.			beginning on3.1.22. The Unit Manager	WIII	
	The Pehah Director w	vas interviewed on 02/08/23			randomly observe staff assisting 3 residents with eating at each meal		
		d utilizing disposable food			3x/week x 4 weeks then weekly x 4 we	eks	
		c utensils were not a speech			then randomly x 4 weeks. Variances w		
		ntervention. This would not			be corrected at the time of observation		
	have been ordered by				and additional education provided whe indicated.	n	
	A joint interview with t	he Director of Nursing			Observation results will be reported to	the	
	(DON) and the Admin	istrator on 02/09/23 at 1:23			Administrator weekly for the next 3		
		t #89 should not have had			months beginning on		
		ainers or plastic utensils			3.8.22 and concerns will be reported to		
	because this was a di	gnity concern.			the Quality Assurance Committee durin	ng	
					monthly meetings.		
		admitted to the facility on			Continued compliance will be monitore		
	-	ses that included unspecified ehavior disturbance and			through the facility's Quality Assurance Program. Compliance will be monitore		
	hypertension.				by the QA Committee for 3 months dur		
					the March through May regularly	ing	
	The annual Minimum	Data Set (MDS) dated			scheduled meetings or until resolved a	nd	
		esident #31's cognition was			additional education/training will be		
	severely impaired and	d was independent with			provided for any issues identified.		
		assistance. She was coded			will be corrected at the time of		
	as not having hallucin				observation and additional education		
	experienced physical	or verbal behaviors.			provided when indicated.		
	·				Observation results will be reported to	the	
		entation in Resident #31's			Administrator weekly for the next 3		
		nart indicating the rationale			months beginning on 3.8.22 and conce		
		eding disposable food			will be reported to the Quality Assurance Committee during monthly meetings.	Je	
	containers or plastic u				Continued compliance will be monitore	d	

Event ID: HZHR11

Facility ID: 923099

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FORM): 02/28/2023 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345421	B. WING			C 09/2023
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
		7	2 CHATHAM BUSINESS PARK		
THE LAURELS OF CHATHAM		P	PITTSBORO, NC 27312		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
 observed to be utilizing containers and plastic while her other 3 table plates and utensils. On 02/07/23 at 11:47 observed to be utilizing containers and plastic while her other 2 table plates and utensils. On 02/0/23 at 11:51 A observed to be utilizing containers plate and room while her other regular plates and utensils. On 02/08/23 at 12:00 PW "eats slowly" so the fa food containers and plate food containers and plate food containers and plate staff Resident #31 was instructed by staff to pfood containers and protected by staff to pfood containers and protected by staff to pfood containers and plate staff Resident #31 was instructed by staff to pfood containers and protected by staff to pfood containers and plate plates at 1:10 PM. She state containers and plate plates at 1:10 PM. She state containers and plate plates and plate plates and plate plates and plates plates and plate plates and plate plates at 1:10 PM. She state plates and plates plates and plates plates and plates plates and plates and plates plates plates and plates p	AM Resident #31 was ng disposable food c utensils in the dining room emates were utilizing regular AM Resident #31 was ng disposable food c utensils in the dining room emates were utilizing regular AM Resident #31 was ng disposable food plastic utensils in the dining 2 tablemates were utilizing ensils. with Nurse Aide #8 on 1 revealed Resident #31 acility gave her disposable olastic utensils, so they do meal cart on the floor. PM the Dietary Manager stated he was told by facility as a "late riser" and was provide her with disposable olastic utensils for all meals. ested speech therapy to ese items. was interviewed on 02/08/23 ed utilizing disposable food c utensils were not a speech intervention. This would not	F 550	through the facility's Quality Assurance Program Compliance will be monitored by the G Committee for 3 months during the Ma through May regularly scheduled meetings or until resolved and addition education/training will be provided for issues identified. The Administrator w be responsible to ensure any recommendations from the QA commit are carried out.	A rch aal any II	

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 02/28/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345421	B. WING				(02/	C 09/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS PA ITTSBORO, NC 27312	ARK		
(X4) ID PREFIX TAG				K	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 550	PM revealed Residen disposable food conta because this was a di 3. Resident #75 was a 07/02/21 with diagnos Unspecified dementia The quarterly Minimur indicated Resident #7 rarely/never understochallucinations, delusio Resident #75 required 1 person with dressim- personal hygiene. During observation or Nurse Aide #9 was ob the memory care unit Nurse Aide #9 stated "feeder." The statement throughout the entire residents were preser During an interview of Nurse Aide #9 stated Resident #75 as a "fe her a "feeder" becaus fed her meals. She st "feeders" if they need A joint interview with t (DON) and the Admin PM revealed it was th never utilize labels su	istrator on 02/09/23 at 1:23 t #31 should not have had ainers or plastic utensils gnity concern. admitted to the facility on see which included a, hypertension, and anxiety. m Data Set dated 01/19/22 5's cognition was coded as od and had no ons, or rejection of care. d extensive assistance with g, eating, toilet use, and n 02/06/23 at 11:53 AM, oserved in the dining room of assisting with meal pass. Resident #75 was a ent could be heard dining room where other nt. n 02/07/23 at 12:19 PM she remembered identifying eder." She stated she called e she needed help being ated she called all residents assistance with meals. he Director of Nursing istrator on 02/09/23 at 1:23 eir expectation that staff ch as "feeder" to describe a e to say a resident required	F	550				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 02/28/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345421	B. WING		_		C 09/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	<u> </u>	
THE LAUF	RELS OF CHATHAM			2 CHATHAM BUSINESS P ITTSBORO, NC 27312	ARK		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 551	Continued From page	• 6	F 551				
F 551 SS=D	Rights Exercised by F	Representative	F 551				3/3/23
	not been adjudged inc court, the resident has representative, in acc any legal surrogate so the resident's rights to state law. The same-s must be afforded treat to an opposite-sex sp valid in the jurisdiction (i) The resident represent exercise the resident's rights are delegated to (ii) The resident retain rights not delegated to including the right to r except as limited by S §483.10(b)(4) The fac of a resident represent the resident to the ext delegated by the reside applicable law. §483.10(b)(5) The fac resident representative decisions on behalf of extent required by the	is the right to exercise those of a resident representative, evoke a delegation of rights, state law. illity must treat the decisions natative as the decisions of tent required by the court or dent, in accordance with islity shall not extend the re the right to make if the resident beyond the e court or delegated by the					
	§483.10(b)(6) If the fa that a resident represe or taking actions that of a resident, the facil	ce with applicable law. Incility has reason to believe entative is making decisions are not in the best interests ity shall report such in the manner required under					

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		ID HUMAN SERVICES MEDICAID SERVICES			FC	ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345421	B. WING			C 02/09/2023
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	, 	
THE LAU	RELS OF CHATHAM			72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 551	State law. §483.10(b)(7) In the c incompetent under th of competent jurisdict	case of a resident adjudged e laws of a State by a court ion, the rights of the resident	F	551		
	representative appoir on the resident's beha- resident representativ rights to the extent ju- competent jurisdiction law.	tercised by the resident need under State law to act alf. The court-appointed ve exercises the resident's dged necessary by a court of n, in accordance with State				
	decision-making auth or court appointment, to make those decision representative's author (ii) The resident's wis be considered in the					
	provided with opportu care planning proces	eticable, the resident must be inities to participate in the s. is not met as evidenced				
	Responsible party, th			F551 Rights Exercised by Re The facility will continue to ens residents are transferred to the when the Responsible Party m request.	sure that e hospital	
	1/9/2023 with diagnost and fracture after a fa	dmitted to the facility on sis that included dementia		Corrective Action: Resident #1 longer resides at the facility. How the facility will identify the have the potential to be affecte Current residents that experien change in condition which may consideration of hospital trans	ose who ed: nce a y result in	
		23 indicated the resident		potential to be affected. Curren		

Event ID: HZHR11

Facility ID: 923099

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		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED
			A. BUILDIN	G	
		245424			C
		345421	B. WING		02/09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
THE LAU	RELS OF CHATHAM			72 CHATHAM BUSINESS PARK	
				PITTSBORO, NC 27312	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLE THE APPROPRIATE DATE
F 551	Continued From page	e 8	F 5	51	
		ely impaired and required	1 0.		for changes in
		with activities of daily living.		were reviewed on 2.21.23 condition. No negative or	
		when activities of daily living.		identified relating to these	
	The resident's medica	al record included a			
		1/28/2023 by Nurse #10.		Systemic changes: 100%	of all licensed
		dicated Resident #10 was		nurses will be inserviced	
		xt to her bed. The nurse		of 2.28.23 on ensuring the	-
	assessed the residen	t for injuries, notified the RP		transferred to the hospital	
		ctor, and placed the resident		Responsible Party makes	
	on neurological obser			Newly hired staff nurses a	
	5			nurses that are hired after	
	Then at 2:35PM Nurs	se #10 documented a		educated by the ADON or	n the facility
	progress note that rea	ad in part, "guest with		policy on ensuring that re-	-
		eathing yet no signs or		transferred to the hospital	
		D notified of clinical situation		Responsible Party makes	
		written for Ativan every 6			
	hours.	-		Monitoring: A QA monitor	ing tool will be
				utilized to ensure ongoing	-
	A phone interview wa	is conducted with the		the DON/designee beginr	
	resident's RP on 2/8/2	2023 at 4:00PM. The RP		The DON/designee will re	eview nursing
	stated when she read	ched the facility on 1/29/2023		documentation 5x/week x	12 weeks.
		he did not recall what time.		Variances will be correcte	d at the time of
		ent was in obvious distress		observation and additiona	al education
	breathing rapidly and	crying. The RP spoke with		provided when indicated.	
		I what was being done to		Observation results will be	e reported to the
		ore comfortable because if		Administrator weekly for t	he next 3
	-	her comfortable, she wanted		months beginning on	
		ed to the hospital. The RP		3.8.22 who will be respon	
		orted giving the resident		reporting identified conce	
	-	stated she would call the		Assurance Committee du	ring monthly
		additional orders if needed.		meetings.	
	The RP stated the res	•		Continued compliance wil	
		eparate occasions and		through the facility's Qual	ity Assurance
		tress. The RP stated she		Program.	
		10 again and stated she		Compliance will be monitor	
		nt transferred to the hospital.		Committee for 3 months of	
	-	10 stated she would call the		through May regularly sch	
		k. The nurse then asked the		meetings or until resolved	
	RP to speak with the	physician on call. The RP		education/training will be	provided for any

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	-	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345421	B. WING				-
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				72	2 CHATHAM BUSINESS PARK		
THE LAUF	RELS OF CHATHAM			Р	ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 551	in transferring the resistated she wanted the she perceived the resister facility. The RP told the call 911 and have the facility did not. The resident's medical progress note dated 1 #10 that read as follow that comfort measure facility and morphine measures used in the Progress note dated 1 Nurse #10 read in part request the resident be order to send resident On 2/8/2023 at 2:47P conducted with Nurse recalled the resident's she notified the physic Resident's RP. She be assessments on the r 3:30PM. Nurse #10 st and assigned to the re- she displayed a chang stated she did speak occasions that night a resident be transferre she informed the RP for comfort measures and comfortable, but the of resident was comforta- called the physician of	asked her what her goal was ident to the hospital. The RP a resident to be comfortable, ident was in distress for treatments provided by the hephysician that she would resident transferred if the al record contained a 1/29/2023 6:45PM by Nurse ws: "Nurse assured family s could be made at the and Ativan were comfort plan of care." 1/29/2023 at 8:50PM by rt, "daughter continues to be transferred." Received t out. M and interview was e #10. She stated she s fall from bed. She stated cian on call and the egan neurological resident 1/28/2023 at tated she was in the facility esident on 1/29/2023 when ge in condition. Nurse #10 with the RP on several and the RP did request the d to the hospital. She stated the facility could provide d keep the resident faughter did not believe the able. Nurse #10 stated she on call and had her speak to	F	551	issues identified.		
	called the physician o					OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C 02/09/2023	

Facility ID: 923099

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/28/2023 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345421	B. WING				C 09/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				72	2 CHATHAM BUSINESS PARK		
	RELS OF CHATHAM			P	PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 551 F 561 SS=D	resident was not on h was not an order for o On 2/9/2021 at 1:00P conducted with the Di Administrator. The Ad resident should have when the RP requests Self-Determination CFR(s): 483.10(f)(1)-(§483.10(f) Self-determ The resident has the r promote and facilitate through support of res not limited to the right (1) through (11) of this §483.10(f)(1) The resi activities, schedules (waking times), health care services consiste assessments, and pla applicable provisions §483.10(f)(2) The resi choices about aspects facility that are signific §483.10(f)(3) The resi with members of the o	 M. The nurse stated the ospice services and there comfort care. M and interview was rector of Nursing (DON) and ministrator stated the been sent to the hospital ed. 3)(8) nination. right to and the facility must resident self-determination sident choice, including but s specified in paragraphs (f) is section. dent has a right to choose including sleeping and care and providers of health ent with his or her interests, n of care and other of this part. dent has a right to make s of his or her life in the 	F	551	DEFICIENCY)		3/3/23
		dent has a right to tivities, including social, nity activities that do not					

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		CONSTRUCTION		NO. 0938-039 ATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	· ,	A. BUILDING			COMPLETED		
		345421	B. WING				C 02/09/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		01.00.1010		
				72	2 CHATHAM BUSINESS PARK				
	RELS OF CHATHAM			P	ITTSBORO, NC 27312				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE		
F 561	Continued From page	e 11	F	561					
		ts of other residents in the		001					
	facility.								
	-	「 is not met as evidenced							
	by:								
		iew, observations, resident			F561 Self-Determination				
		the facility failed to honor a			The facility will continue to honor res	ident			
		ted to showers (Resident			choices related to showers.				
	#66) for 1 of 2 reside	nts reviewed for choices.							
	The finalization is also deal	1.			Corrective Action: Resident #66 is				
	The findings included	1:			receiving showers as scheduled per	-			
	Posidont #66 was ad	mitted to the facility on			resident choice. No negative outcom was identified relating to this observa				
		es that included chronic				auon.			
	obstructive pulmonar				How the facility will identify those wh	0			
		ire (CHF), and muscle			have the potential to be affected:	0			
	weakness.				Current residents have the potential	to be			
					affected. Current resident shower				
	A quarterly Minimum	Data Set (MDS)			schedules were reviewed as of 2.24.	23 to			
	assessment dated 1/	17/23 indicated Resident			ensure that resident choices related	to			
		ntact and displayed no			showers are being honored. No nega	ative			
		n of care. He required total			outcome was identified relating to the	ese			
		for bathing and personal			observations.				
	hygiene.								
	Posidont #6610 active	a coro plan last reviewed			Systemic changes: 100% of nursing assistants and licensed nurses will b				
		e care plan, last reviewed ocus area for ADL self-care			inserviced by the ADON by 2.28.23				
		nd requires assistance with			ensuring that residents are receiving				
	-	lated to decline in mobility			showers as scheduled and per resid				
	and dementia.				choice. Newly hired staff and agency				
					a's and staff and agency licensed nu				
	A review of Resident	#66's nursing progress			that are hired after 2.28.23 will be				
	notes from 9/1/22 to	1/8/23 revealed no refusals			educated by the ADON on the facility				
	of showers document	ted.			policy on ensuring that residents are				
					receiving showers as scheduled and	per			
	-	y's shower schedule indicted			resident choice.				
		heduled to receive a shower							
	-	Saturday evening shift (3:00			Monitoring: A QA monitoring tool wil utilized to ensure ongoing compliance				
	PM to 11:00 PM).		1		I UTUIZED TO ENSURE ONDOIND COMPLIANC		1		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345421 B. WING 02/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK THE LAURELS OF CHATHAM PITTSBORO, NC 27312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 561 Continued From page 12 F 561 Resident #66's Nurse Aide Flow Record for 3.1.23. The Unit Manager/designee will December 2022, January 2023 and February audit scheduled shower documentation 2023 were reviewed and revealed assistance with and interview residents 6x/week x 4 bathing was not documented as provided or weeks then 3x/week x 4 weeks then refused by the resident on 12/31/22, 1/21/23 and weekly x 4 weeks ensure that residents 2/1/23. The form did not differentiate if showers are receiving showers as scheduled and or bed baths were provided to Resident #66. The per resident choice. Variances will be form asked, "Did the resident receive a corrected at the time of audit and shower/bath/bed bath" and the answers were additional education provided when either yes, no, or not applicable. indicated. Audit results will be reported to the On 2/6/23 at 11:12 AM, an interview occurred with Administrator weekly for the next 3 Resident #66 who stated he couldn't remember months beginning on 3.8.23, who will be the last time he received a shower but would like responsible for reporting concerns to the one. He indicated staff provided him with a bed Quality Assurance Committee during bath only. Resident #66 was clean and free from monthly meetings. odors; however, his skin was dry and flaky in Continued compliance will be monitored appearance at the time of the interview. through the facility's Quality Assurance Program. An interview was conducted with Nurse Aide (NA) Compliance will be monitored by the QA #3 on 2/8/23 at 11:36 AM who was familiar with Committee for 3 months during the March Resident #66. Stated she has been working at through May regularly scheduled meetings or until resolved and additional the facility for the past two months and gave Resident #66 a shower when she first came to education/training will be provided for any the facility. She recalled him saying he didn't like issues identified. it, so she had never offered him a shower since. Stated on his scheduled shower days she provided him with a bed bath only. On 2/8/23 at 12:11 PM, an interview was held with NA #4 who was familiar with Resident #66 but stated she could not recall if she gave him a shower or bed bath on his scheduled shower days. NA #5 was interviewed on 2/8/23 at 2:52 PM and explained that in the past Resident #66 would often decline a shower when offered so she gave him a bed bath on his scheduled shower day. NA

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

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/28/2023 MAPPROVED D. 0938-0391	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345421	B. WING _			C 02/09/2023		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE LAUR	ELS OF CHATHAM			72	2 CHATHAM BUSINESS PARK			
				Р	ITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 561	Continued From page		F	561				
	shower or not. She fu Record for bathing did	whether he would like a rther explained the NA Flow In't have a place to state received only whether he						
	Multiple attempts were made to contact NA #6 on 2/8/23 and 2/9/23, without success. She was the NA that had not marked if assistance with bathing was provided on 12/31/22 (Saturday), 1/21/23 (Saturday) or 2/1/23 (Wednesday).							
F 641	Resident #66 to be of scheduled shower day provided with a bed b should be reported to	I stated she would expect fered a shower on his y and if he refused then be ath. In addition, any refusals the nursing staff so that be made in the nursing	F	641			3/3/23	
SS=D	CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on record revi	of Assessments. t accurately reflect the is not met as evidenced ew and staff interview, the			F641 Accuracy of Assessments		010120	
	cognition (Residents #	accurately in the areas of #89, #87 & #19), pressure and diagnoses (Resident			The facility will continue to code assessments to accurately reflect the resident's status. Corrective Action: Residents #87, #114 #28, #89, and #19 had MDS correction completed by 2.9.23 by the Minimum D Set (MDS Careplan coordinator). No negative outcome was identified relatin	s)ata		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/28/2 FORM APPRO OMB NO. 0938-03		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED			
		345421	B. WING		C 02/09/2023		
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • •		
THE LAUF	RELS OF CHATHAM			72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETI		
F 641	Continued From page	e 14	F 64	1			
	1. Resident #87 was	admitted to the facility on MDS assessment dated		to these observations.			
	speech, sometimes n usually understood of Mental Status (BIMS) cognitive conditions, v because Resident #8 understood. The Social Worker (S interviewed on 2/8/23 indicated that she wa the BIMS assessmen She stated that she w was still learning the The MDS Nurse was 10:50 AM. The MDS Resident #87's speec able to understand. S interview should have resident by the SW.	W) Assistant was at 10:17 AM. The SW s responsible for completing t for the MDS assessment. vas new to the facility and process. interviewed on 2/9/23 at Nurse reported that th was not clear, but he was She stated that the BIMS e been conducted for the and (DON) and the terviewed on 2/9/23 at 12:58		How the facility will identify those have the potential to be affected: Current residents with MDS asse that are coded as BIMS not comp due to rarely/never understood a staff interview completed, curren residents with pressure ulcers, an current residents with diagnoses Hypothyroidism and Atrial Fibrilla have the potential to be affected. current residents that meet these were reviewed by 2.24.23 by the Careplan Coordinator to ensure to assessments had been complete accurately reflect each resident's No negative observations were in Systemic changes: The MDS Co and Social Worker were inservice Clinical Resource Specialist on 2 completing assessments that accurately. Monitoring: A QA monitoring too	essments pleted nd no t nd of tition, . All e criteria MDS that ed that s status. dentified. pordinator ed by the 2.28.23 on curately		
	assessments to be ad 2. Resident #114 was 11/17/22 and was rea Resident #114 had a	admitted to the facility on		utilized to ensure ongoing compli the DON/designee beginning on The DON/designee will randomly resident MDS sweekly x 4 week bi-weekly x 4 weeks, then month weeks to ensure that MDS assess are being completed that accurate reflect the residents status. Variate be corrected at the time of audit a	3.1.23. y audit 5 ks, then ly x 4 ssments tely ances will		
	cream (provides a mo facilitating the debride	bist wound environment ement of devitalized tissue) ury (DTI) on the left buttock		additional education provided wh indicated. Audit results will be reported to th	en		

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()(()))	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345421 ATEMENT OF DEFICIENCIES	A. BUILDING B. WING 7: P ID	TREET ADDRESS, CITY, STATE, ZIP CODE 2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 PROVIDER'S PLAN OF CORRECT	FORI OMB NC (X3) DATE COMF 02	D: 02/28/2023 M APPROVED D. 0938-0391 E SURVEY PLETED C /09/2023
	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP! DEFICIENCY)		DATE
January 2023 revealed received treatment to ulcer from 1/12/23 thr The significant changed Set (MDS) assessment that Resident #114 did The Treatment Nurse at 10:45 AM. She statt readmitted from the h buttock on 1/12/23. The MDS Nurse was 10:50 AM. She report that Resident #114 was pressure ulcer to her no pressure ulcer ass She stated that she did the TARs when she co assessment dated 1/1 The Director of Nursint Administrator were inft PM. The DON stated assessments to be act 3. Resident #28 was a 9/30/22. Resident #28 had phy 9/30/22 for Levothyro: tablet by mouth daily the state of the state of the state of the state of the state of the state state of the state of the st	istration Records (TARs) for d that Resident #114 had the left buttock pressure ough 1/24/23. e in status Minimum Data int dated 1/19/23 indicated d not have a pressure ulcer. was interviewed on 2/9/23 ed that Resident #114 was ospital with a DTI to her left interviewed on 2/9/23 at ted that she was not aware as readmitted with a left buttock since there was essment on admission. idn't look at the orders nor ompleted the MDS 19/23. ng (DON) and the terviewed on 2/9/23 at 12:58 that she expected the MDS courate.	F 641	Administrator weekly for the next months beginning on 3.8.23, who responsible for reporting concerns Quality Assurance Committee dur monthly meetings. Continued compliance will be mon through the facility □s Quality Assi Program. Compliance will be monitored by to Committee for 3 months during th through May regularly scheduled meetings or until resolved and ad education/training will be provided issues identified.	will be s to the ring nitored urance the QA ne March ditional	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345421	B. WING				C / 09/2023
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF CHATHAM				72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From page	∋ 16	F	641	1		
	for December 2023 re	nistration Records (MARs) evealed that Resident #28 rroxine and Apixaban during eriod.					
	Minimum Data Set (M	cant change in status IDS) assessment dated Ite that the resident had roidism and Atrial					
	AM. She reviewed th Medication Administra Resident #28 and ver received Levothyroxin MDS look back period	ssed noting Hypothyroidism					
		terviewed on 2/9/23 at 12:58 I that she expected the MDS					
	03/06/20 with diagnos	admitted to the facility on ses that included unspecified order, and hypertension.					
	#89 had unclear spee understood, and som Brief Interview for Me screen and identify co noted as not complete	/27/23 indicated Resident					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 02/28/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMP	SURVEY LETED
		345421	B. WING			_		C 09/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS P PITTSBORO, NC 27312	ARK		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	additional attempts ha Resident #89. An interview was cond 02/07/23 at 11:30 AM mumbled speech and questions. She was a how she was doing, a An interview was cond Assistant on 02/08/23 Assistant revealed tha BIMS assessment wit Resident #89 was not questions; therefore, s was rarely/never unde attempted the assess the same interview, bu respond. She stated s have completed the s interview at 3 different she knows how to assist status but was new to The SW Assistant stati inaccurately because sometimes understant The MDS Nurse was 10:54 AM. She stated attempt to complete the with Resident #89. Sho often confused and di	been completed. Worker notes indicating any ad been made to interview ducted with Resident #89 on . Resident #89 had was slow to respond to ble to state her first name, nd was able to sing a song. ducted with the SW at 10:17 AM. The SW at 10:17 AM. The SW at she had attempted the h Resident #89, but able to answer the she indicated Resident #89 erstood. She stated she ment several times during ut Resident #89 did not she did not know she should taff interview or attempt the t times. She further stated sess residents for cognition MDS assessment process. ted the MDS was coded Resident #89 could d.	F	641)EFICIENCY)		
		3 different times, and then						

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 02/28/2023 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345421	B. WING		c	C 2/09/2023
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIF		
THE LAUF	RELS OF CHATHAM			CHATHAM BUSINESS PARK TTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From page	2 18	F 641			
	(DON) and Administra revealed it was their e be coded accurately. 5. Resident #19 was a 07/23/21 with diagnos diabetes, congestive hypertensive heart an The quarterly Minimu assessment dated 01 #19 had clear speech and able understand for Mental Status (BIM identify cognitive cond completed because R rarely/never understo assessment had not to There were no Social additional attempts we Resident #19.	ad chronic kidney disease. m Data Set (MDS) /22/23 indicated Resident a, was understood by others, others. The Brief Interview MS, used to screen and ditions) was noted as not Resident #89 was od, and the staff been completed. Worker notes indicating any ere made to interview ducted with Resident #19 on I. Resident #19 was alert, ar speech. She could				
	Assistant revealed tha BIMS assessment wit Resident #19 refused and told her to "go aw Resident #19 was rar	at 10:20 AM. The SW at she had attempted the				

Facility ID: 923099

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345421	B. WING				C 109/2023
NAME OF P	ROVIDER OR SUPPLIER		1	SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 641 F 658 SS=D	 #19. She stated she of nor did she write a nor did she write a nor #19's refusal. She state assess residents for of to MDS assessment p stated the BIMS asses inaccurately as Resid and be understood. MDS Nurse was inter AM. She stated Resid able to understand ar interview should have Assistant and should different times. She sis to MDS and was still MDS assessments. A joint interview with t (DON) and Administrate revealed it was their of be coded accurately. Services Provided Me CFR(s): 483.21(b)(3) §483.21(b)(3) Compromises a outlined by the commust-(i) Meet professional strate the facility f correct medication ad (Resident #87) of 4 residuent #87) of 4 residuent #87) 	did not do a staff interview, te addressing Resident ted she knew how to cognitive status but was new process. The SW Assistant ssment was coded ent #19 could understand viewed on 02/08/23 at 10:56 lent #19 is cognitively intact, id be understood. The BIMS e been completed by the SW have been attempted 3 tated SW Assistant was new learning how to complete the Director of Nursing ator at 02/09/23 1:15 PM expectation for the MDS to eet Professional Standards (i) ehensive Care Plans d or arranged by the facility, mprehensive care plan,		641	F658 Services Provided Meet Professional Standards The facility will continue to ensure that correct medication administration route transcribed for residents receiving gast tube feeding with orders for nothing by	is ric	3/3/23

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345421	B. WING				C 09/2023
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	05/2025
					2 CHATHAM BUSINESS PARK		
THE LAUF	RELS OF CHATHAM				ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	20	F	658	mouth.		
	3/25/20 with multiple dysphagia (difficulty s vascular disease and malnutrition. The ann	wallowing) following cerebro severe protein calorie ual Minimum Data Set			Corrective Action: Resident #87 had physician order corrections completed 2.8.23 by the Unit Nurse Manager. No negative outcome was identified relatin to this observation.		
	 (MDS) assessment dated 1/24/23 indicated that Resident #87 was receiving tube feeding. Resident #87 had a physician's order dated 11/10/22 for continuous enteral feeding at 60 milliliter (ml) per hour and "NPO". On 11/11/22, the resident had an order for Melatonin 3 milligrams (mgs) 1 tablet by mouth at bedtime for insomnia. On 2/4/23, the resident had an order for Fluconazole (used to treat fungal infections) 				How the facility will identify those who have the potential to be affected: Current residents that receive gastric to feeding and have orders for nothing by mouth have the potential to be affected Current residents meeting this criteria were audited on 2.21.23 to ensure that correct medication administration route transcribed for all ordered medications No negative outcome was identified	I. the is	
	150 mgs 1 tablet by n Resident #87 was obs AM. He was in bed a feeding was infusing a Nurse #4, assigned to interviewed on 2/8/23 reported that Residen medications were adr Gastrostomy (G) tube physician's orders and and Fluconazole were mouth. She indicated received these orders to be administered the mouth. Nurse #4 was orders for the Melator be given through G tu	houth for infection. served on 2/6/23 at 11:24 nd a continuous tube at 60 ml per hour. D Resident #87, was at 9:30 AM. The Nurse it #87 was NPO, and all his ninistered through e. She reviewed the d verified that the Melatonin e ordered to be given by that the nurse who a should have transcribed it rough G tube and not by s observed to change the nin and the Fluconazole to ibe.			relating to these observations. Systemic changes: All licensed nurses will be inserviced by the ADON by 2.24 on the facility policy for ensuring that the correct medication administration routed transcribed for all ordered medications Newly hired staff and agency nurses the are hired after 2.28.23 will be educated the ADON on the facility policy for ensuring that the correct medication administration route is transcribed for a ordered medications. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance the ADON beginning on 3.1.23. Residents that receive gastric tube feeding and have orders for nothing by mouth will have order audits completed	I.23 ne e is nat I by all e by	
	be given through G tu				feeding and have orders for nothing by	ł	

Facility ID: 923099

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 02/28/2023 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345421	B. WING_				C 09/2023
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUR	RELS OF CHATHAM				2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	received the order for transcribed it to the el stated that the resider have transcribed it to but she did not, it was The Nurse Unit Mana 2/9/23 at 11:30 AM. T that Resident #87 was medications should be through G tube. The Director of Nursir Administrator were int PM. The DON stated staff to transcribe the for residents with G tu ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A reside out activities of daily li services to maintain g personal and oral hyg This REQUIREMENT by: Based on record revi member, resident and failed to trim and clea (Residents #66, #28, and failed to assist wi In addition, the facility with bathing (Residen	Ind Nurse verified that she the Fluconazole and ectronic records. She it was NPO, and she should be given through G tube, a mistake on her part. ger #1 was interviewed on The Unit Manager verified is NPO, and all his e ordered and administered ing (DON) and the terviewed on 2/9/23 at 12:58 that she expected nursing correct administration route tibe. In Dependent Residents		558	then bi-weekly x 4 weeks. Variances we be corrected at the time of the observa and additional education provided where indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.23, who will be responsible for reporting concerns to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility s Quality Assurance Program. Compliance will be monitored by the Q Committee for 3 months during the Matthrough May regularly scheduled meetings or until resolved and addition education/training will be provided for a issues identified. F677 ADL Care Provided for Depender Residents The facility will continue to ensure that dependent residents nails are trimmed and clean, and assistance is provided with shaving and bathing.	tion n e le e e A rch al iny	3/3/23
	with bathing (Residen	t #33). This was for 8 of 12					

Facility ID: 923099

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		D HUMAN SERVICES MEDICAID SERVICES			FORM	: 02/28/2023 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		345421	B. WING		02/0) 09/2023
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			72	2 CHATHAM BUSINESS PARK		
THE LAUF	RELS OF CHATHAM		P	PITTSBORO, NC 27312		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG	(Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 677	Continued From page	22	F 677			
	(ADLs).			Corrective Action: Residents #66, #28, #114, #40, #116, and #58 received		
	The findings included	:		assistance with trimming/cleaning nails		
	1 Resident #66 was a	admitted to the facility on		the time of discovery on 2.9.23, per c r as directed by DON. Resident #33 is	na	
		es that included chronic		receiving assistance with bathing per		
	obstructive pulmonary			schedule and resident choice. Reside	nt	
	congestive heart failu	re (CHF), and muscle		#84 received assistance with shaving a		
	weakness.			the time of discovery on 2.9.23, per c r	na	
	A quartarly Minimum I	Data Sat (MDS)		as directed by DON. No negative outcome was identified relating to thes	•	
	A quarterly Minimum I assessment dated 1/1	17/23 indicated Resident		observations.	e	
	#66 was cognitively in					
		of care. He required total		How the facility will identify those who		
	assistance from staff	for bathing and personal		have the potential to be affected:		
	hygiene.			Current residents that require assistan		
	Posidont #66's activo	care plan, last reviewed		with trimming/cleaning nails, shaving, a bathing have the potential to be affected		
		following areas of need:		All current residents that require	u.	
		mance deficit and requires		assistance with trimming/cleaning nails	s,	
	assistance with ADLs	and mobility related to		shaving, and bathing were observed by	y	
	decline in mobility and			the DON, ADON, and Unit Managers		
	-	in integrity/pressure ulcer		during adl care by c n a⊡s to ensure th	nat	
		obility, deconditioning, e interventions included to		each received assistance as needed. These observations were made betwee	≏n	
	-	enails on shower days to		2.20.23 and 2.24.23. No negative		
	see if they need to be	-		outcome was identified relating to thes	е	
				observations.		
		#66's nursing progress				
		/8/23 revealed no refusals		Systemic changes: 100% of nursing		
	of nail care document	eu.		assistants and licensed nurses were inserviced by the ADON by 2.28.23 on		
	On 2/6/23 at 11:12 AM	A. an interview and		facility policy for providing assistance		
		ent #66 occurred while he		residents that require assistance with		
	was lying in bed. Fing	ernails to both hands were		trimming/cleaning nails, shaving, and		
	•	dark substance noted		bathing. Newly hired staff and agency	сn	
		right hand. Resident #66		a⊡s and newly hired staff and agency	h -	
	stated his nails were I them.	onger than he like to have		nurses that are hired after 2.28.23 will educated by the ADON on the facility	De	

Facility ID: 923099

			000				<u>NO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDIN	NG _			С
		345421	B. WING _				2/09/2023
NAME OF P	ROVIDER OR SUPPLIER	0.0121			TREET ADDRESS, CITY, STATE, ZIP CODE	0	12/09/2023
					2 CHATHAM BUSINESS PARK		
THE LAU	RELS OF CHATHAM				PITTSBORO, NC 27312		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETIO DATE
F 677	Continued From page	e 23	F6	677			
					policy for providing assistance to resid		
		served on 2/7/23 at 9:30			that require assistance with washing h		
		hing TV. His nails were			trimming/cleaning nails, and oral care. Monitoring: A QA monitoring tool will		
	unchanged from prior	observation.			utilized to ensure ongoing compliance		
	On 2/8/23 at 8:45 AM	Resident #66 was			the Unit Manager/designee beginning		
		watching TV. His fingernails			3.1.23. The Unit Manager/designee w		
		ngth with dark substance			randomly observe 5 residents 5x/weel		
	under the nails to the				4 weeks, then 3x/weekly x 4 weeks, th	•	
					weekly x 4 weeks to ensure that		
		l with Nurse Aide (NA) #2 on			assistance is being provided to reside	nts	
		ne was the NA assigned to			that require assistance with		
		6. She stated nail care was			trimming/cleaning nails, shaving, and	4 4la a	
	shower or personal ca	e was a need during a			bathing. Variances will be corrected a time of observation and additional	it the	
		#2 of Resident #66's nails			education provided when indicated.		
		longer than he liked to have					
		ed a dark substance was			Audit results will be reported to the		
	under the nails to the	right hand and stated she			Administrator weekly for the next 3		
	had not noticed the n	eed for nail care during his			months beginning on 3.8.23, who will		
	morning care.				responsible for reporting concerns to t	he	
					Quality Assurance Committee during		
		ed on 2/8/23 at 11:10 AM and			monthly meetings. Continued compliance will be monitored	ad	
	was a need.	vas performed when there			through the facility s Quality Assuran Program.		
	On 2/8/23 at 2:52 PM	l, an interview occurred with					
		iar with Resident #66 but not			Compliance will be monitored by the C	QA	
	-	nim. She explained nail care			Committee for 3 months during the Ma	arch	
		when there was a need			through May regularly scheduled		
	during personal care				meetings or until resolved and addition education/training will be provided for		
		ng was interviewed on			issues identified.		
		d stated she was not aware					
		care from Resident #66 or					
		eded. She added that she ails to be observed on					
		ing personal care with nail					
	care rendered as nee						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/28/2023 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345421	B. WING		-		C 09/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
	RELS OF CHATHAM		7	2 CHATHAM BUSINESS PA	ARK		
			P	ITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	24	F 677				
	2. Resident #33 was a 6/3/21 with diagnoses diabetes, dementia, a						
	Minimum Data Set (M 12/19/22 indicated Re cognitive impairment	nificant change in status IDS) assessment dated esident #33 had severe but displayed no behaviors e required total dependence hygiene and bathing.					
	12/27/22, included an of Daily Living (ADL) and required assistan	care plan, last reviewed area of need for Activities self-care performance deficit ce with ADL's and mobility and decline in mobility.					
		notes were reviewed from nd did not indicate any sistance.					
	receive a shower eve	irsing, Resident #33 was to ry Wednesday and Saturday 3:00 PM to 11:00 PM).					
	December 2022, Jan 2023 were reviewed a bathing was not docu refused by the resider 12/10/22, 12/14/22, 1 1/21/23, 1/25/23, 1/28 asked, "Did the reside shower/bath/bed bath either yes, no or not a	" and the answers were applicable.					
	On 2/6/23 at 10:56 Al	٨, a family member of					

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	PRINTED: 02/28/2023 FORM APPROVED OMB NO. 0938-0391
CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	C 02/09/2023
TREET ADDRESS, CITY, STATE, ZIP CODE	
2 CHATHAM BUSINESS PARK	
ITTSBORO, NC 27312	
	DATE
DEFICIENCY)	
5	STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/28/2023
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		345421	B. WING				C 109/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				7	72 CHATHAM BUSINESS PARK		
THE LAUF	RELS OF CHATHAM				PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	NA #5 who was famili worked the evening s worked at the facility f stated Resident #33 v scheduled so she ma 1/25/23 (Wednesday) She stated Not Applic or bed bath was provi days. A phone call was place 10:57 AM and was un She was assigned to shift on 1/18/23 (Wed Not Applicable for bat A phone call was place 10:58 AM and was un She was assigned to - 12/31/22 (Saturday) flow record as a bath - 1/21/23 (Wednesday) flow record as a bath - 2/1/23 (Wednesday) NA flow record as a b The Director of Nursin 2/9/23 at 1:01 PM and residents to be offered requested and schedu the NA should alert th could be written, and provided. 3. Resident #28 was a 9/30/22 with multiple of mental status. The si Minimum Data Set (M 12/6/22 indicated that	ar with Resident #33 and hift. She stated she had for the past two months and vasn't listed on the shower rked Not Applicable for and 1/28/23 (Saturday). able would mean no shower ded by herself on those we to NA #7 on 2/9/23 at hable to leave a message. Resident #33 the evening nesday) and had marked hing assistance. we to NA #6 on 2/9/23 at hable to leave a message. Resident #33 as follows: and had not marked the NA received. and had not marked the NA	F	677			

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CENTERS FOR MEDICARE & MEDIC	AID SERVICES					APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PR	OVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345421	B. WING				C 09/2023
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE LAURELS OF CHATHAM				2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
PREFIX (EACH DEFICIENCY MUST E						(X5) COMPLETION DATE
 F 677 Continued From page 27 on the staff for personal hygi assessment further indicated had no behavior of rejection Resident #28's current care on 9/30/22 revealed that the of daily living (ADL) self-care required assistance with ADI included "resident requires e with personal hygiene and to and trim and clean on bath of necessary". Resident #28 was observed PM in bed. Her fingernails w at least 1 inch from the tips of were brown substances not fingernails. Resident #28 was again obs 8:30 and 2:41 PM and her fin unchanged from the previou Nurse Aide (NA) #15, assign was interviewed on 2/7/23 at stated that she had noticed r were long and dirty, but she refuse nail care. She added done during shower days an further indicated that she wo resident's nails when she ha Resident #28 was observed AM. Her fingernails were sh The Nurse Unit Manager #1 2/9/23 at 11:30 AM. She stat done during shower days bu long and dirty, staff should tr 	d that the resident of care. plan that was initiated resident had activity e deficit and she L. The approaches extensive assistance o check nail length day and as on 2/6/23 at 12:50 were long and jagged, of her fingers. There ed underneath her erved on 2/7/23 at ngernails remained s observation. the to Resident #28, t 2:42 PM. The NA resident's fingernails knew she would that nail care was id if needed. The NA ould trim and clean s the time. on 2/8/23 at 8:50 iort and clean. was interviewed on ited that nail care was it if the nails were	F	677			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/28/2023 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			_	(X3) DATE COMP	SURVEY LETED
		345421	B. WING				C 09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE LAU	RELS OF CHATHAM			72 CHATHAM BUSINESS PITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	resident's nails and no The Director of Nursir Administrator were int PM. The DON stated	ot to wait for shower days.	F 67	7			
	11/17/22 with multiple hemiplegia/hemipares infarction affecting the The significant chang Set (MDS) assessme that Resident #114's of she needed extensive hygiene. The assess the resident had no be Resident #114's currer initiated on 11/17/22 r had activity of daily liv and she required assi approaches included assistance with perso Resident #114 was of AM. Her fingernails w half an inch from the fivere brown substance fingernails. She state nails short and clean. had offered to trim an was tired of asking. Resident #114 was ag	sis following cerebral e left non dominant side. e in status Minimum Data nt dated 1/19/23 indicated cognition was intact, and e assistance with personal ment further indicated that ehavior of rejection of care. ent care plan that was revealed that the resident <i>v</i> ing (ADL) self-care deficit istance with ADL. The "resident requires extensive onal hygiene". bserved on 2/6/23 a 11:34 rere long and dirty, at least tips of her fingers. There es underneath her she reported that nobody d clean her nails and she					
	had activity of daily liv and she required assi approaches included assistance with perso Resident #114 was of AM. Her fingernails w half an inch from the t were brown substanc fingernails. She state nails short and clean. had offered to trim an was tired of asking. Resident #114 was ag	ving (ADL) self-care deficit istance with ADL. The "resident requires extensive onal hygiene". bserved on 2/6/23 a 11:34 vere long and dirty, at least tips of her fingers. There es underneath her ed that she would like her She reported that nobody d clean her nails and she					

Facility ID: 923099

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COM	PLETED
		345421	B. WING				C / 09/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	02	103/2023
TUE 1 AU				7	72 CHATHAM BUSINESS PARK		
THE LAUP	RELS OF CHATHAM			F	PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677		evious observations. assigned to Resident #114,	F	677	,		
	reported that Resider assistance with perso care. She stated that care. She stated that	 /7/23 at 2:41 PM. She at #114 needed extensive boal hygiene including nail the resident did not refuse she would trim and clean when she had the time. 					
	8:51 AM. Her fingern She stated that noboo clean them and she h NA #15 was interview The NA reported that trim and clean residen	gain observed on 2/8/23 at hails remained long and dirty. dy had offered to trim and to hate to keep asking the staff. wed on 2/8/23 at 9:30 AM. she didn't get the chance to ht's nails yesterday, but she ext shift to trim and clean her done either.					
	2/9/23 at 11:30 AM. S done during shower of long and dirty, staff sl	ger #1 was interviewed on She stated that nail care was lays but if the nails were hould trim and clean the ot to wait for shower days.					
	PM. The DON stated	ng (DON) and the terviewed on 2/9/23 at 12:58 I that personal hygiene ould be provided when					
	11/25/19 with multiple persistent vegetative						

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 02/28/2023 MAPPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345421	B. WING		_		C 09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
THE LAU	RELS OF CHATHAM			72 CHATHAM BUSINESS F PITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Resident #84's curren 11/4/22 revealed that daily living (ADL) self- total assistance with A included "resident req personal hygiene". Resident #84 was obs in bed and he was un facial hair seemed to growth. Another observation w AM, and 1:50 PM. The was still unshaven. Nurse Aide (NA) #10, was interviewed on 2/ reported that she prov resident. When asked should be shaved, she know, she usually wo moved to day shift. The Director of Nursir enter Resident #84's is She observed the ress resident needed to be The Director of Nursir Administrator were int PM. The DON stated including shaving sho needed.	Resident #84 had a d a feeding tube in place. It care plan that was dated the resident had activity of care deficit and required ADL. The approaches uires total assistance with served on 2/6/23 at 2:09 PM shaven. The amount of be at approximately 3 days vas made on 2/7/23 at 8:46 e resident was in bed and assigned to Resident #84, 7/23 at 1:51 PM. She vided AM care to the d how often the resident e responded that she didn't rked night shift and recently bg (DON) was observed to room on 2/7/23 at 1:52 PM. ident and agreed that the e shaved. bg (DON) and the terviewed on 2/9/23 at 12:58 that personal hygiene	F 677		DEFICIENCY)		

Facility ID: 923099

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	D: 02/28/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345421	B. WING				C 09/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	07/02/20 with diagnoss stenosis, neuropathy, thrombosis of unspect The quarterly Minimur assessment dated 12 #40's cognition was m required extensive as toilet use, bed mobility was not coded as hav delusions, or rejection Resident #40's care p indicated, in part, he f Living (ADL) self-care required assistance w neuropathy, spinal ste for mobility. The goal would improve curren mobility, transfers, ea hygiene through the m included to encourage to the fullest possible required extensive as hygiene and oral care length and trim and cl necessary. A review of the Showe Resident #40 was to m Monday and Thursday A review of the Nurse documented Residem 02/06/23. There were no other m	es which included spinal and chronic embolism and ified vein. m Data Set (MDS) /13/22 indicated Resident noderately impaired and he sistance of one person with y, and personal hygiene. He ring hallucinations, n of care.	F	677			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/28/2023 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		345421	B. WING				C / 09/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DBE	(X5) COMPLETION DATE
TAG	REGULATORY OR L	SCIDENTIFTING INFORMATION)	TAG		DEFICIENCY)	RIATE	
F 677	Continued From page	32	F	677			
		/07/23 at 10:04 AM revealed					
		wn debris under all 10 of his ated he would like his nails					
		have "not gotten around to					
		on 02/08/23 at 10:11 AM 0 continued to have brown					
	debris under all 10 of	his fingers. Resident #40					
	indicated he would lik	e them cleaned.					
	An interview and obse 02/08/23 at 10:26 AM	ervation occurred on with Nurse Aide #11 (NA)					
	revealed Resident #4	0 had brown debris under all					
	•	#11 stated she is familiar d had developed a rapport					
	with him. She indicate	ed his nails had brown debris					
		vould clean his nails when the afternoon. She stated					
		#40 every day at 2 PM. She					
		Resident #40 on 02/07/23,					
		nails because he told her to Resident #40 refuses ADL					
		notified the nurse each					
		urse #6 at 02/08/23 at 2:50 familiar with Resident #40					
		le indicated Resident #40					
		en and the Nurse Aides is refusals. He indicated he					
	typically documented	Resident #40 refusals of					
	ADL care but did not o should.	document as much as he					
	-	he Director of Nursing and					
	the Administrator on 0 revealed it was their e	02/09/23 at 1:08 AM expectation that residents'					

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	-	D HUMAN SERVICES					FORM): 02/28/2023 MAPPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345421	B. WING			_		C 09/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS P PITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	 needed. Residents' na ensure cleanliness and 7. Resident #116 was 01/03/23 with diagnoss Parkinson's disease, I with agitation. The 5-day Medicare M assessment dated 01. #116's cognition was I required extensive as bed mobility, dressing personal hygiene. He rejection of care. Resident #116's care indicated he had an A (ADL) self-care perfor assistance with ADLs deconditioning decline and vision abilities word disabilities, health star goal included Resider wash his face and har cues. Interventions imresident to participate possible with each int length and trim and clinecessary. Review of the shower Resident #116's show Monday and Thursday 	ed during baths and as ails should be kept clean to ad good hygiene. admitted to the facility on see which included hypertension, and dementia Minimum Data Set (MDS) (10/23 indicated Resident moderately impaired and sistance with one person for t, eating, toilet use, and was coded as not having plan dated 01/03/23 ctivities of Daily Living mance deficit and required and mobility due to e, Parkinson's dementia, buld fluctuate according to tus, and time of day. The ht #116 would be able to hds with setup and verbal cluded to encourage to the fullest extent eraction and check nail ean on bath day and as	F	677				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/28/2023 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMF	SURVEY PLETED
		345421	B. WING			C 02/09/2023	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	RELS OF CHATHAM			72	2 CHATHAM BUSINESS PARK		
				P	PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From page	9 34	F	677			
	An observation on 02	/07/23 at 8:37 AM revealed					
) fingernails were jagged					
	and approximately 1/4	4 (one-quarter) inches long.					
		n, Resident #116 stated his					
	nails were long and h	e wanted them cut.					
	An observation on 02	/08/23 at 8:25 AM revealed					
) fingernails were jagged					
		4 (one-quarter) inches long.					
		terview with the Nurse Unit					
	-	ducted on 02/08/23 at 9:39					
		lent #116's nails were long, e cut. She stated Resident					
		and NAs were able to cut					
		ails are to be cut as needed					
	and NAs are able to r	eview each residents'					
	,	gives a brief overview of					
		needs) to determine what					
		dent requires. She stated Resident #116 had a history					
	of refusing care.	Resident # 110 had a history					
	or relating bare.						
		terview with Nurse Aide #8					
		on 02/08/23 at 9:41 AM.					
		amiliar with Resident #116's					
		ated that his nails were d to be cut. She stated she					
		116 a bath on 02/06/23, and					
		his nails, but he refused.					
	She indicated she wo	uld typically tell the nurse if					
		d ADL care. She stated she					
	had not attempted to refusal on 02/06/23.	trim his nails since his last					
	A joint interview with t	he Director of Nursing and					
	the Administrator on (-					
	revealed it was their e	expectation that residents'					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP			
		345421	B. WING				09/2023		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
THE LAUF	RELS OF CHATHAM			72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE		
F 677	nails should be check needed. Residents' na ensure cleanliness ar 8. Resident #58 was a 09/20/19 with diagnos contractures of the lef ankle, hip, and knee, knee and wrist, and a right and left shoulder Review of Quarterly N assessment, dated 07 #58 ' s cognition was required total depend for dressing, personal was coded to have im upper and lower extre coded. Review of Resident # reviewed 01/27/23, in read she has an Activ Self Care Performand assistance with ADL's Bathing: Check nail le bath day and as nece to the nurse. Provide when a full bath or sh Keep fingernail trimm A review of Resident # notes from 10/1/22 to of nail care document An observation occur 02/06/23 at 02:40 PM her eyes open. Finge medium in length, pas	ted during baths and as ails should be kept clean to ad good hygiene. admitted to the facility on ses that included ft elbow, right lower leg, left lower leg, ankle, hip, dhesive capsulitis of the rs. <i>N</i> inimum Data Set (MDS) 1/25/23, revealed Resident severely impaired. She ence of one staff member I hygiene, and bathing. She apairment on both sides of emities. No rejection of care 58 ' s care plan last cluded a focus area that rities of Daily Living (ADL) ce Deficit and requires s. Interventions included ength and trim and clean on essary. Report any changes Resident with a sponge bath ower cannot be tolerated. ed and clean. #58's nursing progress 1/8/23 revealed no refusals	F	677					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 02/28/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345421	B. WING			-		C 09/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS PA PITTSBORO, NC 27312	ARK		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	36	F	677				
	02/07/23 at 09:56 AM PM. She was lying in Fingernails to both ha past the tips of fingers were jagged on the tip An interview and obse 09:45 AM of Resident with her eyes open. A with Unit manager #2 Resident #58 's finge needed to be trimmed to be completed by N when there was a need An interview on 02/08 conducted with NA #1 Resident #58 at the ti nail care when there was personal care tasks. An interview on 02/08 conducted with Nursin reported that she was and that the resident was and that the resident was be confirmed that Re needed to be trimmed to residents who need #58's fingernails were She confirmed that Re needed to be trimmed Resident #58 this mon her nails. She further assistance performing	ervation on 02/08/23 at #58. She was lying in bed n interview was conducted . She confirmed that rnails were jagged and l. She stated nail care was ursing Assistants (NAs) ed. /23 at 09:50 AM was 4 who was not assigned to me stated she completes was a need and during /23 at 10:00 AM was ng Assistant (NA) #12. She assigned to Resident #58 was dependent on staff for e. NA #12 stated that the e for providing fingernail care led assistance. Resident t then observed by NA #12. esident #58's fingernails I. She stated she bathed rning but did not trim or file stated she would need g nail care on Resident #58 ontinuously move her hands						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING		с		
		345421	B. WING		02/09/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	DE		
	RELS OF CHATHAM			72 CHATHAM BUSINESS PARK			
	CELS OF CHATHAM			PITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTIO		
F 677	Continued From page	e 37	F 67	77			
	-	ducted on 02/09/23 at 01:00					
		of Nursing (DON). She					
		for nail care to be performed					
	at least weekly and a	s needed.					
	An interview was con	ducted on 02/09/23 at 01:08					
	PM with the Administ						
		ail care to be performed as					
	needed.						
		event/Heal Pressure Ulcer	F 68	36	3/3/23		
SS=E	CFR(s): 483.25(b)(1)	(i)(ii)					
	§483.25(b) Skin Integ	arity					
	§483.25(b)(1) Pressu						
		ehensive assessment of a					
	resident, the facility n						
		s care, consistent with					
	-	ds of practice, to prevent does not develop pressure					
		vidual's clinical condition					
		ey were unavoidable; and					
		essure ulcers receives					
		and services, consistent					
	with professional star	ndards of practice, to vent infection and prevent					
	new ulcers from deve	•					
		is not met as evidenced					
	-	iew, observations, and staff		F686 Treatment Services to Preven	t/Heal		
	interviews, the facility			Pressure Ulcer			
	.	reducing air mattress was					
		esident's weight for 3 of 12		The facility will continue to ensure the	at		
	#58, #87, and #14).	or pressure ulcers (Resident		alternating pressure reducing air mattresses are set according to resid weight.	dent		
	The findings include:			Corrective Action: Residents #58, #1 and #5 had alternating pressure redu			
	Review of the operati	ional manual for the		air mattresses readjusted according	-		

Event ID: HZHR11

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		D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/28/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345421	B. WING			C / 09/2023
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			7	2 CHATHAM BUSINESS PARK		
THE LAUF	RELS OF CHATHAM		P	ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	alternating air mattres	e 38 ss revealed the following: ion: The pressure of the	F 686	resident weight at the time of di 2.8.23 by the nurse.	scovery on	
	mattress can be adjus patients ' correspond weight setting buttons setting buttons to sele Pressure levels will ra millimeters of mercury 1. Resident #58 was a 09-20-2019 with diagu traumatic seizures, cor right lower leg, ankle, leg, ankle, hip, knee a capsulitis of the right a Resident #58's active an order dated 11/01/ mattress for proper fu	sted by choosing the ing weight setting using the a (+) and (-). Use the weight ect the desired level. ange from 20 to 60 γ (mmHg). admitted to the facility on noses that included post ontractures of the left elbow, hip, and knee, left lower and wrist, and adhesive and left shoulders. physician orders included 21 for nursing to monitor air nction every shift.		How the facility will identify thos have the potential to be affected residents with alternating press reducing air mattresses have th to be affected. Current resident alternating pressure reducing air mattresses were inspected on 2 the Central Supply Coordinator that alternating pressure reduci mattresses were adjusted accor resident weight. No negative of were identified relating to these inspections. Systemic changes: All nursing and licensed nurses will be inse the ADON by 2.28.23 on the factor	d: Current ure e potential ts with ir 2.23.23 by to ensure ng air rding to utcomes assistants erviced by cility	
	assessment, dated 10 #58 ' s cognition was current pressure ulcer device to the bed. Review of Resident # 11/01/21, last reviewer focus area that read s skin integrity/pressure injury, inability to repo- status and incontinent Pressure reduction ai A review of Resident a revealed she had a hi	ed 01/27/23, included a she was at risk for impaired a injury R/T: traumatic brain osition self, altered nutrition ce. Intervention included: r mattress to bed.		expectation that alternating pres reducing air mattresses are set to resident weight. Newly hired agency c n a □ s and staff and a licensed nurses will be educate ADON on the facility expectatio alternating pressure reducing at mattresses are set according to weight. Monitoring: A QA monitoring to utilized to ensure ongoing comp the Central Supply Coordinator/ beginning on 3.1.23. The Centr Coordinator/designee will inspe residents with alternating press reducing air mattresses 2x/day for 2 weeks then daily 5x/week	according staff and gency d by the n that ir resident ol will be bliance by /designee ral Supply ct ure 5x/week	

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				PLE CONSTRUCTION		0. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · /	E SURVEY PLETED
						С
		345421	B. WING		02	2/09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
THE LAU	RELS OF CHATHAM			72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIOI DATE
F 686	Continued From page	e 39	F 68	36		
		edication Administration		weekly x 4 weeks to ensure	that the	
		led nursing staff had been		alternating pressure reducir		
	documenting daily th	e alternating pressure air		mattresses are set accordin	g to resident	
	mattress was function	ning properly.		weight. Variances will be co		
				time of inspection and addit		
		rred of Resident #58 on		education provided when in	dicated.	
		<i>I</i> . She was lying in bed with alternating air mattress was		Audit results will be reported	d to the	
	set on 700 pounds (II			Administrator weekly for the		
	intervals.			months beginning on 3.8.23		
				responsible for reporting co		
	An observation occur	rred of Resident #58 on		Quality Assurance Committee		
		<i>I</i> , 10:28 AM and at 03:58		monthly meetings.		
		bed with her eyes closed.		Continued compliance will b		
	-	attress was set on 700		through the facility s Qualit	ly Assurance	
	pounds (lbs) and 10	min cycle intervais.		Program.		
	An interview and obs	ervation on 02/08/23 at		Compliance will be monitore	ed by the QA	
	09:45 AM of Residen	it #58's. She was lying in bed		Committee for 3 months du		
		The alternating air mattress		through May regularly sche		
		ds (lbs) and 10 min cycle		meetings or until resolved a		
		w was conducted with Unit		education/training will be pr	ovided for any	
	-	nfirmed that the air mattress nd the nurses are to check		issues identified.		
		he stated staff sometimes hit				
		ing care. She corrected the				
	weight to 125lbs.	5				
		nducted with Nurse #5 on				
		A. She stated she checks air				
mattresses in the AM. She indicated checked Resident #58's air mattress						
		to pull the Medication				
		d (MAR) up on the computer				
		had signed the task off as				
		stated she only checked to				
	-	working on the machine,				
	she did not check the					
	confirmed she did no	t realize the mattress was				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/28/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345421	B. WING		_	(02/) 09/2023
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUF	RELS OF CHATHAM			72 CHATHAM BUSINESS P PITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page set at 700lbs.	÷40	F 68	5			
	PM with the Director of stated she expected t	ducted on 02/09/23 at 01:00 of Nursing (DON). She the alternating air mattress cording to the resident ' s					
	PM with the Administr expectation was for th according to resident 2. Resident #14 was 02/03/22 with diagnos	ne air mattress to be set ' s weight. readmitted to the facility on ses which included type 2 dementia, chronic kidney					
	Resident #14 was to I	ated 08/30/22 indicated have an air mattress on her etting based on weight every					
	assessment dated 01 #14's cognition was m required extensive as with bed mobility, drea	Minimum Data Set (MDS) /31/23 indicated Resident noderately impaired and esistance with one person ssing, and toilet use. She a pressure ulcer/injury and esure ulcer.					
	risk for impaired skin to decondition, decline poor food intake, and included to minimize r likelihood of pressure next review date. Inte	a of Resident #14 was at integrity/pressure injury due e in mobility, incontinence, fragile skin. The goal risk in an effort to reduce injury development through					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/28/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345421	B. WING		_		C 09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
THE LAUF	RELS OF CHATHAM			72 CHATHAM BUSINESS F PITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	and monitor settings f based on weight. Review of Resident # Resident #14 weigher and 113.4 pounds on An observation on 02 Resident #14 was lyir pressure reducing air to 150 lbs. An observation on 02 Resident #14 was lyir pressure reducing air to 150 lbs. An observation on 02 Resident #14 was lyir pressure reducing air to 150 lbs. Nurse #6 was intervie PM. He stated he was and her care needs. H the mattress settings times, the settings cal during personal care. mattress was set to 1 120 pounds to match indicated he worked of recall if he changed th his shift. The Central Supply C on 02/08/23 at 2:06 P #14 received the alter	for function and setting 14's vital signs revealed d 112.6 pounds on 1/02/23 02/07/23. /06/23 at 1:23 PM revealed ng in bed. The alternating mattress showed it was set /07/23 at 11:46 AM revealed ng in bed. The alternating mattress showed it was set /08/23 at 08:29 AM revealed ng in bed. The alternating mattress showed it was set	F 68				
	Review of Resident # Resident #14 weigher and 113.4 pounds on An observation on 02 Resident #14 was lyir pressure reducing air to 150 lbs. An observation on 02 Resident #14 was lyir pressure reducing air to 150 lbs. An observation on 02 Resident #14 was lyir pressure reducing air to 150 lbs. Nurse #6 was intervie PM. He stated he was and her care needs. H the mattress settings times, the settings can during personal care. mattress was set to 1 120 pounds to match indicated he worked of recall if he changed th his shift. The Central Supply C on 02/08/23 at 2:06 P #14 received the alter	d 112.6 pounds on 1/02/23 02/07/23. /06/23 at 1:23 PM revealed og in bed. The alternating mattress showed it was set /07/23 at 11:46 AM revealed og in bed. The alternating mattress showed it was set /08/23 at 08:29 AM revealed og in bed. The alternating mattress showed it was set /08/23 at 08:29 AM revealed og in bed. The alternating mattress showed it was set wed on 02/08/23 at 2:03 is familiar with Resident #14 He stated he tries to check every shift because, at n be accidentally changed He stated he saw the 50 pounds, and moved it to Resident #14's weight. He on 02/06/23, and could not he mattress settings during oordinator was interviewed M. She indicated Resident nating pressure reducing 2022. Typically, the Durable					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/S		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		345421	B. WING			02/09/2023		
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
THE LAUF	RELS OF CHATHAM				72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 686	if a resident gains or line a joint interview with (DON) and the Admin PM revealed it was the alternating pressure resident distribution of the resident was contractures and two stages assessment period. The resident distribution of the following: "air line distribution of	change the weight settings loses weight. th the Director of Nursing histrator on 02/09/23 at 1:11 heir expectation that reducing mattresses were to rs weight. dmitted to the facility bess that included soure injuries. Interventions ducing air mattress to the rly Minimum Data Set (MDS) icated the resident was mpaired, dependent on staff ful activities of daily living. led with three stage 3 a 4 injuries during the al record contained an order mattress to bed for low settings based on weight, function and settings. The /2022. Il record included a weight of 159 pounds (lbs)	F	686				
	mattress was observe	M the pressure reducing ed to be set on 220lbs during wound care nurse. The						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION	(X3) DATE SUF COMPLET C		
		345421	B. WING _				09/2023	
NAME OF P	ROVIDER OR SUPPLIER		- I [STR	EET ADDRESS, CITY, STATE, ZIP CODE			
THE LAU	RELS OF CHATHAM				HATHAM BUSINESS PARK TSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 686 F 688 SS=D	wound care nurse sta be set that high. She should be set accordi The floor nurses assig responsible to check and proper settings. An interview was con 2/7/2023 at 2:15PM. S resident's mattress fo check the settings. SI who was responsible accurate. On 2/9/2023 at 1:30P conducted with the Di stated Resident #5's reducing air mattress his weight. Increase/Prevent Dec CFR(s): 483.25(c)(1)- §483.25(c) Mobility. §483.25(c)(1) The fac resident who enters th range of motion does range of motion does range of motion unless condition demonstrate of motion is unavoida §483.25(c)(2) A resid motion receives appro- services to increase r prevent further decreas §483.25(c)(3) A resid receives appropriate s	ted the mattress should not further stated the mattress ing to the resident's weight. gned to the resident's are in the mattress for function ducted with Nurse #8 on She stated she checked the r function, but she did not ne stated she was not sure for ensuring settings are M an interview was rector of Nursing. She alternating pressure should be set according to crease in ROM/Mobility (3) cility must ensure that a ne facility without limited not experience reduction in as the resident's clinical es that a reduction in range ble; and ent with limited range of		586			3/3/23	

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	-	D HUMAN SERVICES MEDICAID SERVICES	1		PRINTED: 02/28/202 FORM APPROVED OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345421	B. WING		02/09/2023
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
THE LAUF	RELS OF CHATHAM			2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 688	reduction in mobility is This REQUIREMENT by: Based on record revi interviews, the facility right-hand palm guard bilateral elbow extens as ordered for 2 of 3 r of motion. The findings included 1. Resident #58 was a 09-20-2019 with diagr contractures of the lef ankle, hip, and knee, knee and wrist, adhes and left shoulders. Resident #58 had a p 04/07/22 to position b (BUE) splints daily fol hours or as tolerated. hand/creases of elbow rinse, and dry thoroug stretching to BUE at th wrists, and hands as th Review of quarterly M assessment, dated 10	able independence unless a s demonstrably unavoidable. is not met as evidenced ew, observations, and staff failed to apply the d (Resident #87) and ion splints (Residents #58) residents reviewed for range : admitted to the facility on noses that included it elbow, right lower leg, left lower leg, ankle, hip, sive capsulitis of the right hysician ' s order dated ilateral elbow extension lowing AM care for up to 4 Provide hygiene to BUE ws with warm soapy water, ghly. Provide slow gentle he shoulders, elbows, tolerated prior to application.	F 688	F688 Increase/Prevent Decrease in ROM/Mobility The facility will continue to ensure that palm guards and splints are applied as ordered for range of motion. Corrective Action: Resident #58 contin to wear splints as ordered. Resident # continues to wear the palm guard as ordered. No negative outcome was identified relating to these observation How the facility will identify those who have the potential to be affected: Curr residents with orders for splints and pa guards have the potential to be affected Current residents with orders for splint and palm guards were reviewed by the Rehab Services Director as of 2.24.23 ensure that splints and palm guards at being worn as ordered. No negative outcomes were identified relating to th observations. Systemic changes: All licensed nurse and nursing assistants were inserviced	s ues t87 s. ent alm d. s e to e e se s
	#58 ' s cognition was range of movement in both sides of upper & Review of Resident # (a system of commun used to document res	severely impaired, and npairment was noted on		the ADON as of 2.28.23 on the facility expectation that residents must have splints applied as ordered to prevent further contractures. Monitoring: A QA monitoring tool will t utilized to ensure ongoing compliance the RSD/designee beginning on 3.1.23	be

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345421 B. WING 02/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK THE LAURELS OF CHATHAM PITTSBORO, NC 27312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 688 Continued From page 45 F 688 read; at risk for further contracture development The RSD/designee will observe residents related to: traumatic brain injury (TBI), with palm guards and splints 5x/week x 2 quadriplegia, and has actual multiple weeks then 3x/week x 2 weeks then contractures. Interventions including Position weekly x 4 weeks then every other week x bilateral elbow extension splints following AM 4 weeks to ensure that palm guards and care for up to 4 hours or as tolerated. Provide splints are being worn as ordered. hygiene to both upper extremities (BUE) Variances will be corrected at the time of hand/creases of elbows with warm soapy water, audit and additional education provided rinse, and dry thoroughly. Provide slow gentle when indicated. stretching to BUE at the shoulders, elbows, Audit results will be reported to the wrists, and hands as tolerated prior to application. Administrator weekly for the next 3 Record review of Resident #58's active physician months beginning on 3.8.23, who will be orders located on the Medication Administration responsible for reporting concerns to the Record (MAR) were reviewed. The MAR for Quality Assurance Committee during January and February 2023 revealed nursing staff monthly meetings. documented they positioned bilateral elbow Continued compliance will be monitored extension splints daily on day shift for through the facility s Quality Assurance contractures, time for application read "day shift". Program. No refusals or documentation that splints had not been applied. Nurse #7 initialed the MAR on Compliance will be monitored by the QA 2/6/23 and 2/7/23 and Nurse #5 initialed the MAR Committee for 3 months during the March through May regularly scheduled on 02/08/23 indicating the task had been meetings or until resolved and additional completed. education/training will be provided for any Record review of Resident #58's nursing notes issues identified. from 10/01/22 through 02/07/23 revealed no documentation of splint refusal or intolerance of splint application. An observation occurred of Resident #58 on 02/06/23 at 02:40 PM. She was lying in bed with her eyes open. Her bilateral arms were bent at the elbows with hands by her face and there were no elbow splints noted. An observation occurred of Resident #58 on 02/07/23 at 09:56 AM, 10:28 AM and at 03:58 PM. She was lying in bed with her eyes open. Her

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

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 02/28/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345421	B. WING_					C 09/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				72	2 CHATHAM BUSINESS PARK			
THE LAUP	RELS OF CHATHAM			Ρ	ITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 688	by her face and there noted. An interview was com PM with Nurse #7. Sh the MAR for the applie elbow splints on 2/6/2 applied them. She ind not tolerate the splints difficult to apply them Physical Therapy (PT An interview with Unit observation of Reside 02/08/23 at 09:45 AM her eyes open withou applied. Unit Manage applied because Resi them. She also stated discussed it on 02/07/ document that Reside the splints. The interview were to report to thera tolerating the splints. Physical Therapy (PT An interview with Nurs conducted on 02/08/2 confirmed she was the #58. An order to apply the MAR and were sig # 5 confirmed Reside splints on and she did prior to applying the s where the splints were interview.	ent at the elbows with hands were no elbow splints ducted on 02/07/23 at 3:07 te confirmed she had signed cation of Resident #58 ' s 3 and 2/7/23 but had not licated Resident #58 could a and further stated it was . As far as she knew) had not been informed. . Manager #2 and ent #58 were conducted on . She was lying in bed with t her ordered elbow splints r #2 stated they were not dent #58 was not tolerating l she, and Nurse #7 was to ent #58 was not tolerating iew further revealed staff apy if the residents were not She was unaware if) had not been informed. se #5 and observation were 3 at 09:52 AM. Nurse #5 e nurse caring for Resident y the elbow splints was on gned off by Nurse #5. Nurse in #58 did not have elbow I not know why she signed it plints. She did not know e located at time of	F	588				
	An interview with Nur	sing Assistant (NA) #12 and						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345421	B. WING				C 09/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 688	02/08/23 at 10:00 AM gets report from the or resident can or cannot can look at the care p do so. She further sta Resident #58 was sup applied because she her. An interview was com PM with the Director of stated she expected so orders. She also state tolerate the splints, sh document and Physic notified. She further so the splint, she expect refusal. She was unav being applied to Resid An interview was com PM with the Administr expectation was for so orders. 2. Resident # 87 was 3/25/20 with multiple hemiplegia/hemipares vascular disease affer The annual Minimum assessment dated 1/2 Resident #87 had imp on both upper and low Resident # 87 had a p 11/11/22 to apply righ after AM care as toler	ducted of Resident #58 on I. She stated she normally ff going NA as to what each of do. She also stated she blan/kardex, but she did not ted she was unaware that oposed to have splints had never seen them on ducted on 02/09/23 T 12:58 of Nursing (DON). She splints to be applied per ed if the resident cannot he expected nursing to cal Therapy (PT) to be tated if the resident refused ed nursing to document the ware the splints were not dent #58. ducted on 02/09/23 at 01:08 rator. He stated his plints to be applied per admitted to the facility on diagnoses including sis following cerebro cting right dominant side. Data Set (MDS) 24/23 indicated that bairment in range of motion	F	688			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	2: 02/28/2023 APPROVED 0: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345421	B. WING				(02/0) 09/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 688	Continued From page	e 48	F	688				
	reviewed. One of the resident was at risk for development related it and contracture of rig extremities. The goal develop any further or approaches included right hand after AM ca remove palm guard fr care as tolerated. Resident #87 was obs AM, and on 2/7/23 at hand was in fist positi guard noted. Nurse #4, assigned to interviewed on 2/7/23 observed the resident the resident was supp guard on, but she cou- might be in the laund that she had not know palm guard. Nurse Aide (NA) #10, was interviewed on 2/ stated that she provid She reported that she wearing a splint or pa and she didn't know ti supposed to be weari hand. Resident #87 was aga	to right sided hemiplegia ht upper and lower was for the resident not to ontractures. The to apply right palm guard to are as tolerated, and to om right hand prior to PM served on 2/6/23 at 11:24 11:05 AM in bed. His right on and there was no palm b Resident #87, was at 11:06 AM. The Nurse t's right hand and stated that bosed to have the right palm ild not find it in the room, it ry. The Nurse indicated that with the resident to refuse the assigned to Resident #87, (7/23 at 12:05 PM. The NA ed AM care to the resident. a had not seen the resident Im guard on his right hand hat the resident was ing a device on his right						
	-	nt was still not wearing a						

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						FORM	MAPPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		345421	B. WING				C 109/2023
NAME OF P	PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 345421 B. WING ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM TTSBORO, NC 27312 (xi) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY OR LSC IDENTIFING INFORMATION) ID PREFIX (xi) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH ORRECTWE ADTON OR LSC IDENTIFING INFORMATION) ID PREFIX (xi) ID PREFIX RECOLLATORY OR LSC IDENTIFING INFORMATION) ID PREFIX PROVIDER SPARK PITTSBORO, NC 27312 F 688 Continued From page 49 F 688 F 688 The Nurse Unit Manager #1 was interviewed on 2/9/23 at 11:30 AM. The Unit Manager verified that Resident #87 had a physician's order for the right-hand palm guard and stated that the palm guard should have been applied every day. She reported that she was not aware that the resident's palm guard was not in his room. F 732 The Director of Nursing (DON) and the Administrator were interviewed on 2/9/23 at 12:58 PM. The DON stated that she expected the palm guard should have been applied every day. She reported that the arequirements. The facility must post the following information S483.35(g) (1) List arequirements. The facility must post the following information on a daily basis: (i) Fractilty name. (ii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registrend nurses (as defined under State law). (C) Certified nu			REET ADDRESS, CITY, STATE, ZIP CODE			
THE LAUF	RELS OF CHATHAM						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page	49	F 6	88			
	2/9/23 at 11:30 AM. T that Resident #87 had right-hand palm guard guard should have be reported that she was resident's palm guard The Director of Nursin Administrator were int PM. The DON stated guard to be applied as Posted Nurse Staffing CFR(s): 483.35(g)(1)- §483.35(g) Nurse Sta §483.35(g) Nurse Sta §483.35(g)(1) Data re must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categ unlicensed nursing sta resident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must po	The Unit Manager verified d a physician's order for the d and stated that the palm een applied every day. She is not aware that the was not in his room. (d) and the terviewed on 2/9/23 at 12:58 that she expected the palm is ordered. (a) Information (d) ffing Information. (quirements. The facility g information on a daily and the actual hours worked tories of licensed and aff directly responsible for in unses or licensed defined under State law). des.	F 7	'32			3/3/23

Facility ID: 923099

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						FORM	APPROVED 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	TMENT OF HEALTH AND HUMAN SERVICES F RS FOR MEDICARE & MEDICAID SERVICES OME T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) PROVIDER OR SUPPLIER 345421 B. WING (X2) MULTIPLE CONSTRUCTION B. WING (X3) PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		C 09/2023				
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				7	2 CHATHAM BUSINESS PARK		
THE LAUP	RELS OF CHATHAM			F	PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 732	 (B) In a prominent play residents and visitors §483.35(g)(3) Public is staffing data. The fact written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fact posted daily nurse states and the communit is greater. This REQUIREMENT by: Based on record revises and the fact of the staffing Information and Schedule/Assignment days reviewed. The findings included A review of the Staff Scheets and timecard daily Posted Nurse Statistic from 01/06/23 through discrepancies in the and actual nursing staticensed Registered N Practical Nurses (LPN Medication Aides (MA (NAs). Review of the daily Posted Nurse Staff Name Name Name Name Name Name Name Name	access to posted nurse sility must, upon oral or e nurse staffing data e for review at a cost not to y standard. data retention cility must maintain the affing data for a minimum of uired by State law, whichever is not met as evidenced ew and staff interviews, the y accurate Posted Nurse s compared to the Staff t Sheets for 31 out of 31 : Schedule/Assignment reports compared to the taffing Information sheets n 02/06/23 revealed areas of actual hours worked aff who worked including the Jurses (RNs) and Licensed vs), and the unlicensed vs), and Nursing Assistants	F	732	F732 Posted Nurse Staffing Information The facility will continue to display accurate Posted Nurse Staffing Information as compared to the Staff Schedule/Assignments Sheets. Corrective Action: The Posted Nurse Staffing Information from 2.9.23, the da of discovery, was reviewed and corrections made as necessary, by the DON. No negative outcome was identified relating to this observation. How the facility will identify those who have the potential to be affected: Subsequent Posted Nurse Staffing Information after 2.9.23 has the potentit to be affected. Posted Nurse Staffing Information after 2.9.23 was reviewed of	ate	
	Information sheets for compared to timecard	r 01/06/23 through 02/06/23 I reports revealed there n the Posted Nurse Staffing			2.23.23 by the Administrator to ensure that Posted Nurse Staffing Information accurate as compared to the Staff	is	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			FORM AF OMB NO. 0	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		345421	B. WING _		C 02/09/	2023
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	Ē	
THE LAUI	RELS OF CHATHAM			72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE C	(X5) OMPLETIO DATE
F 732	Continued From page	e 51	F 7	32		
	Information although	RNs were working for the /23, 01/25/23, 01/27/23, and		Schedule/Assignment Sheets negative outcomes was identi to these observations.		
The number of licensed staff and actual hours worked of licensed staff on 1st shift were incorrect for the following days: 01/06/23, 01/07/23, 01/09/23, 01/10/23, 01/11/23, 01/12/23, 01/13/23, 01/14/23, 01/15/23, 01/16/23, 01/17/23, 01/18/23, 01/19/23, 01/20/23, 01/21/23, 01/22/23, 01/23/23, 01/24/23, 01/25/23, 01/26/23, 01/27/23, 01/30/23, 01/31/23, 02/01/23, 02/02/23, 02/03/23,		Systemic changes: The Sche Coordinator was inserviced by Administrator on 2.24.23 on th policy for ensuring that Posted Staffing Information is accurat compared to the Staff Schedule/Assignment Sheets	r the le facility I Nurse e as			
			Monitoring: A QA monitoring utilized to ensure ongoing cor the ADON/designee beginning The ADON/designee will revie Nurse Staffing Information and Schedules/Assignment Sheet 4 weeks then 3x/week x 4 we weekly x 4 weeks to ensure th Nurse Staffing Information is a Variances will be corrected at audit and additional education when indicated.	npliance by g on 3.1.23. w Posted d Staff s 5x/week x eks then at Posted accurate. the time of		
	actual hours worked staff on 2nd shift were days: 01/06/23, 01/07 01/12/23, 01/13/23, 0 01/18/23, 01/21/23, 0 01/26/23, 01/27/23, 0 02/02/23, 02/04/23, 0 The number of actual	ed and unlicensed staff and of licensed and unlicensed e incorrect for the following 7/23, 01/08/23, 01/11/23, 01/14/23, 01/16/23, 01/17/23, 01/22/23, 01/23/23, 01/25/23, 01/30/23, 01/31/23, 02/01/23, 02/05/23, and 02/06/23.		Audit results will be reported to Administrator weekly for the m months beginning on 3.8.23, w responsible for reporting cond Quality Assurance Committee monthly meetings. Continued compliance will be through the facility □s Quality Program.	ext 3 vho will be erns to the during monitored	
	days: 01/09/23 and 0 The number unlicens	incorrect for the following 1/28/23 ed staff and actual hours staff on 2nd shift were		Compliance will be monitored Committee for 3 months durin through May regularly schedu meetings or until resolved and	the March led	

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CENTER STATEMENT (AND PLAN OF NAME OF PI	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER RELS OF CHATHAM	TEMENT OF DEFICIENCIES	ì í	NG	TREET ADDRESS, CITY, STATE, ZIP CODE 2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	FORM OMB NC (X3) DATE COMP (02/	2LETED C (09/2023 (X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	DATE
F 732	actual hours worked of staff on 3rd shift were days: 01/06/23, 01/07 01/12/23, 01/13/23, 0 01/18/23, 01/21/23, 0 01/27/23, 01/30/23, 0 02/04/23, 02/05/23, a The number unlicensed worked of unlicensed incorrect for the follow	ving days: 01/10/23, 3. ed and unlicensed staff and of licensed and unlicensed incorrect for the following 7/23, 01/08/23, 01/11/23, 1/14/23, 01/16/23, 01/17/23, 1/22/23, 01/25/23, 01/26/23, 1/31/23,02/01/23, 02/02/23, nd 02/06/23. ed staff and actual hours staff on 3rd shift were ving days: 01/09/23,	F	732	education/training will be provided for issues identified.	any	
	01/29/23. An interview on 02/09 conducted with the Ce She stated she was re the daily Posted Nurs based on the actual w the day and posting th Central Supply Coord any nursing staff calle unaware she had to a she was unaware Me unlicensed staff. She unaware the Register listed on the Posted N sheet if they were not An interview on 02/09 conducted with the Di She confirmed the da Information sheets we have included the RN	entral Supply Coordinator. esponsible for completing e Staffing Information sheet vorking assignment sheet for nem in a viewable area. The inator confirmed that when ed out for the day, she was adjust the posting sheet and dication Aides (MAs) were then stated she was ed Nurses (RNs) were to be Jurse Staffing Information on a medication cart.					

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					OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
					С
		345421	B. WING		02/09/2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE LAUF	RELS OF CHATHAM			72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO
F 732	Continued From page	e 53	F 73	2	
	Staffing Information s correct actual working number of staff for the				
F 757 SS=D	Drug Regimen is Free CFR(s): 483.45(d)(1)	e from Unnecessary Drugs -(6)	F 75	7	3/3/23
	§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-				
	§483.45(d)(1) In exce duplicate drug therap				
	§483.45(d)(2) For exc	cessive duration; or			
	§483.45(d)(3) Withou	t adequate monitoring; or			
	§483.45(d)(4) Without adequate indications for its use; or				
	§483.45(d)(5) In the p consequences which reduced or discontinu	indicate the dose should be			
	stated in paragraphs section.	mbinations of the reasons (d)(1) through (5) of this is not met as evidenced			
	by: Based on record rev	iew, Medical Director and acility failed to transcribe vital		757 Drug Regimen is Free from Unnecessary Drugs	
	sign parameters for a as ordered for 1 of 6	blood pressure medication residents whose iewed (Resident #223).		The facility will continue to ensure vital sign parameters for blood pre medications are transcribed as ord Corrective Action: Resident #223 l	essure dered.

Event ID: HZHR11

Facility ID: 923099

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CENTER	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES	1			FORM OMB NC	0: 02/28/2023 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE COMP	LETED
		345421	B. WING				09/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 757	10/13/22 with diagnost fibrillation, anxiety dis- weakness. A nursing progress not part, that therapy had #223 was not doing w pressure dropped dur was in the building an #223's condition. An of parameters for Metop medication) 12.5 milling medication if blood pr or heart rate less than Review of the Septem revealed an order dat 12.5 mg by mouth twi The parameters of wh were not listed with the Review of the Octobe Administration Record Metoprolol was being parameters of when to The November 2022 of the Metoprolol was ch a day. There were not hold the medication a The December 2022 of revealed the Metopro no parameters of when ordered.	dmitted to the facility on ses that included atrial order, and muscle the dated 9/28/22 read, in reported that Resident rell because her blood ing therapy. The physician d was updated on Resident order was provided with new rolol (a blood pressure grams (mg). Hold the essure is less than 110/70 n 60. ther 2022 physician orders ed 9/20/22 for Metoprolol ce a day for Hypertension. then to hold the medication e order. r 2022 Medication d (MAR) revealed the provided with no to hold the medication listed. physician orders indicated hanged to 12.5mg one time to parameters of when to s ordered 9/28/22. MAR was reviewed and lol was being provided with en to hold the medication as	F	757	medication transcribed as ordered on 2.23.23. No negative outcome was identified relating to this observation. How the facility will identify those who have the potential to be affected: Curr residents with orders for blood pressur medications have the potential to be affected. Current residents with orders blood pressure medications had order reviews completed on 2.23.23 by the D to ensure that vital sign parameters we transcribed as ordered. No negative outcomes were identified relating to the reviews. Systemic changes: All licensed nurses will be inserviced by the ADON by 2.28 on the facility policy that vital sign parameters for blood pressure medications will be transcribed as ordered. Newly hired staff and agency licensed nurses will be educated by the ADON on the facility policy that vital sign parameters for blood pressure medications will be transcribed as ordered. Newly hired staff and agency licensed nurses will be educated by the ADON on the facility policy that vital sign parameters for blood pressure medications will be transcribed as ordered. Monitoring: A QA monitoring tool will b utilized to ensure ongoing compliance the DON/designee beginning on 3.1.23 The DON/designee will randomly revie residents with orders for blood pressure medications weekly x 4 weeks then bi-weekly x 4 weeks then randomly x 4 weeks to ensure that vital sign parame for blood pressure medications are transcribed as ordered. Variances will	e for pON re ese 3.23 e gn e by 3. w 3 e ters	
	(MDS) assessment da				corrected at the time of review and		

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		D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 02/28/2023 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY PLETED
		345421	B. WING			C /09/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF CHATHAM			72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 757		evere cognitive impairment.	F 7	57 additional education provided when indicated.		
	orders and MARs wei the Metoprolol was be parameters of when to ordered on 9/28/22. On 2/8/23 at 10:03 AI interviewed. She was verbal order on 9/28/2 medication parameter medication. The 9/28/ reviewed as well as th February 2023 physic stated she must have hold parameters for th the verbal order. A phone interview occ Director on 2/9/23 at verbal order was prov for the Metoprolol, the to be transcribed and he felt there was no s	the nurse that took the 22 for the Metoprolol rs of when to hold the (22 nursing note was be September 2022 through cian orders and MARs. She forgotten to transcribe the be Metoprolol after receiving curred with the Medical 11:34 AM and stated if a rided with hold parameters en he would have expected it followed. He further stated erious harm caused as he ication and monitored her		Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.23, who will responsible for reporting concerns to Quality Assurance Committee during monthly meetings. Continued compliance will be monito through the facility □ s Quality Assura Program. Compliance will be monitored by the Committee for 3 months during the M through May regularly scheduled meetings or until resolved and addition education/training will be provided for issues identified.	the ed ice QA arch	
F 761 SS=D	nurses to transcribe a received. Label/Store Drugs an CFR(s): 483.45(g)(h)(§483.45(g) Labeling o Drugs and biologicals	d stated she expected the iny verbal orders that were d Biologicals	F 7(61		3/3/23

Facility ID: 923099

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		345421	B. WING				C 109/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF CHATHAM				2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	professional principle appropriate accessor instructions, and the of applicable. §483.45(h) Storage of §483.45(h)(1) In acco Federal laws, the fact biologicals in locked of temperature controls, personnel to have acc §483.45(h)(2) The fac locked, permanently a storage of controlled the Comprehensive E Control Act of 1976 a abuse, except when t package drug distribu quantity stored is min be readily detected. This REQUIREMENT by: Based on observatio and staff, the facility f patches for 1 of 4 (R observed for medicat The findings included On 2/7/2023 at 9:30A administering medica resident asked Nurse she was in the room. the draw of the bedsit #9's bed and pulled of creme patches (Lidoo	s, and include the y and cautionary expiration date when f Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. cality must provide separately affixed compartments for drugs listed in Schedule II of Orug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can r is not met as evidenced n, interview with resident ailed to secure medication esident #16) residents ion administration.	F	761	F761 Label/Store Drugs and Biological The facility will continue to secure medication patches in accordance with State and Federal laws. Corrective Action: The patches for Resident #16 were removed from the room and secured in the medication ca No negative outcome was identified as result of this observation. How the facility will identify those who have the potential to be affected: Curre residents with physician orders for	rt. a	

Facility ID: 923099

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						OMB N	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	1 Y /	E SURVEY
			A. BUILDIN	G			С
		345421	B. WING				2/09/2023
	ROVIDER OR SUPPLIER	010121			TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	2/09/2023
					2 CHATHAM BUSINESS PARK		
THE LAUF	RELS OF CHATHAM				ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 761	Continued From page	57		64			
F 701	Continued From page		F 76	61	madiantics watches have the material	4	
		able drawer, and applied Resident #16. After exiting			medication patches have the potential be affected. Current residents with	10	
	the resident's room, t				physician orders for medication patche	es	
		regarding the storage of			were reviewed by the Unit Manager or		
		nt #16's bedside table.			2.23.23 to ensure that medication pate		
		esident did not have an			were secured in accordance with State		
		er the patch and the patches			and Federal laws. No negative outcor	ne	
	should be secured so				was identified as a result of these		
		further stated the resident es the facility had, therefore			observations.		
		ing the patches into the			Systemic changes: 100% of licensed		
	facility for her.				nurses and medication aides will be		
	····· ·				inserviced by the ADON as of 2.28.23	on	
	At 9:15AM on 2/7/202	23 and interview was			the facility policy for securing medicati		
	conducted with Resid	lent #16. She stated she			patches in accordance with State and		
		am patches over the generic			Federal laws. After this date all newly		
	•	She also prefered the			hired staff nurses, agency nurses, and		
		er room. She further stated			medication aides will be educated by t	he	
		n stored in her bedside table			ADON on this facility policy upon hire.		
		"a month and a half", and nd why there was an issue			Monitoring: A QA monitoring tool will b	20	
	with storage now.	id wity there was all issue			utilized to ensure ongoing compliance		
					the Unit Manager/designee beginning	-	
	On 2/07/2023 at 10:3	1 AM a second interview			3.1.23. The Unit Manager/designee w		
	was conducted with N	Nurse #9. She stated			audit 3 residents with physician orders		
	Resident #16's was p				medication patches 5x/week x 2 week		
	medication storage a	•			then 3x/week x 2 weeks then weekly x		
	secured on the medic	cation cart.			weeks then bi-weekly x 4 weeks to en		
	An interview was con	ducted with the Director of			that medication patches are secured in accordance with State and Federal law		
		at 1:00PM. She stated			Variances will be corrected at the time		
	•	have medication stored			audit and additional education provide		
	unsecure in their roor				when indicated.		
					Audit results will be reported to the		
					Administrator weekly for the next 3		
					months beginning on 3.8.23, who will I		
					responsible for reporting concerns to t	he	
					Quality Assurance Committee during monthly meetings.		

Event ID: HZHR11

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345421	B. WING				C 09/2023
NAME OF PI	ROVIDER OR SUPPLIER		-	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page	2 58	F	761	Continued compliance will be monitored through the facility s Quality Assuranc Program. Compliance will be monitored by the Q. Committee for 3 months during the Mar through May regularly scheduled meetings or until resolved and additiona education/training will be provided for a issues identified.	e A rch al	
	Resident Records - Io CFR(s): 483.20(f)(5),		F 8	342			3/3/23
	 (i) A facility may not resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a co agrees not to use or o 	lease information that is					
		dance with accepted is and practices, the facility al records on each resident ented; e; and					
	all information contair regardless of the form records, except when (i) To the individual, o						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345421	B. WING				/09/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE LAU	RELS OF CHATHAM				72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	 (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health an eglect, or domestic vactivities, judicial and law enforcement purp purposes, research predical examiners, further a serious threat to he by and in compliance §483.70(i)(3) The factor record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from th there is no requireme (iii) Five years from th there is no requireme (iii) For a minor, 3 year legal age under State §483.70(i)(5) The me (i) Sufficient informatii (ii) A record of the ression of the reservect of the ression of the ress	yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings, ooses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. Hity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident; ident's assessments; ve plan of care and services or preadmission screening valuations and loted by the State; 's, and other licensed	F	842			

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		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
			A. BUILDING			С
		345421	B. WING			2/09/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		2/09/2023
				72 CHATHAM BUSINESS PARK	0002	
THE LAUF	RELS OF CHATHAM			PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
E 040		00				
F 842			F 84			
		iew and staff interviews, the ain accurate medical records		F842 Resident Records- Information	-identifiable	
		dent #123), and respiratory		The facility will continue t	o maintain	
		. This was for 1 of 7 closed		accurate medical records		
	records reviewed.			and respiratory care.		
	The findings included	Ŀ		Corrective Action: Reside	ent #123 no	
	·····g- ·····			longer resides at the facil		
	1a. Resident #123's p	physician orders included an		outcome was identified re	elating to these	
		or skin prep to the right foot		observations.		
		nitor every shift for changes				
		an and wound care nurse for		How the facility will identi have the potential to be a	-	
	treatment change.			residents with orders for		
	The April 2022 and M	lav 2022 Treatment		respiratory care have the		
	-	ds (TARs) were reviewed		affected. TAR⊡s for curr	-	
	and revealed the righ	t foot blister wound care had		with orders for wound car	re and respiratory	
		d as completed or refused by		care were reviewed on 2		
	the resident for the fo			that medical records for w		
	· · ·	to 3:00 PM) on 4/3/22,		respiratory care were acc		
	4/6/22, 4/7/22, 4/9/22 4/29/22 and 5/1/22.	2, 4/14/22, 4/22/22, 4/27/22,		negative outcomes were to these observations.	identified relating	
		PM to 11:00 PM) on 4/8/22,				
	4/12/22 and 5/6/22.			Systemic changes: All lic	censed nurses	
				were inserviced by the Al		
		g progress notes from 3/1/22		2.28.23 on the facility pol		
		al any refusals of wound		that medical records for w		
	care by Resident #12	3.		respiratory care are accu		
	On 2/8/23 at 10.17 M	M, an interview occurred		hired staff and agency nu hired after 2.28.23 will be		
		lanager #1 who was familiar		ADON on the facility polic	-	
		She was scheduled for the		that medical records for v		
		/9/22, 4/14/22, 4/27/22, and		respiratory care are accu		
	4/29/22. She recalled	l completing the wound care				
	to Resident #123's bl			Monitoring: A QA monito		
		been completed. The		utilized to ensure ongoing		
	-	#1 stated she had forgotten		the Treatment nurse/desi		
	to accument the wou	nd care as completed on the		on 3.1.23. The Treatmer	it nurse/designee	

Facility ID: 923099

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		D HUMAN SERVICES MEDICAID SERVICES			FORM	2: 02/28/2023 APPROVED 0: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345421	B. WING		02/	C 09/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
			7	2 CHATHAM BUSINESS PARK		
	RELS OF CHATHAM		F	PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	2/9/23 at 11:45 AM, w Resident #123. She w shift on 4/7/22 and co refusing wound care t she completed the wo to sign it was completed The Director of Nursir 2/9/23 at 1:01 PM and nursing staff to compl as well as to document refused by the resident Multiple phone calls w was assigned to Resis shift of 4/12/22 with nur- b. Resident #123's ph order dated 9/27/17 for shift, remove inner can Clean around trached replace gauze. The April 2022 and M Administration Record and revealed the track documented as comp resident for the follow - Day shift (7:00 AM to 4/4/22, 4/6/22, 4/7/22 4/27/22, 4/29/22 and - Evening shift (3:00 F 4/12/22 and 5/6/22.	curred with Nurse #2 on the was familiar with vas scheduled for the day uld not recall Resident #123 o her foot blister. She stated bund care but had forgotten ed. The was interviewed on d indicated she expected the ete wound care as ordered the tit was completed or nt. Were made to Nurse #3 who dent #123 on the evening to success. Tysician orders included an for tracheostomy care every nnula, clean, and replace. stomy area, pat dry and ay 2022 Treatment ds (TARs) were reviewed heostomy care had not been leted or refused by the ing: to 3:00 PM) on 4/3/22, 4/9/22, 4/14/22, 4/22/22, 5/1/22. PM to 11:00 PM) on 4/8/22,	F 842		eks at d be ne d ce A rch hly al	
	- Evening shift (3:00 F 4/12/22 and 5/6/22.	PM to 11:00 PM) on 4/8/22, progress notes from 3/1/22				

Facility ID: 923099

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE COMF	
		345421	B. WING			09/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF CHATHAM			72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 842	tracheostomy care by On 2/8/23 at 10:17 AI with the Nurse Unit M with Resident #123. S day shift on 4/6/22, 4/ 4/29/22. She recalled Resident #123 after n completed. The Nurs she had forgotten to o care as completed on A phone interview occ 2/9/23 at 11:45 AM, w Resident #123. She v shift on 4/7/22 and co	A Resident #123. M, an interview occurred lanager #1 who was familiar She was scheduled for the 19/22, 4/14/22, 4/27/22, and completing tracheostomy to nedication pass had been the Unit Manager #1 stated document the tracheostomy the TAR. curred with Nurse #2 on who was familiar with vas scheduled for the day ould not recall Resident #123 y care. She stated she ostomy care but had	F 8	42		
F 867 SS=D	2/9/23 at 1:01 PM and nursing staff to compl ordered as well as to or refused by the resi Multiple phone calls v was assigned to Resi shift of 4/12/22 with n QAPI/QAA Improvem CFR(s): 483.75(c)(d)(§483.75(c) Program f monitoring. A facility must establis policies and procedur collections systems, a	vere made to Nurse #3 who dent #123 on the evening o success. ent Activities (e)(g)(2)(i)(ii) reedback, data systems and sh and implement written	F 8	67		3/3/23

Facility ID: 923099

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 02/28/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345421	B. WING				02/) 09/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CO	DDE	•	
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD B		(X5) COMPLETION DATE
F 867	following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representative information will be used are high risk, high volu- opportunities for impro- §483.75(c)(2) Facility systems to identify, co- information from all de not limited to the facility §483.75(c)(3) Facility and evaluation of perfi- including the methodod development, monitor §483.75(c)(4) Facility including the methodod systematically identify analyze and use data adverse events in the facility will use the dat prevent adverse even §483.75(d) Program s systemic action. §483.75(d)(1) The fac	ide, at a minimum, the maintenance of effective luse of feedback and input other staff, residents, and es, including how such ed to identify problems that ume, or problem-prone, and ovement. maintenance of effective ollect, and use data and epartments, including but ty assessment required at ling how such information p and monitor performance development, monitoring, formance indicators, ology and frequency for such ing, and evaluation. adverse event monitoring, by which the facility will r, report, track, investigate, and information relating to facility, including how the ta to develop activities to ts. systematic analysis and	F	367	DEFICIENC	Y)		
	-	improvement and, after ctions, measure its success,						

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CENTER STATEMENT (AND PLAN OF NAME OF P THE LAUI (X4) ID PREFIX	ROVIDER OR SUPPLIER RELS OF CHATHAM SUMMARY STA (EACH DEFICIENCY	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345421 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIEVING INFORMATION)	A. BUILD B. WING	ING	(EACH CORRECTI	E, ZIP CODE RK LAN OF CORRECTION VE ACTION SHOULD BI	FORM OMB NC (X3) DATE COMP (02/	LETED
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	i		ED TO THE APPROPRIA FICIENCY)	TE	DATE
					DEF	-ICIENCY)		
F 867	and track performance improvements are real §483.75(d)(2) The fac- implement policies ad (i) How they will use a determine underlying impacting larger syste (ii) How they will deve will be designed to eff level to prevent quality safety problems; and (iii) How the facility wi of its performance improvem §483.75(e) Program a §483.75(e)(1) The face performance improven high-risk, high-volume consider the incidence of problems in those a outcomes, resident sa resident choice, and c §483.75(e)(2) Perform activities must track m resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activities distinct performance i number and frequenc	e to ensure that alized and sustained. cility will develop and ddressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or ill monitor the effectiveness provement activities to hents are sustained. activities. cility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. mance improvement nedical errors and adverse yze their causes, and e actions and mechanisms and learning throughout the	F	867				

Facility ID: 923099

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/28/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345421	B. WING				C / 09/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7	2 CHATHAM BUSINESS PARK		
THE LAUP	RELS OF CHATHAM			P	ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	assessment required Improvement projects annually a project tha problem-prone areas collection and analysi (c) and (d) of this sect §483.75(g) Quality as §483.75(g)(2) The qua assurance committee governing body, or de functioning as a gove activities, including im program required und (e) of this section. The (ii) Develop and imple action to correct ident (iii) Regularly review a data collected under to resulting from drug re available data to make This REQUIREMENT by: Based on record revi and staff interviews, to Assurance and Perfor (QAPI) committee fail procedures and monit committee put into pla recertification and cor 1/24/20. This was for cited in the areas of A Services Provided Me and Increase/Prevent	facility's services and as reflected in the facility at §483.70(e). must include at least t focuses on high risk or identified through the data s described in paragraphs tion. sessment and assurance. ality assessment and reports to the facility's esignated person(s) ming body regarding its uplementation of the QAPI er paragraphs (a) through e committee must: ement appropriate plans of ified quality deficiencies; and analyze data, including he QAPI program and data gimen reviews, and act on e improvements. is not met as evidenced ews, observations, resident, he facility's Quality mance Improvement ed to maintain implemented	F	867	F867 QAPI/QAA Improvement Activi The facility will continue to ensure tha quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develop and implements appropriate plans of action to correct identified quality deficiencies.	at the	

Facility ID: 923099

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		MEDICAID SERVICES			OMB NO. 0938-0
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345421	B. WING	С	
		343421	D. WING		02/09/2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE
THE LAUR	ELS OF CHATHAM			72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETO THE APPROPRIATE DATE
F 867	Continued From none		F 00	~~	
F 00/	Continued From page		F 86		
		annual recertification and		Corrective Action: The fa	
		3/17/22 in the areas of ne duplicate citations during		to code assessments to the resident □s status.	accurately reliect
		of record shows a pattern of		The facility will continue	to ensure that the
		o sustain an effective QAPI		correct medication admi	
	program.			transcribed for residents	receiving gastric
				tube feeding with orders	
	The findings included	:		mouth.	
				The facility will continue	
	This citation is cross	referenced to:		palm guards and splints	
				ordered for range of mot	
		cord review and staff		The facility will continue	
		failed to code the Minimum ssments accurately in the		accurate medical record and respiratory care.	s for wound care
		esidents #89. #87 & #19),		Residents #87, #114, #2	8 #89 and #19
	÷ ,	lent #114) and diagnoses		had MDS corrections co	
		of 31 residents whose MDS		2.9.23. No negative out	
	were reviewed.			identified relating to thes	
				Resident #87 had physic	
		ecertification survey of		corrections completed o	
	1/24/20, the facility fa			negative outcome was id	lentified relating
		ly in the areas of Activities of		to this observation.	
		active diagnosis, discharge, medications and bowel and		Resident #58 continues ordered. Resident #87 d	
		mpled residents reviewed.		the palm guard as order	
		impled residents reviewed.		outcome was identified r	-
	In an interview with th	ne Administrator on 2/9/23 at		observations.	
		epeat citation in MDS		Resident #123 no longer	resides at the
		be related to human error.		facility. No negative out	
				identified relating to thes	e observations.
	2. F658- Based on re	cord review, observation		How the facility will ident	ify those who
		e facility failed to transcribe		have the potential to be	
		n administration route for 1		residents with MDS asse	
		esidents reviewed for gastric		coded as BIMS not com	
	-	orders for nothing by mouth		rarely/never understood	
	(NPO).			interview completed, cur	
	D · · · · · · · · ·	ecertification survey of		with pressure ulcers, and residents with diagnoses	

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	COMPLETED
			A BOILDING		С
		345421	B. WING	·····	02/09/202
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	•
				72 CHATHAM BUSINESS PARK	
THE LAUP	RELS OF CHATHAM			PITTSBORO, NC 27312	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPL TO THE APPROPRIATE DAT
F 867	Continued From page	a 67	F 86	37	
1 007			FOU	-	
		iled to accurately transcribe diabetic ulcers and a surgical		Hypothyroidism and Atri have the potential to be	
		dents reviewed with pressure		current residents that m	
	ulcers.			were reviewed by 2.24.2	
				assessments had been	
	In an interview with th	ne Administrator on 2/9/23 at		accurately reflect each r	
	1:30 PM, he indicated	d the facility had experienced		No negative observation	
	some staff turn-over a	and felt the information may			
		available to the MDS Nurse		Current residents that re	
	for proper coding of the	he MDS assessment.		feeding and have orders	
				mouth have the potentia	
				Current residents meeti	
		cord review, observations,		were audited on 2.21.23	
	right-hand palm guar	the facility failed to apply the		correct medication adm transcribed for all order	
		sion splints (Residents #58)		No negative outcome w	
		residents reviewed for range		relating to these observ	
	of motion.	residente reviewed for range			
				Current residents with o	orders for splints
	During the facility's re	ecertification survey of		and palm guards have t	
	3/17/22, the facility fa	iled to apply splints as		affected. Current reside	
	ordered for 1 of 2 res	idents reviewed for		splints and palm guards	were reviewed by
	contractures and limit	ted range of motion.		the Rehab Services Dire	
				to ensure that splints an	
	An interview with the			being worn as ordered.	•
		1:30 PM, and he indicated		outcomes were identifie	d relating to these
		e staff turn-over to include		observations.	
		cility was utilizing agency as a lack in oversight and		Current residents with o	orders for wound
		he splints were applied as		care and respiratory car	
	ordered.			potential to be affected.	
				current residents with or	
				care and respiratory car	e were reviewed
	4. F842- Based on re	cord review and staff		on 2.23.23 to ensure that	
		failed to maintain accurate		for wound care and resp	piratory care were
		ound care (Resident #123),		accurate. No negative of	
		(Resident #123). This was		identified relating to the	se observations.
	for 1 of 7 closed reco	rds reviewed.			
				Systemic changes: The	e MDS Coordinator

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			()() · · · · - · - ·		OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345421	B. WING	С	
	ROVIDER OR SUPPLIER	5-0-21		STREET ADDRESS, CITY, STATE, ZIP CODE	02/09/2023
				72 CHATHAM BUSINESS PARK	
THE LAURELS OF CHATHAM				PITTSBORO, NC 27312	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLÉTIO
F 867			F 867		
	 1/24/20, the facility farmedical records in the showers, accuchecks nursing assessment reviewed for complete records. An interview with the conducted 2/9/23 at facility had experience nursing staff, to inclue The facility was utilized the statement of the shower o	e and accurate medical Administrator was 1:30 PM and indicated the red some challenges due to de management turnover. ing agency staff and felt the be a result of the need for		 and Social Worker were inservice Clinical Resource Specialist on 2. completing assessments that acc reflect the resident s status. All licensed nurses will be inservice the ADON by 2.24.23 on the facilit for ensuring that the correct media administration route is transcribed ordered medications. Newly hired and agency nurses that are hired 2.28.23 will be educated by the A the facility policy for ensuring that correct medication administration transcribed for all ordered medications. ADON as of 2.28.23 on the facility on ensuring that medical records wound care and respiratory care accurate. Newly hired staff and a nurses that are hired after 2.28.23 educated by the ADON on the face policy on ensuring that medical records wound care and respiratory care accurate. The facility s quality assurance committee will be inserviced by the Regional Clinical Coordinator on the procedures for developing and implementing appropriate plans or to correct identified quality concervice identified quality concervice. 	28.23 on urately ced by ty policy cation d for all d staff after DON on the route is titions. ssistants of that ed as ctures. ed by the y policy for are gency 3 will be cility cords are are

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	D: 02/28/2023 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345421	B. WING				C 1 09/2023
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	02/	03/2023
72 CHATHAM BUSINESS PARK		CHATHAM BUSINESS PARK					
THE LAU	RELS OF CHATHAM			PIT	TSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	Continued From page	e 69	F		implementing, and monitoring the corrective action plan and recognizing when an action plan may need to be revised. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 3.1.23. DON/designee will randomly audit 5 resident MDS sweekly x 4 weeks, the bi-weekly x 4 weeks, then monthly x 4 weeks to ensure that MDS assessme are being completed that accurately reflect the resident s status. Variance will be corrected at the time of audit a additional education provided when indicated. A QA monitoring tool will be utilized to ensure ongoing compliance by the AD beginning on 3.1.23. Residents that receive gastric tube feeding and have orders for nothing by mouth will have order audits completed 3x/week x 4 weeks then weekly x 4 weeks then bi-weekly x 4 weeks. Variances will be corrected at the time of the observation and additional education provided when bi-weekly x 4 weeks. Variances will be corrected at the time of the observation and additional education provided when indicated. A QA monitoring tool will be utilized to ensure ongoing compliance by the AD beginning on 3.1.23. Residents that receive gastric tube feeding and have orders for nothing by mouth will have order audits completed 3x/week x 4 weeks then weekly x 4 weeks then bi-weekly x 4 weeks. Variances will be corrected at the time of the observation and additional education provided when indicated. A QA monitoring tool will be utilized to ensure ongoing compliance by the RSD/designee beginning on 3.1.23. RSD/designee will observe residents palm guards and splints 5x/week x 2 weeks then weekly x 4 weeks then every other weekly x 4 weeks then e	The hen hts hts hd DON e b DON e hen hen he k x	

Event ID: HZHR11

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 02/28/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345421	B. WING	;			C 09/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THELAUE	RELS OF CHATHAM			7	2 CHATHAM BUSINESS PARK		
				P	ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	Continued From page	≥ 70	F	867	 Variances will be corrected at the time audit and additional education provide when indicated. A QA monitoring tool will be utilized to ensure ongoing compliance by the Treatment nurse/designee beginning 3.1.23. The Treatment nurse/designee will randomly audit TAR s for 3 guess with orders for wound care and/or respiratory care 5x/week x 2 weeks the stax/week x 2 weeks then weekly x 4 w then bi-weekly x 4 weeks to ensure th documentation for wound care and/or respiratory care is accurate. Variance will be corrected at the time of audit a additional education provided when indicated. Audit results will be reported to the Administrator monthly for the next 3 months beginning on 3.8.22 and cond will be reported to the Quality Assurar Committee during monthly meetings. A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Coordinator. The Regional Clinical Coordinator will attet the facility quality assurance committee the facility quality assurance committee to correct quality concerns. Variance be corrected and/or additional education education provided when indicated. Continued compliance will be monitor through the facility a Quality Assurance 	ed on ee is ien eeks iat eeks iat es nd eerns nce on swill ion ed	
FORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: HZ	HR11	Fa	cility ID: 923099 If contin	auntion choo	t Page 71 of 72

Event ID: HZHR11

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		ID HUMAN SERVICES			FORM APPROVED
		MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		с
		345421	B. WING		02/09/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1
				72 CHATHAM BUSINESS PARK	
THE LAUP	THE LAURELS OF CHATHAM			PITTSBORO, NC 27312	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		
iAo		,		DEFICIENCY)	
F 867	Continued From page	e 71	F 86	7	
				Program.	
				Compliance will be monitored by the Compliance will be monitored by the Complexity of the Complexity o	QA
				Committee and the Regional Clinical Coordinator for 3 months or until reso	lyed
				and additional education/training will l	
				provided for any issues identified.	
				·····	

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