PRINTED: 05/10/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345421	B. WING _				C / <b>17/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		1 04	1112024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	investigation survey we through 4/17/24. The compliance with the r	equirement CFR 483.73, ness. Event ID #TE6U11.	F	000			
	survey was conducted 4/17/24 Event ID#TE were investigated NC NC00212613, NC002	complaint investigation d from 4/14/24 through 6U11. The following intakes 00215701, NC00214347, 10701, NC00210483, 108516, NC00204138, and					
F 550 SS=D	deficiency. Resident Rights/Exer	•	F 5	550			5/8/24
	self-determination, ar access to persons an	Rights. In to a dignified existence, Ind communication with and Industrial discription with a services inside and Including those specified in					
	with respect and dign resident in a manner promotes maintenand	and in an environment that be or enhancement of his or ognizing each resident's ity must protect and					
ABORATORY	access to quality care	cility must provide equal regardless of diagnosis, SUPPLIER REPRESENTATIVE'S SIGNATUR	F		TITLE		(X6) DATE

Electronically Signed 05/08/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

Any denciency 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.

NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF CHATHAM  THE LAURELS OF CHATHAM  STREET ADDRESS, CITY, STATE, ZIP CODE  72 CHATHAM BUSINESS PARK PITTSBORKO, NC 27312  In PROVIDER PLAN OF CORRECTION  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 550  Continued From page 1  severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  § 483.10(b) (Exercise of Rights)  The resident of the facility and as a citizen or resident of the funited States.  § 483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprised from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights are resident of the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights are resident of the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights are reprised from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights are reprised from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights are required under this subpart.  This RECUIREMENT is not met as evidenced by:  Based on record review, observation, and staff and resident interviews, the facility failed to provide stool incontinence care on night shift for a dependent resident which caused him to feel angry (Resident #59) and failed to communication during care and understand what to expect (Resident #15). This deficient practice affected 2 of 3 residents reviewed for dignity.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
THE LAURELS OF CHATHAM  THE LAURELS OF CHATHAM  (PATI) (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 550  Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  \$483.10(b) Exercise of Rights.  The resident has the right to exercise his or her rights as a resident of the facility must ensure that the resident can exercise his or her rights as a resident of the facility in the exercise of his or her rights as a resident or the right sand to be supported by the facility in the exercise of his or her rights are required under this subpart.  This REQUIREMENT is not met as evidenced by:  Based on record review, observation, and staff and resident interviews, the facility failed to provide stool incontinence care on night shift for a dependent resident which caused him to feel angry (Resident #59) and failed to communicate with a resident. A reasonable person expects to be provided communication during care and understand what to expect (Resident #15). This deficient practice affected 2 of 8 residents  ### TITSBORO, NC 27312  ### PREMIXENTES PANC PIPPICATION SHOWED COMMENTON (CRO) STATE (ACM CORRECTION)  ### PREMIXENTES PANC PIPPICATION SHOWED COMMENTON (CRO) STATE (ACM CORRECTION)  ### PREMIXENTES PANC PIPPICATION SHOWED COMMENTON (CRO) STATE (ACM CORRECTION)  ### PROMISERS LAND OF COMMENTON (CRO) STATE (ACM COMMENTON			345421	B. WING			
FREETX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 550  Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  §483.10(b) Exercise of Rights.  The resident has the right to exercise his or her rights as a resident of the facility must ensure that the resident can exercise his or her rights and resident exercise his or her rights and to be supported by the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights are required under this subpart.  This REGUIREMENT is not met as evidenced by:  Based on record review, observation, and staff and resident interviews, the facility failed to provide stool incontinence care on night shift for a dependent resident which caused him to feel angry (Resident #59) and failed to communicate with a resident. A reasonable person expects to be provided communication during care and understand what to expect (Resident #15). This deficient practice affected 2 of 3 residents					72 CHATHAM BUSINESS PARK	04/11/2024	
severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  §483.10(b) Exercise of Rights.  The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.  §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.  This REQUIREMENT is not met as evidenced by:  Based on record review, observation, and staff and resident interviews, the facility failed to provide stool incontinence care on night shift for a dependent resident which caused him to feel angry (Resident #59) and failed to communicate with a resident. A reasonable person expects to be provided communication during care and understand what to expect (Resident #15). This deficient practice affected 2 of 3 residents	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETION	
deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.  1. F550:	F 550	severity of condition, must establish and n practices regarding t provision of services residents regardless  §483.10(b) Exercise The resident has the rights as a resident or resident of the Un  §483.10(b)(1) The faresident can exercise interference, coercio from the facility.  §483.10(b)(2) The refree of interference, ore reprisal from the faci rights and to be supplexercise of his or her subpart.  This REQUIREMENT by:  Based on record revand resident interviet provide stool inconting dependent resident wangry (Resident #59) with a resident. A read be provided communication what to expendent practice affer reviewed for dignity.  Findings included:	or payment source. A facility naintain identical policies and ransfer, discharge, and the under the State plan for all of payment source.  of Rights. right to exercise his or her of the facility and as a citizen ited States.  cility must ensure that the	F 55	The Laurels of Chatham wishes to hat this submitted plan of correction stance its written allegation of compliance. Calleged compliance is May 8, 2024. Preparation and/or execution of this profession to the constitute admission to the scope and several of any of the cited deficiencies, or conclusions set forth in the statement deficiencies. This plan is prepared an executed to ensure continuing compliation with regulatory requirements.	l as pur  lan ner erity of d/or	

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F 550	Continued From page	e 2	F t	550					
	Resident #59 was ad	mitted to the facility on			The facility will continue to provide time	elv			
	9/1/23 with the diagn				incontinence care on night shift for	,			
	•				dependent residents. The facility will				
	Resident #59's Minim	num Data Set dated 3/29/24			continue to communicate with resident	s			
	documented the resid	dent had an intact cognition,			during care so that they understand wh	nat			
		understands others. The			to expect.				
		f assistance of one with all							
	activities of daily livin	g. The resident was			Resident #59 will continue to have time	•			
	incontinent of stool.				staff assistance with incontinence care night shift as evidenced by DON and C				
	Resident #59's care	olan dated 3/20/24			A Preceptor observation of being odor	, IN			
		an activity of daily living			free on night shift 5.1.24. No negative				
		was incontinent of stool and			ongoing psychosocial outcome was				
		e to check during routine			identified relating to this observation.				
	rounds and as neede	d for incontinence.							
					Resident #15 will continue to have staf				
	On 4/15/24 at 11:47 a				communicate with her during care so the	nat			
		lent #59. Resident #59			she understands what to expect as				
		ng Assistants (NA) on night			evidenced by Regional Clinical Nurse				
		und until the morning about The staff on night shift do			observation of care on 5.1.24. No				
		ght or take hours to come			negative ongoing psychosocial outcom was identified relating to this observation				
		ng up. "This happened just			was identified relating to this observation	ווכ.			
		"I put the call light on and			Current residents that require assistan	ce			
		r more than 2 hours because			with incontinence care on night shift ha				
		very 2 hours and had not			the potential to be affected. Current				
		nt; this made me feel angry."			residents that require assistance with				
	The NA (NA #11) fina	lly came about 5:00 am			incontinence care on night shift were				
	,	d could see the time) and			observed during night shift rounds on				
	-	t #59 also commented that			5.1.24 by the DON and C N A Preceptor				
		dication for his liver that			to ensure that they were being provide	d			
		stools, and he had to have			with timely incontinence care. No				
		gularly. The Resident stated			negative psychosocial outcome was				
		"I can smell stool. Sitting in d the smell to remain."			identified relating to these observations	٥.			
	Stool that long caused	uno sinon to remain.			Current residents that are rarely				
	On 4/16/24 at 2:30 no	m contact with NA #11 who			understood/rarely understand have the	<u>.</u>			
	-	d night shift 4/15/24 to			potential to be affected. Current reside				
	Resident #59 was un				that are rarely understood/rarely				

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F 550	The DON stated the with night shift staff a providing care. This individually and durin meeting in March 202 thought this was additeducation.  2.  Resident #15 was ad 8/24/19 with the diagonal Resident #15's quarted documented the residuate to confusion. The understood and rarely had behaviors of yelli 7-day look back period psychotic disorder with Resident #15's care spells and yelling out approach in a quiet, of participation in activitic changes in mood or band harm to others at threatened by others consistency in timing On 4/14/24 at 11:05 and Resident #15. The from NA #5. NA #5 wattempting to place the supproach in the staff of the supproach in the supproa	om an interview was irector of Nursing (DON). facility has had a problem inswering call lights and was reported by residents githe resident council 24. The DON stated, "I ressed." We provided staff dmitted to the facility on mosis of seizure.  The provided staff dmitted to the facility on mosis of seizure.  The provided staff dmitted to the facility on mosis of seizure.  The provided staff dmitted to the facility on mosis of seizure.  The provided staff dmitted to the facility on mosis of seizure.  The provided staff dmitted to the facility on mosis of seizure.  The provided staff dmitted to the facility on mosis of seizure.  The resident was rarely given the facility of the provided to the pr	F 5	understand were observed du the DON, ADON, Unit Manage Preceptor, and Regional Clinic between 4.30.24 and 5.3.24, t that staff were communicating so that they understand what t  100% of all nursing assistants licensed nurses will be inservic ADON as of 5.7.24 on the faci ensuring that residents that re assistance with incontinence of shift are provided with timely in care.  100% of all nursing assistants licensed nurses will be inservic ADON as of 5.7.24 on the faci expectation that staff will community that residents during care so t understand what to expect.  A QA monitoring tool will be ut ensure ongoing compliance by DON/designee beginning on 5 DON/designee will randomly of residents on night shift 3x/wee then 3x/week x 4 weeks then to weeks, then bi-weekly x 4 wee ensure that staff are providing incontinence care. Variances corrected at the time of observadditional education provided indicated.  A QA monitoring tool will be ut ensure ongoing compliance by	ers, C N A cal Nurse o ensure during care to expect.  and ced by the lity policy for quire care on night ncontinence  and ced by the lity municate that they  dilized to y the cas.24. The observe 3 ek x 4 weeks weekly x 4 eks, to timely s will be yation and when  dilized to y the		
	attempting to place the sleeve and the reside				y the 5.8.24. The		

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F 550	Continued From page	e 4 ne resident appeared angry	F t	550	communication between staff and 3		
		ne resident appeared angry and wide eyes. NA #5 had			residents 5x/week x 2 weeks then		
	not talked to the resid	lent to inform the resident			3x/week x 2 weeks then weekly x 4		
	_	place during this time. The			weeks then bi-weekly x 4 weeks to ens	ure	
		ınintelligible words and			that staff are communicating with		
		er hand on her arm after			residents during care so that they		
		the NA to place the arm in			understand what to expect. Variances		
		ntinued to remain silent and resident of what care was			will be corrected at the time of observa and additional education provided whe		
		hat to expect. The surveyor			indicated.	11	
		to distract, guide, and			maioatoa.		
		t stopped yelling and looked					
	at the surveyor with s				Observation results will be reported to	the	
	,	•			Administrator weekly for the next 3		
	On 4/14/24 at 12:55 p	om an interview was			months beginning on 5.15.24 and		
		5. NA #5 stated she spoke			concerns will be reported to the Quality	/	
		norning at the start of care			Assurance Committee during monthly		
		stated the resident talked to			meetings.		
		stated when she tried to			04:	.1	
	-	eft arm in the sleeve the			Continued compliance will be monitore		
		ocking her arm/elbow and hit m/hand. NA #5 stated she			through the facility's Quality Assurance Program and through random		
		ed the resident at this time to			observations.		
		Iready let the resident know			observations.		
		ng place and the resident			Compliance will be monitored by the Q	Α	
		not talking now, she was			Committee for 3 months or until resolve		
	yelling.				and additional education/training will be	Э	
					provided for any issues identified.		
	On 4/17/24 at 11:55 a						
		irector of Nursing (DON).					
	The DON was inform						
		lack of communication					
		4. The DON stated that she nt #15's behaviors and staff					
		dent during care and if the					
		op providing care at that					
	time.	or providing out out that					
F 561	Self-Determination		F!	561			5/8/24
SS=D	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		' `	- <b>-</b> .			

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F 561	promote and facilitate through support of renot limited to the right (1) through (11) of the \$483.10(f)(1) The reactivities, schedules waking times), healt care services consist assessments, and papplicable provisions \$483.10(f)(2) The rechoices about aspect facility that are significable statement of the community activities facility.  \$483.10(f)(3) The rewith members of the community activities facility.  \$483.10(f)(8) The reparticipate in other are religious, and comminterfere with the right facility.  This REQUIREMENT by:  Based on record reinterview, the facility right to refuse care was attempted to dress the results of the control of th	rmination. e right to and the facility must be resident self-determination esident choice, including but hats specified in paragraphs (f) his section.  sident has a right to choose (including sleeping and h care and providers of health tent with his or her interests, lan of care and other is of this part.  sident has a right to make ets of his or her life in the ficant to the resident.  sident has a right to interact community and participate in both inside and outside the	F 56	F561: The facility will continue to honor resirights to refuse care.  Resident #15 will continue to have he		
	verbal behaviors res	isting this care. This deficient f 2 residents reviewed for		rights to refuse care honored by staff evidenced by Regional Clinical Nurse	as	

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F 561	Continued From pag	e 6	F 56	1			
	choices.			observation of care on 4.30.24.	No		
				negative psychosocial outcome	was		
	Findings included:			identified relating to this observa			
	Resident #15 was admitted to the facility on 8/24/19 with the diagnoses of seizure disorder			_			
				Current residents have the pote	ntial to be		
	and psychotic disord	er with delusions.		affected. Current residents were			
				observed during care by the DO			
		erly Minimum Data Set dated		Unit Managers, C N A Preceptor			
		e resident had severely		Regional Clinical Nurse between			
		he resident had verbal		and 5.4.24 to ensure that reside	-		
	look back period. Th	es per week during the 7-day		to refuse care were being honor negative outcome was identified			
	T	aff member for dressing. The		to these observations.	relating		
	resident was coded f	•		to these observations.			
	Tesident was coded i	or reladar or care.		100% of nursing assistants and	licensed		
	Resident # 15's care	plan had a need for crying		nurses will be inserviced by the			
		t. The interventions were to		of 5.7.24 on ensuring that reside			
	1	calm manner, encourage ties of daily living, report		to refuse care are being honored	d by staff.		
	changes in mood or	behavior to include anger		A QA monitoring tool will be utilized	zed to		
	and harm to others a	and self, agitation, and feeling		ensure ongoing compliance by t	he		
	_	. The resident was to have		DON/designee beginning on 5.8			
	consistency in timing	of care and caregivers.		DON/designee will randomly ob			
				staff to resident interactions 5x/v			
		am an observation was done		weeks then 3x/week x 2 weeks			
		er room during morning care.		weekly x 4 weeks then bi-weekly	-		
		to be attempting to place the		weeks to ensure that staff are he	•		
		to her sleeve and the her elbow and yelled loud,		resident rights to refuse care. will be corrected at the time of o			
	_	s while looking at the NA with		and additional education provide			
		dent also appeared angry by		indicated.	od Willom		
		ne resident was yelling					
	· ·	and slapped NA #5 with an		Observation results will be report	rted to the		
		ht upper arm after repeated		Administrator weekly for the nex			
		o place the arm in the sleeve.		months beginning on 5.15.24 ar			
		I the resident's arm in the		concerns will be reported to the			
	gown. The resident	looked at the NA with an		Assurance Committee during me			
		ed yelling again. NA #5 then		meetings.			
	placed the sheet on	the resident's bare legs and					

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F 561	Continued From page	÷ 7	F 5	561					
	the resident kicked it NA placed the sheet a	off with her right leg. The again to cover the resident's ident kicked the sheet off			Continued compliance will be monitore through the facility's Quality Assurance Program and through random observations.				
	On 4/14/24 at 12:00 pm an interview was conducted with Unit Supervisor #2. Unit Supervisor #2 was informed of the incident with Resident #15 regarding resisting care and verbal and physical behavior. Unit Supervisor #2 stated if the resident resisted care NA #5 should have waited and not dressed the resident at the time. From the incident, it sounded like the resident had not wanted care at the time.  On 4/14/24 at 12:55 pm an interview was conducted with NA #5. NA #5 stated when she tried to place the resident's left arm in the sleeve the resident resisted by locking her arm/elbow and hit her with that same arm/hand. NA #5 stated the resident had resisted by body language and had not cooperated by refusing to bend her arm and slapped her. NA #5 stated she placed the sheet over the resident's bare legs and the				Compliance will be monitored by the Q Committee for 3 months or until resolve and additional education/training will be provided for any issues identified.	ed			
	once the care was do hitting and yelling. Now with care because the visitors frequently car stated the resident was wanted to place her a sheets on her legs. To communication that the	ne resident had not wanted NA #5 stated the resident e care, but in NA #5's thad to be covered to							

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	RELS OF CHATHAM			7:	2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		
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F 561 F 565 SS=E	The DON was inform behavior and NA #5's during care on 4/14/2 resident resisted care and hit staff, the staff stop providing care a was occurring.  Resident/Family Grou CFR(s): 483.10(f)(5)(	am an interview was irector of Nursing (DON). ed of Resident #15's response to the behavior 4. The DON stated if any with resulting behaviors member were expected to address why the behavior up and Response		561			5/8/24
	and participate in res (i) The facility must progroup, if one exists, we reasonable steps, with to make residents and upcoming meetings in (ii) Staff, visitors, or or resident group or fample (iii) The facility must providing assistance requests that result frow (iv) The facility must be resident or family groups concerning is in the facility.  (A) The facility must be response and rational (B) This should not be	ident groups in the facility. Tovide a resident or family with private space; and take the approval of the group, d family members aware of a timely manner. Ther guests may attend tilly group meetings only at s invitation. Torovide a designated staff and who is responsible for and responding to written tom group meetings. Tonsider the views of a up and act promptly upon the commendations of such the sues of resident care and life the able to demonstrate their le for such response. The construed to mean that the ant as recommended every					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345421	B. WING				0 17/2024
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		2 CHATHAM BUSINESS PARK		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 565	family member(s) or or representative(s) mer families or resident residents in the facilit. This REQUIREMENT by: Based on record revinterviews, the facility council concerns reganight shift. (Resident provide the residents meeting without staff months reviewed (Marketter) for the months reviewed (Marketter) for new that to wait a long time answer call lights. The bells were to be answered the was everyone's resident council meeting without and to wait a long time answer call lights. The bells were to be answered the was everyone's resident council meeting without and concern the month before the month before the month before the month before the month provide call business from last mer waiting a long time for the month growing and the formal the month growing and the month growing and the month growing and the formal the month growing and the month growing and the formal the fo	cident has a right to roups.  cident has a right to have bether resident et in the facility with the expresentative(s) of other yy.  The is not met as evidenced et and staff and resident er failed to resolve resident er failed to a private resident council interference for 2 of 4 erch 2024 and April 2024).  The interference for 2 of 4 erch 2024 and April 2024).  The interference for 2 of 4 erch 2024 and Friedrich er staff to the facility response was call evered within 3 to 5 minutes. Ponsibility to answer call ersist a guest, leave the light erting minutes/concern form	F	565	F565: The facility will continue to resolve resident council concerns related to time response to call bells on night shift. The facility will continue to provide residents with a private resident council meeting without staff interference.  Residents #23, #41, and #77 will continue to have timely staff response to call bell on night shift as evidenced by DON and NA Preceptor observations on 4.30.24 5.1.24. No negative psychosocial outcome was identified relating to this observation.  Residents #23, #41, and #77 will continue to have private resident council meeting without staff interference as evidenced Resident Council meeting held on 5.2.2 by the Administrator and Activity Director Current residents have the potential to affected. Current residents were observed during the night shift on 4.30. to 5.2.24 by the DON and C N A Preceptor ensure that call bells were respondentially. No negative outcome was identified relating to these observations.	I lue ls d C to lue gs by 24 or . be 24 otor d to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
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NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				7:	2 CHATHAM BUSINESS PARK			
THE LAUF	RELS OF CHATHAM				PITTSBORO, NC 27312			
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F 565	Continued From page	e 10	F 5	565				
	On 4/16/23 at 2:15 pr	m during the resident council			Current residents were observed by the	9		
	meeting, Resident #s	23, 41, and 77 voiced that			Administrator during a Resident Counc	il		
		sistants were not rounding			meeting on 5.2.24 , to ensure the			
	and providing care ar	nd it was taking hours for			residents were allowed to have a private	te		
	staff to answer the ca	all light. This had been going			resident council meeting without staff			
	on since before Marc	h 2024. It had gotten better			interference. No negative outcome was	5		
	for a little while but w	as an ongoing problem at			identified relating to these observations	S.		
	this time and discuss	ed again at the 4/2/24						
	resident council meet	ting.			100% of nursing assistants and license			
					nurses will be inserviced by the ADON			
	On 4/16/24 at 2:55 pr				of 5.7.24 on ensuring that call bells are			
		ctivity Coordinator. The		responded to timely. 100% of all staff				
	•	stated the concern during the	be inserviced by the ADON as of 5.7.24					
		ting that night shift nursing			on ensuring that residents are allowed	to		
		ounding and providing care			have private resident council meetings			
	_	nswer the call light was an			without staff interference.			
		s reported at the March 2024						
		reported as a problem at			A QA monitoring tool will be utilized to			
		g. The Activity Coordinator			ensure ongoing compliance by the			
	stated that managem	ent was aware.			DON/designee beginning on 5.8.24. T			
	0:- 4/47/04 -+ 40:45 -				DON/designee will randomly observe o			
	On 4/17/24 at 12:15 p	irector of Nursing (DON).			bell response time on night shift 3x/we	ек		
		<b>3</b> ( )			x 4 weeks then weekly x 4 weeks then	ŧ		
		facility has had a problem nswering call lights and			bi-weekly x 4 weeks to ensure that staf are responding to call bells on night shi			
	•	ng. This was reported by			timely. Variances will be corrected at			
		the resident council meeting.			time of observation and additional	uic		
		nought this was addressed."			education provided when indicated.			
		ucation last month. The			cadeation provided when indicated.			
	· ·	not aware this remained a			A QA monitoring tool will be utilized to			
		not informed this problem			ensure ongoing compliance by the			
	remained after the 4/	•			Administrator/designee beginning on			
	meeting.	2,2			5.8.24. The Administrator/designee will	I		
					observe Resident Council meetings			
	2.				monthly x 3 months to ensure that staff	:		
		m a resident council meeting	are allowing residents to have private					
	•	ty room. There were 4			resident council meetings without staff			
		ce and a sign was posted on			interference.			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345421	B. WING _				C <b>17/2024</b>
	ROVIDER OR SUPPLIER			72 CH	ET ADDRESS, CITY, STATE, ZIP CODE NATHAM BUSINESS PARK SBORO, NC 27312		11/2027
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 565	disturb. NA #8 entered meeting was in progres asking, and asked for On 4/17/24 at 9:20 ar conducted with NA #8 the resident council in the sign was observed know better not to entered was thinking and were look for the Activity Council of the Machine of the Activity Council of the Activity Cou	the meeting and not to ed the activity room while the ess, interrupted without the Activity Coordinator.  In an interview was B. NA #8 stated she entered neeting unannounced when don the door in error. "I ter and did not know what I that ahead and interrupted to coordinator."  In during the resident council entered the activity room ent #s 23, 41, and 77 voiced private, and she was not "This was wrong."  In an interview was ectivity Coordinator. The tated the resident council sted not to enter and staff red during this time.	F	A m cc A m C th P ol C C au	Observation results will be reported to the dministrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quality assurance Committee during monthly neetings.  Continued compliance will be monitored by the facility's Quality Assurance trogram and through random beervations.  Compliance will be monitored by the Quality additional education/training will be rovided for any issues identified.	d A ed	
F 580 SS=D	meeting was private a while the meeting wa Notify of Changes (In CFR(s): 483.10(g)(14) S483.10(g)(14) Notific (i) A facility must imm consult with the residual consult with t	and no staff should enter s in progress. jury/Decline/Room, etc.) )(i)-(iv)(15)	F 5	580			5/8/24
		, 100140110					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	` ′	3) DATE SURVEY COMPLETED	
		345421	B. WING				C <b>17/2024</b>	
	ROVIDER OR SUPPLIER	100-20		s 7	TREET ADDRESS, CITY, STATE, ZIP CODE 2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	1 04/	17/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	results in injury and her physician intervention (B) A significant chan mental, or psychosocy deterioration in health status in either life-the clinical complications (C) A need to alter trea need to discontinue treatment due to advect commence a new for (D) A decision to transesident from the facility When making notifully (ii) When making notifully (iii) When making notifully (iii) The facility must a resident and the residen	en there is- ving the resident which as the potential for requiring n; ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or ); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph . record and periodically mailing and email) and	F	580				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345421	B. WING		C 04/17/2024
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF CHATHAM		7	STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	1 04/11/2024
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locations that compart, and must sproom changes be under §483.15(c). This REQUIREMI by: Based on record interviews with the Physician Assista staff, the facility faprovider of a new caused by a knee immobilizer was resident #102's for the leg just about also failed to notification.  The findings inclusion 1) Resident #102 3/2/24 with diagnoright femur, bullout disorder that cause blisters) and psorion the hospital dischindicated Resider well-padded kneed removed for hygie A review of Residincluded an order knee immobilizer	uration, including the various aprise the composite distinct ecify the policies that apply to tween its different locations 9).  ENT is not met as evidenced reviews, observations, and e Orthopedic nurse, Orthopedic nt, Responsible Party (RP), and illed to notify the orthopedic y acquired pressure ulcer immobilizer and that the knee ot being worn as ordered for ractured distal femur (the area we the knee joint). The facility yithe RP of the addition and ation prescribed for Resident r 2 of 2 residents reviewed for ded:  was admitted to the facility on oneses that included fracture of the is pemphigoid (an autoimmune es itchy raised rashes and large asis.  The property of the included of the included fracture of t	F 580	F580: The facility will continue to ensure that resident physicians and responsible parties are notified when there is a new pressure ulcer identified and/or a medication change.  Resident # 102 sorthopedic provider was notified of the newly acquired pressure ulcer by the facility nurse on 4.17.24. No negative outcome was identified relating to this observation. Resident #173 no longer resides in the facility. No negative outcome was identified relating to this observation.  Current residents have the potential to affected. An audit was conducted between 5.1.24 5.3.24 by the DON, ADON, and Unit Managers to ensure the resident physicians and responsible parties were notified of any new pressure ulcers and/or medication changes. No negative outcomes were identified related to these observations.  100% of licensed nurses were inservice by the ADON as of 5.7.24 on the facility policy for ensuring that resident physicians and responsible parties are notified of any new pressure ulcers and medication changes.	be nat ure o ting ed

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	•	7/1//2027
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F 580	Continued From pag	e 14	F 5	80		
	3/14/24 indicated Re right knee immobilize for hygiene purposes. A review of Resident included an order da immobilizer to be wo hygiene, check skin i removed every shift.  A nursing progress n PM, and completed be Resident #102 had a the ankle area. The hospice were notified.  A skin/wound progres 6:01 PM and comple indicated there was a unstageable wound the area measured 3 cerem in width and 0.3 cerem in width and outle physician and would evaluate on 4/4/24.  A wound provider provider provider and the physician and would evaluate on 4/4/24.  A wound provider provider provider and the last few day treating the wound. The wound is an unstageable medical device brace wound, however there	#102's physician orders ted 3/19/24 for right knee rn at all times. Remove for integrity. Replace padding if ote dated 4/3/24, timed 2:43 by Nurse #3 read that new unstageable wound to wound care nurse and it.  ss note dated 4/3/24, timed ted by the wound nurse a sudden onset of a new to the right inner ankle. The ntimeters (cm) in length, 2.3 cm in depth. There was 90% riwound was red. The hall		A QA monitoring tool will be ensure ongoing compliance DON/designee beginning DON/designee will audit 5 x 4 weeks, then 3 charts 3 weeks, then 3 charts week ensure that resident physis responsible parties are no pressure ulcers and/or me changes. Variances will be the time of observation an education or corrective active when indicated.  Observation results will be Administrator weekly for the months beginning on 5.15 concerns will be reported assurance Committee during meetings.  Continued compliance will through random observation the facility's Quality Assurance Committee for 3 months of and additional education/typrovided for any issues identicated.	ce by the con 5.8.24. The charts 3x/week 8x/week x 4 kly x 4 weeks to cians and tiffied of any new edication recorrected at d additional tion provided  e reported to the ne next 3 c.24 and to the Qualityring monthly  I be monitored ons and through ance Program.  ored by the QA or until resolved raining will be	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		345421	B. WING _			C <b>04/17/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	E .	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	An orthopedic progrethat Resident #102 has brace that was to be hygiene purposes. The pressure ulcer to the Anursing progress or that Resident #102 has new wound to riwill not be worn. This maintain skin integrit reference of contactive regarding the new would be discontinued A review of the April Administration Recoknee immobilizer was 4/9/24, 4/10/24, 4/11/2/24 for the follow held to maintain held to maintain hot in place per Off per manage.	and 0.2 cm in depth. 80% present to the wound.  The sess note dated 4/4/24 read had a postop hinged knee removed for skin checks and there was no mention of a right inner ankle.  The dated 4/4/24 indicated had been seen at the recommendations for the stay on and only removed for ecks. The note read "resident ght inner ankle so knee brace is to encourage and ty". The note made no ling the orthopedic provider ound or asking if the brace ed.  2024 Treatment right (TAR) indicated the right is not used on 4/3/24, 4/4/24, 1/24 and 4/12/24.  Ing progress notes for 4/1/24 to 4/15/24 indicated himobilizer was not in use 4, 4/10/24, 4/11/24 and wing reasons: gement in skin integrity. Director of Nursing (DON) ment due to wound	F	580		
	4/16/24 at 9:52 AM,	d with Nurse Aide (NA) #1 on who was assigned to care for e 7:00 AM to 3:00 PM shift.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ISTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345421	B. WING _				C <b>17/2024</b>
	ROVIDER OR SUPPLIER			72 CH	ET ADDRESS, CITY, STATE, ZIP CODE ATHAM BUSINESS PARK SBORO, NC 27312	1 04/	11/2024
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	not being used due to right inner ankle and management to leave 4/16/24 at 10:50 AM called the orthopedic wound that was ident decision not to use the had gotten the wound wound nurse stated rin Resident #102's be knee immobilizer due ankle and the increase caused. She thought Resident #102 to her 4/4/24 by the floor nunew wound caused by A phone interview on Nurse on 4/16/24 at 3 received a call from the Resident #102 had a inner ankle from the I the immobilizer was unaway pressure ulcer to the	ght knee immobilizer was to the pressure area on the had been told by the the brace off.  If with the wound nurse on who stated that she had not provider regarding the	F	580	DEFICIENCY)		
	with Unit Manager #1 the orthopedic clinic wound and decision on the right leg. She orthopedic provider h prior to 4/16/24.	M, an interview occurred who stated she spoke with on 4/16/24 regarding the new not to place the immobilizer was unable to state if the ad been notified verbally ewed on 4/17/24 at 9:50 AM.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	' '	TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		4/17/2024
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	ankle wound was ide she notified the medinospice of the new wo follow-up with the orth and she sent a note a right ankle but did no know. She further stareturned from her appimmobilizer was in play wound nurse thought #102 not to wear the pressure area on her.  The DON and Region interviewed on 4/17/2 explained the orthoped 4/16/24 regarding the 4/3/24 and that the righeing used. They we orthopedic provider had becare a was first identified decision was made no immobilizer to preventhe right leg and they with the orthopedic procurred with the Ortwith Resident #102. So clinic on 4/4/24, assed brace would have besee any open wound areas with bandages	n duty when the right inner ntified on 4/3/24. She stated cal director, family, and ound. Resident #102 had a hopedic provider on 4/4/24 about the new wound to her t call the provider to let him ated when Resident #102 cointment, the right knee face, but the DON and it was best for Resident splint due to the new ankle.  The look and it was best for Resident splint due to the new ankle.  The look and it was notified on the end of the end	F 5			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3	B) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	0.0.2.		STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		04/17/2024
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	immobilizer was chose communication from pressure wound to R nor the decision not to 4/16/24.  2. Resident #173 was cumulative diagnoses dementia with behave The Quarterly Minimulative diagnoses dementia with behaviors.  Review of a Physician Depakote (anticonvuldaily for bipolar disorge pisode. There was resident #173's med Physician that Resident #173's Resident #173's Resident #173's Resident #173's Resident #173's Resident involving an #173's Resident involving an #173's Resident Resident Resident involving Resident She stated the nurse along with all the nurse along with all the nurse	the facility regarding the esident #102's right ankle or put the immobilizer prior to as admitted on 8/13/23 with sof Alzheimer's Disease, fors, and Bipolar Disease.  The Data Set dated 9/18/23 and severe cognitive poited physical and wandering and odcumentation in the lical record by nursing or the ent #173's RP was notified.  The was no documentation in the was no documentation in the lical record by nursing or the ent #173's RP was notified.  The was no documentation in the lical record by nursing or the ent #173's RP was notified of epakote dose.  The pletted on 4/15/24 at 3:45 ar #1. She recalled the urse not notifying Resident ition of Depakote to her the RP to become upset and the time was re-educated at the time	F 5	80		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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NAME OF D	201/1050 00 01 1001 150	343421	B: Wiite	_	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	17/2024
NAME OF PR	ROVIDER OR SUPPLIER				, , ,		
THE LAUR	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677 SS=D	speaking the Resider someone from the fact of the addition at 2:45 PM with Resident #173 was didelirium at the hospital hospital for a fall on 1 she discovered the addition at the discovered the additional form the additional form the went to discuss her of the Nursing (DON) when the side an investigation was determined that a procedure by letting hoppakote or the increase and the side effects along Seroquel (antipsychological Nurse Consultant stated it with facility management to the RP anytime there resident medication additional documented in the rease and the additional	n. He stated he did not recall at #173's RP but expected cility to have notified her RP Depakote.  It was completed on 4/16/24 dent #173's RP. She stated agnosed with drug induced all when she went to the 0/8/23 and that was how didition of the Depakote to ication regimen. The RP he facility notified her so she concerns with the Director of she picked up Resident he RP stated the DON would atten to see what failed and it the nurse did not follow her know of the addition of hase of the Depakote. The cown about the new order for have asked questions about with her recently prescribed tic).  Inpleted on 4/17/24 at 11:00 of Nursing (DON) and the ultant. The Regional Nurse has the expectation of the hat the floor nurses notify was a new or change in a nd then to ensure that it was sidents medical record.		580 677			5/8/24
	. , , ,	ent who is unable to carry iving receives the necessary					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	E SURVEY IPLETED
		345421	B. WING			C I/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		1/1//2024
				72 CHATHAM BUSINESS PARK		
THE LAUF	RELS OF CHATHAM			PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 677	Continued From page	e 20	F 6	77		
	personal and oral hyg This REQUIREMENT by: Based on record rev and resident interview provide dependent re	good nutrition, grooming, and giene; is not met as evidenced iew, observation, and staff ws, the facility failed to esidents nail care (Resident led to provide hair care and		F677: The facility will continue to endependent residents nails are and clean, and assistance is p	trimmed	
	facial hair shaving (R	esident #59) for 2 of 7 or activities of daily living.		shaving facial hair and washir  Residents #59 and #92 receiv	ng hair.	
		admitted to the facility on oses of post-traumatic stress ion.		assistance with trimming/clear 4.17.24 per c n a as directed to Resident #59 received assistate hair care and facial hair shaving 4.17.24, per c n a as directed	ning nails on by DON. ance with ng on	
	documented an intac or rejection of care. T	num Data Set dated 3/29/24 t cognition and no behaviors The resident required staff bathing and personal care.		No negative outcome was ide relating to these observations  Current residents that require	ntified	
	deficit and could refu	plan dated 3/29/24 an activity of daily living se care, needs assistance aily living, and to keep his		with trimming/cleaning nails, s facial hair, and washing hair h potential to be affected. All c residents that require assistar trimming/cleaning nails, shavi hair, and washing hair were of the DON, ADON, Unit Manage	nave the current nce with ng facial bserved by	
	documentation for pe	#59's Nursing Assistant (NA) rsonal care, including facial ocumented "yes" for each h 4/16/24.		A Preceptor during ADL care to ensure that each received associated. These observations between 4.30.24 & 5.1.24. Noutcome was identified relating	by c n a's to sistance as were made lo negative	
	observed to be in his	ch).		observations.  100% of nursing assistants ar nurses were inserviced by the 5.7.24 on facility policy for pro assistance to residents that re assistance with trimming/clear	ADON as of oviding equire	

NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF CHATHAM  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 677  Continued From page 21 conducted with Resident #59. Resident #59 stated he would like to have his hair washed, face shaved, and nail care. He commented he would rather stay in his bed for care. "They can wash my hair in bed but had not offered ever in bed or were supposed to come back after morning care." Resident #59 stated it had been weeks since he had nail care. He had refused to take a shower in the past, so a bed bath was offered, and a partial bed bath was provided. His hair was not washed. The NA had no comment about the  STREET ADDRESS, CITY, STATE, ZIP CODE  72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312   PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE)  PREFIX (EACH CORRECTION SHOULD BE (EACH CORRECTIVE)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CO		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
THE LAURELS OF CHATHAM  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL CONDUCTED SHAPPOPRIATE DEFICIENCY)  F 677  Continued From page 21 conducted with Resident #59. Resident #59 stated he would rather stay in his bed for care. "They can wash my hair in bed but had not offered ever in bed or were supposed to come back after morning care." Resident #59 stated it had been weeks since he had nail care. He had refused to take a shower in the past, so a bed bath was provided. His hair was not washed. The NA had no comment about the  TEGENATION STREET ADDRESS, CITY, STATE, ZIP CODE  72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312  ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE) Shaving facial hair, and washing hair.  F 677  Shaving facial hair, and washing hair.  A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee beginning on 5.8.24. The DON/designee will randomly observe 5 residents 5x/weekly x 4 weeks, then 3x/weekly x 4 weeks, then 3x/weekly x 4 weeks, then weekly x 4 weeks to ensure that assistance is being provided to residents that require assistance with trimming/cleaning nails,			345421	B. WING				_
THE LAURELS OF CHATHAM  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 677  Continued From page 21 conducted with Resident #59. Resident #59 stated he would like to have his hair washed, face shaved, and nail care. He commented he would rather stay in his bed for care. "They can wash my hair in bed but had not offered ever in bed or were supposed to come back after morning care." Resident #59 stated it had been weeks since he had nail care. He had refused to take a shower in the past, so a bed bath was offered, and a partial bed bath was provided. His hair was not washed. The NA had no comment about the  72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312  ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Shaving facial hair, and washing hair.  4 QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee beginning on 5.8.24. The DON/designee will randomly observe 5 residents 5x/weekly x 4 weeks, then weekly x 4 weeks to ensure that assistance is being provided to residents that require assistance with trimming/cleaning nails,	NAME OF P	ROVIDER OR SUPPLIER	0.0.2.			STREET ADDRESS CITY STATE ZIP CODE	1 04	11112024
CX4) ID   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETION DATE      F 677   Continued From page 21   Conducted with Resident #59. Resident #59   Stated he would like to have his hair washed, face shaved, and nail care. He commented he would rather stay in his bed for care. "They can wash my hair in bed but had not offered ever in bed or were supposed to come back after morning care." Resident #59 stated it had been weeks since he had nail care. He had refused to take a shower in the past, so a bed bath was offered, and a partial bed bath was provided. His hair was not washed. The NA had no comment about the   ID ON/designee beginning on 5.8.24. The DON/designee will randomly observe 5 residents 5x/weekly x 4 weeks, then 3x/weekly x 4 weeks, then 3x/weekly x 4 weeks, then 4 weeks to ensure that assistance is being provided to residents that require assistance with trimming/cleaning nails,		101.52.1 01.1 00.1 2.2.1				, , ,		
F 677  Continued From page 21 conducted with Resident #59. Resident #59 stated he would like to have his hair washed, face shaved, and nail care. He commented he would rather stay in his bed for care. "They can wash my hair in bed but had not offered ever in bed or were supposed to come back after morning care." Resident #59 stated it had been weeks since he had nail care. He had refused to take a shower in the past, so a bed bath was provided. His hair was not washed. The NA had no comment about the  PREFIX TAG  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  Shaving facial hair, and washing hair.  A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will randomly observe 5 residents 5x/weekly x 4 weeks, then 3x/weekly x 4 weeks, then weekly x 4 weeks to ensure that assistance is being provided to residents that require assistance with trimming/cleaning nails,	THE LAUF	RELS OF CHATHAM						
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since he had nail care. He had refused to take a shower in the past, so a bed bath was offered, and a partial bed bath was provided. His hair was not washed. The NA had no comment about the 3x/weekly x 4 weeks, then weekly x 4 weeks to ensure that assistance is being provided to residents that require assistance with trimming/cleaning nails,							•	
and a partial bed bath was provided. His hair was provided to residents that require assistance with trimming/cleaning nails,		since he had nail care	e. He had refused to take a			3x/weekly x 4 weeks, then weekly x 4		
not washed. The NA had no comment about the assistance with trimming/cleaning nails,							ng	
						1 .		
resident's hair or nails. NA #5 indicated the shaving facial hair, and washing hair.						shaving facial hair, and washing hair.	٠,	
resident usually refused a shower but accepted  Variances will be corrected at the time of							of	
all care in his bed. observation and additional education		all care in his bed.	·					
provided when indicated.						provided when indicated.		
On 4/15/24 at 12:05 pm Unit Supervisor #2 was interviewed and informed of Resident #59's hair,  Observation results will be reported to the						Observation regults will be reported to	tha	
interviewed and informed of Resident #59's hair,  nails, and facial hair and that the resident agreed  Observation results will be reported to the  Administrator weekly for the next 3			-				ıne	
to receive care in his bed. The Unit Supervisor months beginning on 5.15.24 and						_		
stated she would have the NA assigned assist the concerns will be reported to the Quality							/	
resident with hair wash, nail care, and facial hair  Assurance Committee during monthly		resident with hair was	sh, nail care, and facial hair			Assurance Committee during monthly		
trim in his bed. The resident had depression and meetings.						meetings.		
declined to leave his room. The Unit Supervisor			•					
had not observed the resident's hair, facial hair, or nails.  Continued compliance will be monitored through the facility's Quality Assurance			resident's hair, facial hair,					
Program and random observations.		Of Halls.					į	
On 4/16/24 at 9:30 am Resident #56 was lying in		On 4/16/24 at 9:30 ar	m Resident #56 was lying in			1 regram and random observations.		
his bed and his hair appeared greasy and Compliance will be monitored by the QA						Compliance will be monitored by the Q	A	
clumped. The resident stated he had not had his Committee for 3 months or until resolved								
hair washed in the bed and his facial hair and and additional education/training will be							Э	
nails remained the same. The resident stated he provided for any issues identified.						provided for any issues identified.		
would accept care in his bed, he did not want a shower. Resident #56 stated he had not declined Date of compliance: 5.8.24						Date of compliance: 5.9.24		
care in his bed, but he had asked staff to come						Date of compliance. 3.0.24		
back after breakfast.		·	2 donoù stan to donio					
On 4/16/24 at 9:40 am Unit Supervisor #2 was								
interviewed. She stated Resident #59 had his hair washed by an NA in his bed yesterday. The								

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY MPLETED
		345421	B. WING			C 04/17/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		741112024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 677	hair or nail care. Sha shower but usually on 4/16/24 at 9:55 and #7 stated Residuaccepted care in his noticed the resident today, but the resident today, but the resident NA #7 stated the reswashed in the bed, NA did not commen offered. NA #7 state refused nail care or she would ask him to sure why his facial hwere long and had be considered with NA and facial hair and nails.  On 4/17/24 at 9:50 and conducted with NA and #59 always accepted about the approach #6 had not worked was not aware of his conducted with the Inte DON was not a received nail care, for The DON stated resident.	aware if staff offered facial are stated the resident refused of accepted care in his bed.  am NA #7 was interviewed.  am NA #7 was interviewed.  and #59 refused a shower but to bed. NA #7 stated she is hair was greasy appearing tent had not wanted a shower. Sident's hair could have been but she had not offered. The to twhy hair care was not ed the resident had not facial hair care before and his morning. NA #7 was not hair was long, and his nails black soil underneath.  am an observation was done is hair was washed, but his remained the same.  am an interview was and the resident docare. She explained it was and the resident recently and is hair and nails needing care.  am an interview was Director of Nursing (DON).  ware Resident #59 had not facial shaving, and hair care.  didents that do not get out of heir care provided in the bed,	F 6	77		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		345421	B. WING _			C <b>04/17/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	•	V-7117202-1
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 23	F6	77		
	02/15/24 with diagn protein-calorie malr food).	s admitted to the facility on osis that moderate nutrition (inadequate intake of mum Data Set (MDS)				
	#92 's cognition wa behaviors or rejection maximum assistance shower/bath, and diassistance of 1 for p	O2/21/24 indicated Resident us moderately impaired with no on of care. He required se of 1 for toileting hygiene, ressing and moderate personal hygiene. He had so with range of motion to both				
	02/23/24, revealed #92 had a functional assistance with self deconditioning, decongnition, and wour	tive care plan, last reviewed a focus that read Resident al ability deficit and required -care/mobility related to line in mobility, blindness, ands. The interventions were to keep fingernails				
		nt #92's nursing progress 4 to 04/15/24 revealed no documented.				
	12:49 PM. Resident hand were discolore and long. His pointe of an inch past the his right hand were	conducted on 04/14/24 at t #92 's fingernails on his left ed (yellowish), thick, jagged, er and pinky nails extended 1/4 tip of finger. The fingernails on discolored (yellowish), thick, is thumb, pointer and pinky				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345421	B. WING		04/17/2	024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	1 04/17/2	.027
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE CO	(X5) MPLETION DATE
F 677	Continued From page	e 24	F 67	77		
	fingernails extended finger.	1/4 of an inch past the tip of				
	3:42 PM of Resident room in his wheelcha pulled beside him. The changes in the reside fingernails continued jagged, thick, and dis					
	An observation and interview were conducted on 04/16/24 at 10:20 AM with Resident #92. He was observed in his room in his wheelchair. He stated he would like his fingernails to be cut but no one had offered to do so. He stated if someone would offer to cut his fingernails, he would let them.					
	04/16/24 at 10:25 AM stated the Nursing As responsible for clean nails during showers/	ervation were conducted on If with Unit Manager #2. She assistants (NAs) were ing and cutting residents baths and/or when they see mmed. No one had reported				
	needed to be trimmed	ernails were long or that they d. She verified Resident olored (yellowish), thick, eded to be cut.				
	PM with Nursing Assishe was the NA assignay and stated she dresidents. The protocouts and as needed	iducted on 04/16/24 at 12:11 istant (NA) #4. She indicated gned to Resident #92 for that id nail care daily with her col was to do nail care during I. She also stated she nat Resident #92's nails were veral occasions.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345421	B. WING _		1	C <b>17/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	BE	(X5) COMPLETION DATE	
F 677	AM with the Director of Regional Nurse Cons was unaware Resided been performed. She Assistants (NAs), and nail care during show	ducted on 04/17/24 at 10:46 of Nursing (DON) and the sultant. The DON stated she int #92 's nail care had not indicated Nursing I Nurses were to perform ers and as needed. If they doing nail care they are to		584		5/8/24	
SS=D	S 483.25 Quality of car Quality of care is a furth applies to all treatment facility residents. Base assessment of a resident residents received accordance with professor plan, and the resident REQUIREMENT by:  Based on record revision interviews with the Minurse, Orthopedic Phothe facility failed to applie for a resident with a finarea of the leg just abordered (Resident #1 transferred a resident and pain to the right he #30). This was for 2 cowell-being.	Indamental principle that and care provided to ed on the comprehensive dent, the facility must ensure a treatment and care in essional standards of ensive person-centered sidents' choices.  The is not met as evidenced seems, observations and edical Director, Orthopedic sysician Assistant and staff, oply a right knee immobilizer ractured distal femur (the cove the knee joint) as 102). In addition, the facility is with an obvious deformity hip/leg after a fall. (Resident of 3 residents reviewed for		F684: The facility will continue to ensure that residents receive treatment and care accordance with professional standard practice, the comprehensive person-centered care plan, and the resident schoices.  Resident #102 received a new order of 4.15.24 to discontinue the right knee immobilizer. This order was carried of by the Unit Manager on the same date	in ds of on ut	G/G/E I	
	The findings included  1) Resident #102 was	: s admitted to the facility on		No ongoing negative outcome was identified relating to this observation. Resident #30 was treated in the hosp	tal		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	I` ´com	
		345421	B. WING_			C <b>4/17/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	0.0.2.	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		4/17/2024
				72 CHATHAM BUSINESS PARK	-	
THE LAUF	RELS OF CHATHAM			PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From page	e 26	F 68	34		
	3/2/24 with diagnoses right femur.	s that included fracture of the		on 10.18.23 and returned to the 10.23.23. No ongoing negative was identified relating to this control of the co	e outcome	
	indicated Resident #* well-padded knee imit removed for hygiene  A review of Resident included an order dat knee immobilizer to be for hygiene, replace pashift.  The admission Minimassessment dated 3/4 #102 had severe cog range of motion to on required maximum as hygiene, bathing, and An orthopedic provide 3/14/24 indicated Resight knee immobilizer	#102's physician orders ed 3/2/24 to 3/19/24 for right e worn at all times. Remove badding if removed every  um Data Set (MDS) 8/24 indicated Resident nitive impairment and limited e lower extremity. She esistance with toileting I bed mobility.  er progress note dated sident #102 was to wear the r which could be removed		Current residents with splints of have the potential to be affected residents with orders for splint were audited by the Regional Nurse on 5.1.24 to ensure that applied per physician sorder negative outcomes were idented to these observations.  Current residents that fall in the have the potential to be affected. Current residents that have fall facility in the past 90 days were the Regional Clinical Nurse or ensure that post fall measures carried out per physician orded negative outcomes were idented to these observations.	or braces ed. All is or braces Clinical t each was . No diffied relating the facility ed. Illen in the re audited by a 5.1.24 to s were rs. No diffied relating	
	for hygiene purposes.  A review of Resident #102's physician orders included an order dated 3/19/24 for right knee immobilizer to be worn at all times. Remove for hygiene, check skin integrity. Replace padding if removed every shift.  An orthopedic progress note dated 4/4/24 read that Resident #102 had a postop hinged knee brace that was to be removed for skin checks and hygiene purposes.  A nursing progress note dated 4/4/24 indicated that Resident #102 had been seen at the			by the ADON as of 5.7.24 on a splints and braces are applied physician orders and post fall are carried out per physician of A QA monitoring tool will be ut ensure ongoing compliance by DON/designee beginning on 5 DON/designee will audit 3 ressplints or braces 5x/week x 4 3x/week x 4 weeks then week to ensure that splints or brace applied per physician orders. will be corrected at the time of and additional education or co	per measures orders.  tilized to y the 5.8.24. The idents with weeks then ly x 4 weeks s are Variances f observation	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345421	B. WING		C 04/17/2024	1
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	04/17/2024	
				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 PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE COMPLET	TION
F 684	Continued From page	÷ 27	F 68	34		
	T	recommendations for the tay on and only removed for		action provided when indicated.		
	hygiene and skin che	cks. The note read "resident ht inner ankle so knee brace is to encourage and		A QA monitoring tool will be utilized ensure ongoing compliance by the DON/designee beginning on 5.8.24 DON/designee will audit 3 resident have fallen in the facility weekly x	I. The s that	
		d (TAR) indicated the right not used on 4/3/24, 4/4/24,		weeks to ensure that post fall mea are carried out per physician order Variances will be corrected at the t observation and additional educati corrective action provided when in	sures s. me of on or	
	that the right knee imit 4/3/24, 4/4/24, 4/9/24 4/12/24 for the following the Held per manager the Held to maintain the Not in place per less of the Market of the Market the Held to maintain the Not in place per less of the Not in place per less of the Market the Market the Market the Market the Held to the Market the Not in place per less of the Not in place pe	/1/24 to 4/15/24 indicated mobilizer was not in use , 4/10/24, 4/11/24 and ng reasons:		Observation results will be reported Administrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quassurance Committee during month meetings.  Continued compliance will be monthrough random observations and the facility's Quality Assurance Proceedings of Compliance will be monitored by the Committee for 3 months or until resund additional education/training was provided for any issues identified.	d to the lality hly tored through gram. le QA solved	
	4/16/24 at 10:50 AM valled the orthopedic decision not to use th to a new wound on R ankle. The wound nure decided it was in Resent to wear the kneet	with the wound nurse on who stated that she had not provider regarding the e right knee immobilizer due esident #102's right inner ase stated management ident #102's best interest immobilizer due to the akle and the increased				

Facility ID: 923099

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345421	B. WING _		_		C 17/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 72 CHATHAM BUSINESS PA PITTSBORO, NC 27312		1 0-1	11/2027
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	( (EACH CORREC CROSS-REFEREN	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	had been sent with Forthopedic appointmenurse letting them know caused by the right know. A phone interview of Nurse on 4/16/24 at received a call from the reporting Resident # her right inner ankle and that the immobility She added the clinic developed a pressur or that the immobility consistently.  On 4/17/24 at 9:25 A with Unit Manager # the orthopedic clinic wound and decision on the right leg. She orthopedic provider hyprior to 4/16/24.  Nurse #3 was interving She was the nurse of ankle wound was idea she notified the medit hospice of the new whollow-up with the orthopedic provider hyprior to 4/16/24.  Nurse #3 was interving the wound was idea she notified the medit hospice of the new whollow-up with the orthopedic provider hyprior to 4/16/24.  Nurse #3 was interving the wound was idea she notified the medit hospice of the new whollow-up with the orthopedic provider hyprior to 4/16/24.	e caused. She thought a note Resident #102 to her ent on 4/4/24 by the floor now of the new wound	F	584			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,			(X3) DATE SURVEY COMPLETED	
		345421	B. WING _			C	
	ROVIDER OR SUPPLIER	1 20.2		STREET ADDRESS, CITY, STATE, ZIP C 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		4/17/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	The DON and Regio interviewed on 4/17/2 explained the orthop 4/16/24 regarding the being used due to a ankle. The DON stat to use the knee imm pressure areas to the have inquired further On 4/17/24 at 5:00 Foccurred with the Orwith Resident #102, the clinic on 4/4/24. Resident #102 had a femur but due to her conservative managimmobilizer was cho 4/16/24 that the facilimmobilizer to Resid area on her right ank the facility was notific Resident #102 was reported by the careful att when moving her rig 2. Resident #30 was 05/26/21 with diagnor Disease, Dementia, osteoporosis, and fa The quarterly Minimulassessment dated 0 #30 's cognition was dependent on staff for transfers, toilet hygie	der had been made aware.  Inal Nurse Consultant were 24 at 10:03 AM and edic provider was notified on e right knee immobilizer not wound on the right inner led a decision was made not obilizer to prevent further e right leg and they should rewith the orthopedic provider.  PM, a phone interview thopedic PA who was familiar and stated he saw her last in the further stated that a bad fracture to the right age and fragility, ement with a knee sen. He was made aware ity was not applying the knee ent #102 due to the pressure kle. The Orthopedic PA stated ed today (4/17/24) the if not getting out of bed it would nee immobilizer to the right ention needed to be made the leg.  I admitted to the facility on oses that included Alzheimer's history of stroke, lls.	F 6	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVE COMPLETED	(X3) DATE SURVEY COMPLETED	
		345421	B. WING		C <b>04/17/2024</b>		
	ROVIDER OR SUPPLIER	1 0.0.2.		STREET ADDRESS, CITY, STATE, ZIP COD 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		24	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COM	(X5) PLETION DATE	
F 684	Continued From pag	e 30	F 6	84			
	#30 was observed or on her back. She wa staff members with n They noticed Reside "unlike the other hip physician was notifie	10/18/23 revealed Resident in the floor at 2:15 AM lying is lifted back to bed by two oted pain in her right hip. In the was and was misshaped. The d, and new orders received in the mister Tylenol, and apply ice					
	#30 was observed or on her back. Nurse # and the right hip app and different from the was lifted back to be given 650 milligrams	d 10/18/23 revealed Resident in the floor at 2:15 AM lying it 0 noted pain to right hip eared to be out of alignment e other hip. Resident #30 d, ice applied, and Tylenol (mg) was given. The d, and new orders received.					
	10/18/23 revealed Remergency room on pain rated at a level being the worst pain area. The physician was having a lot of pemergency department pain, then do hip x-rand A Post Falls Evaluation was completed by No.	on, Background, mendation (SBAR) dated esident #30 was sent to the 10/18/23 at 4:20 AM due to 5 on a 1-10 scale with 10 to the right trochanter (hip) estated that if Resident #30 ain to send out to the ent (ED) and if not much ay stat. Hip x-ray ordered.  on Form, dated 10/18/23, urse #10 indicated Resident e floor beside bed, lying on					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345421	B. WING			C <b>04/17/2024</b>		
	ROVIDER OR SUPPLIER			72 (	REET ADDRESS, CITY, STATE, ZIP CODE CHATHAM BUSINESS PARK TSBORO, NC 27312	1 04/	11/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 684	Continued From page		F	684				
	incontinence care at 2 on the floor at 2:15 A	dent #30 had been provided 2:00 AM and was observed M. It also indicated that she ing position in bed prior to						
	PM with the Medical l resident falls the nurs the floor and if there w	ducted on 04/16/24 at 12:05 Director (MD). He stated if a se was to assess them on was pain voiced and/or t was to be transferred to the ed.						
	7:48 AM with Nurse # remembers Resident explained that the Nu the resident at approximate then stated she came 15 minutes later when from Resident #30's resident #30's resident #30's room the floor on the left sin position and voiced palso stated she assess and noticed her right alignment and looked She then had the Nurher in transferring Rebed, each had one sin the bed. Nurse #10 sin moving the resident would cause additional further stated, "I didn' floor with a fractured resident was having at the emergency departs."	#30's fall on 10/18/23. She rising Assistant had changed kimately 2:15 AM. Nurse #10 a up the hall approximately in she heard a noise coming from. Upon entering in she observed her lying on de of the bed in a supine ain to her right hip area. She seed the resident on the floor hip appeared to be out of a different from the other hip. It is in the de of her body lifting her to tated she was aware that with a possible hip fracture all damage and pain. She it want to leave her on the hip". The physician stated if a lot of pain to send her to tement (ED) and if not in						
	much pain, then do h	ip x-ray STAT (order should t's needed urgently). Nurse						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345421	B. WING			1	C
NAME OF PE	ROVIDER OR SUPPLIER	0.0.2.		_	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	17/2024
					72 CHATHAM BUSINESS PARK		
THE LAUF	RELS OF CHATHAM				PITTSBORO, NC 27312		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	l	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	HE APPROPRIATE	
F 684	Continued From page	÷ 32	F	684			
	#10 indicated she ord						
		know why she chose to do					
		sidents pain and hip/leg					
		company was not able to					
	•	AT, so she was transferred ergency medical services					
	(EMS).	ergency medical services					
	(=).						
		ducted on 04/17/24 at 10:46					
		of Nursing (DON) and the					
	Regional Nurse Cons resident falls the nurs	sultant. The DON stated If a					
		ng them from the floor. If the					
	resident complains of						
	-	to contact the Medical					
	Director (MD) and cal						
		oital. She was unaware					
	pain and deformity to	sident #30 after she noted the right hip.					
		e made to contact Nursing 04/16/24 and 04/17/24 with					
	no success. NA #3 was Resident #30 's fall of	as on duty at the time of on 3/18/23.					
F 686 SS=G	Treatment/Svcs to Pr CFR(s): 483.25(b)(1)	event/Heal Pressure Ulcer (i)(ii)	F	686			5/8/24
	§483.25(b) Skin Integ	rity					
	§483.25(b)(1) Pressu						
	-	hensive assessment of a					
	resident, the facility m						
	. ,	s care, consistent with Is of practice, to prevent					
	· ·	loes not develop pressure					
	· ·	vidual's clinical condition					
		ey were unavoidable; and					
		essure ulcers receives					
	necessary treatment	and services, consistent					

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES				OIVID IN	J. 0930 <del>-</del> 0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION		SURVEY PLETED
							С
		345421	B. WING				/17/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,                                    </u>	-
				72	CHATHAM BUSINESS PARK		
THE LAUF	RELS OF CHATHAM			P	ITTSBORO, NC 27312		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 686	Continued From page	e 33	F	686			
	with professional star						
	promote healing, pre						
	new ulcers from deve						
		Γ is not met as evidenced					
	by:						
	Based on record rev			F686:			
	interviews with the O			The facility will continue to ensure that			
	Assistant, Orthopedic			skin integrity underneath splints or brace	ces		
		rector, Hospice Aide, and			is assessed.		
	-	d to assess Resident #102's			The feelith will engineer to be an arranged by		
		ilizer used following a · (the area of the leg just			The facility will continue to ensure that protective skin care orders are transcril		
	above the knee joint)				per physician orders.	Jeu	
		nstageable (full thickness			per priysician orders.		
		n which the extent of tissue			Resident #102 received a new physicia	ans	
		cer cannot be confirmed			order to discontinue the right knee		
	_	ped is obscured by eschar			immobilizer on 4.15.24. This order was	S	
		ad skin), slough (yellow			carried out on the same day by the Uni	t	
		and thick) and granulation			Manager.		
	tissue (part of the hea	aling process in which			Resident #92 had protective skin care		
		ntaining new connective			order per wound care consultant		
	-	form around the edges of			recommendation transcribed by the Un	it	
		ulcer to the right inner ankle.			Manager on 4.16.24.		
	· ·	d to transcribe and provide			O		
	·	o a recently healed pressure			Current residents with splints or braces		
		This deficient practice ents reviewed for pressure			have the potential to be affected. Curr residents with splints or braces had au-		
	ulcers.	ills reviewed for pressure			completed by the Regional Clinical Nur		
	ulocis.				on 5.1.24 to ensure that residents with	30	
	The findings included	<b>i</b> :			splints or braces had orders to check s	kin	
	g				integrity underneath the devices. No		
	1) Resident #102 was	s admitted to the facility on			negative outcomes were identified rela	ting	
		s that included fracture of the			to these assessments.	-	
	right femur, bullous p	emphigoid (an autoimmune					
		itchy raised rashes and large			Current residents followed by the would		
		s. She was admitted to the			care consultant have the potential to be		
	facility on hospice se	rvices.			affected. Current residents followed by		
					the wound care consultant were audite		
	∣ The hospital discharg	ge summary dated 3/2/24			by the Regional Clinical Nurse on 5.1.2	:4.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_			С	
		345421	B. WING _			, ا	)4/17/2024	
NAME OF P	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	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	<u>,                                    </u>	(X5)	
PRÉFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION DATE	
F 686	Continued From pa	nge 34	F	686				
	indicated Resident	#102 was to wear the			to ensure that all wound care consult	ant		
	well-padded knee i	mmobilizer which could be			recommendations were transcribed p	er		
	removed for hygien	ie.			physician orders. No negative outcor			
				were identified relating to. these audi	S.			
	A review of Resider							
		lated 3/2/24 to 3/19/24 for right			100% of licensed nurses will be inser			
		be worn at all times. Remove			by the ADON as of 5.7.24 on the facil	ity		
		e padding if removed every			expectation that routine skin integrity			
	shift.				checks underneath splints and brace be conducted and all wound care	3 WIII		
	The becaling care	alan included a feetie area			consultant recommendations will be			
		olan included a focus area for being at risk for impaired			transcribed per physician orders.			
	skin integrity/pressi	- · · · · · · · · · · · · · · · · · · ·			l'anscribed per priysician orders.			
	• • •	cline in mobility, incontinence,			A QA monitoring tool will be utilized to	,		
	malnutrition, fragile			ensure ongoing compliance by the	•			
	mamaman, nagno	onin, and one or mo.			DON/designee beginning on 5.8.24.	The		
	A nursing progress	note dated 3/8/24 revealed			DON/designee will audit 3 residents v			
		rsonal care was provided by			splints or braces 5x/week x 4 weeks			
		nd right knee immobilizer was			3x/week x 4 weeks then weekly x 4 w			
	present.				to ensure that routine skin integrity ch	iecks		
					underneath splints and braces are			
	The admission Min	imum Data Set (MDS)			conducted. Variances will be correct	∍d at		
	assessment dated	3/8/24 indicated Resident			the time of audit and additional educa	ition		
		ognitive impairment and limited			provided when indicated.			
	_	one lower extremity. She						
		assistance with toileting			A QA monitoring tool will be utilized to	)		
		nd bed mobility. There were			ensure ongoing compliance by the			
		but she was coded for			DON/designee beginning on 5.8.24.	The		
	pressure reducing				DON/designee will audit 3 residents			
	•	ntervention to manage skin			followed by the wound care consultar	IT		
		on of nonsurgical dressing			5x/week x 4 weeks then 3x/week x 4	ıro		
	other than to feet a	nd application of ons other than to feet.			weeks then weekly x 4 weeks to ensu			
	omunems/medicall	ons other than to leet.			that recommendations are transcribe physician orders. Variances will be	ı hei		
	A review of the wee	ekly skin assessment dated			corrected at the time of audit and			
		eted by Nurse #1 indicated that			additional education provided when		<b> </b>	
	Resident #102 had	•			indicated.			
	1.35IGOIL # TOZ HAG	wouldo.						
	An orthopedic prov	ider progress note dated			Audit results will be reported to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345421	B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER	040421			TREET ADDRESS, CITY, STATE, ZIP CODE	04	1/17/2024	
NAME OF PI	ROVIDER OR SUPPLIER							
THE LAUF	RELS OF CHATHAM				2 CHATHAM BUSINESS PARK			
				Р	ITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 686	Continued From page	Continued From page 35						
	3/14/24 indicated Resident #102 was to wear the right knee immobilizer and was okay to remove for hygiene.			386	Administrator weekly for the next 3 months beginning on 5.15.24 and concerns will be reported to the Quality Assurance Committee during monthly	<i>(</i>		
	3/16/24 and 3/25/24 a	y skin assessments dated and completed by the wound Resident #102 had no new			meetings.  Continued compliance will be monitore through random observations and thro			
	A review of Resident included an order dat immobilizer to be wor	#102's physician orders led 3/19/24 for right knee on at all times. Remove for ntegrity, replace padding if			the facility's Quality Assurance Program  Compliance will be monitored by the Q  Committee for 3 months or until resolve and additional education/training will be provided for any issues identified.	n. A ed		
	3/27/24 and complete	ly skin assessment dated ed by Nurse #2 read that o new wounds identified.						
	11:26 AM stated Resi chronic conditions. He nursing Resident #10 antibiotic for the treat It was noted she had upper extremities but	note dated 4/3/24 and timed ident #102 was seen for her e referenced that per 12 had recently completed an ment of bullous pemphigoid. sores to her chest and there was no mention of a potential to her right inner ankle.						
	2:43 PM, and comple Resident #102 had a	oted dated 4/3/24, timed sted by Nurse #3 read that new unstageable wound to wound care nurse and						
	4/3/24 and completed	y skin assessment dated d by Nurse #3 read that ne new wound present.						
	A skin/wound progres	ss note dated 4/3/24, timed						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION  G	(X3	OMPLETED
		345421	B. WING			C <b>04/17/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	ı	04/17/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	6:01 PM and compleindicated there was a unstageable wound the area measured 3 cere cm in width and 0.3 completies is to notify the physician. Will have a 4/4/24.  A wound provider provindicated Resident # prescribed leg brace ankle. A right inner a over the last few day treating the wound. The was an unstageable medical device brace wound, however the tissue present. The allength, 3 cm in width necrotic tissue was pure A review of the physiciated 4/4/24 to clear the right inner ankle, periwound, apply Medressing used for more and cover with a foar needed if soiled.  An orthopedic progressing used that Resident #102 heressure ulcer to the Resident #102's care	ted by the wound nurse a sudden onset of a new to the right inner ankle. The natimeters (cm) in length, 2.3 cm in depth. There was 90% riwound was red. The hall family, hospice, and wound provider evaluate on the provider evaluate of the provider	F 68			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		OMPLETED
		345421	B. WING _			C <b>04/17/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		0-111/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 686	6 Continued From page 37		F 6	586		
	integrity related to unankle.	ınstageable to right medial				
	that Resident #102 ulcer to the right inn in-house. The area and 2.2 cm in width  A wound provider p indicated Resident pressure wound me in width and 0.2 cm necrotic tissue pres right inner ankle wo pressure) that had i  On 4/16/24 at 9:52 with Nurse #4 who e #102 was wearing t was removed by the	revaluation dated 4/10/24 read had an unstageable pressure her ankle that was acquired measured 4.6 cm in length.  rogress note dated 4/11/24 #102's right inner ankle heasured 4 cm in length, 2.7 cm in depth. There was 60% ent. Resident being seen for hund (medical device related mproved from last visit.  AM, an interview occurred explained that when Resident he right knee immobilizer it explained that when last visit.				
	her to any changes to the skin or pressure areas.  Nurse Aide (NA) #1 was interviewed on 4/16/24 at 9:56 AM and stated that when she provided personal care to Resident #102, she loosened the right knee immobilizer to make sure her skin was clean and dry and that there were no open areas. She went onto explain she was caring for Resident #102 on 4/3/24 and noticed the open area to her right inner ankle. She notified the nurse duty of her findings.  On 4/16/24 at 10:35 AM, a wound care observation occurred of Resident #102 with the wound care nurse. Resident #102 had been premedicated for pain prior to the dressing change. Yellow slough was present to the center					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ ' '	PLE CONSTRUCTION	' '	TE SURVEY MPLETED
		345421	B. WING			C <b>)4/17/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312		4/11/2024
(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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 686	wound bed visible slight drainage present and Wound care was consigns or symptoms or boots were present at was functioning correct. The wound care nurse 4/16/24 at 10:45 AM wound when it was fis saw where the right with the ankle. Wound care was to be seen by the following day. She stoloosened the brace to personal care tasks, been reported to the care nurse added the very fast on Resident. The Medical Director at 11:39 AM and state multiple co-morbidities pressure ulcers such pemphigus bullous distatus. He felt the right the pressure ulcer to avoidable.  On 4/16/24 at 1:51 Poccurred with the wor (PA). She explained twice. The first time seen sugar and the statement of the pressure with the wor (PA). She explained twice. The first time seen sugar and the statement of the pressure with the wor (PA). She explained twice. The first time seen sugar and the pressure with the wor (PA). She explained twice. The first time seen sugar and the pressure with the wor (PA). She explained twice. The first time seen sugar and the pressure with the work (PA).	e pressure area with pink ghtly. There was moderate I no odor to the wound. Inpleted as ordered without if discomfort. Protective and alternating air mattress ectly.  The was interviewed on and stated she assessed the rest identified on 4/3/24 and the immobilizer ended at the was provided, and she is wound provider the ated the aides would have no look under it during any open areas would have nurse on duty. The wound is pressure area developed in #102.  The was interviewed on 4/16/24 and that Resident #102 had the state placed her at risk for as her age, fragile skin, fragnosis, and her hospice that knee immobilizer causing the right inner ankle was	F 6	,		
	touch the ankle area.	t which was observed to She felt the pressure ulcer ure of the right knee Idn't say whether the area				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
		345421	B. WING			1	C / <b>17/2024</b>
	ROVIDER OR SUPPLIER			72	TREET ADDRESS, CITY, STATE, ZIP CODE  CHATHAM BUSINESS PARK  ITTSBORO, NC 27312	1 04/	11/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 686			F	686			
	pressure ulcer came	•					
	Nurse on 4/16/24 at 3 received a call from the Resident #102 had a inner ankle from the Resided the clinic was a pressure ulcer to the stated she asked the	curred with UNC Orthopedic 3:00 PM. She stated she had he facility today reporting pressure ulcer to her right knee immobilizer. She unaware she had developed e ankle on 4/3/24. She facility if the immobilizer or hygiene and was told best they could".					
	3:42 PM who cared for second shift (3:00 PM she had never removimmobilizer to look at	d with Nurse #5 on 4/16/24 at or Resident #102 on the If to 11:00 PM). She stated ed the right knee the skin under the brace bene done by the NAs and					
	at 8:36 AM. She had assessment on Resid	lent #102 on 3/27/24. A a return call that was not					
	on 4/17/24 at 8:37 AM #102 on the night shi He completed the ski Stated he "believed" immobilizer to comple would not have remo	Is completed with Nurse #1 If who cared for Resident If (11:00 PM to 7:00 AM). In assessment on 3/10/24. If the removed the knee If the skin assessment but If the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ISTRUCTION		PLETED
		345421	B. WING _				C 17/2024
	ROVIDER OR SUPPLIER			72 CH	T ADDRESS, CITY, STATE, ZIP CODE ATHAM BUSINESS PARK BBORO, NC 27312	1 04	1112027
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	An observation occur the application of the Resident #102. Onco on correctly the end oright ankle.  On 4/17/24 at 9:50 A with Nurse #3 and strimmobilizer was loos the NA Resident #10 the closures of the brack the NA came of the provide personal care and assess added that she didn't immobilizer to the rig	would have removed the time.  Tred with Unit Manager #1 of right knee immobilizer to be the immobilizer was placed of the brace rested on the  M, an interview occurred atted that when the right knee ened for personal care from 2's skin would be red around ace. She explained that on to her and told her about the right inner ankle. It was do nurse and to the hospice  AM, an interview was ospice aide who comes into the assistance to Resident	F	586	DEFICIENCY)		
	at 11:13 AM who propersonal care to Res 3:00 PM shift. She st loosened the right kn	re or bathing assistance to					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  IG	, ,	DATE SURVEY COMPLETED
		345421	B. WING			C
	ROVIDER OR SUPPLIER	1 0.0.2.		STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	l	04/17/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPLICATION OF THE APPLICA	OULD BE	(X5) COMPLETION DATE
F 686	with Resident #102. clinic on 4/4/24, ass brace would have be see any open wound areas with bandage: that Resident #102 Ifemur but due to her conservative managimmobilizer was chefor pressure ulcers abe removed for hygichecks.  2. Resident #92 was 02/15/24 with diagnomirabilis (a species urinary tract of the hidiseases and moder malnutrition (inadequation of the hidiseases and moder malnutrition (inadequation of the hidiseases and moder malnutrition of the hidiseases and moder malnutrition of the hidiseases and moder malnutrition.  The admission Minimassessment dated 0 #92 's cognition was behaviors or rejection maximum assistance of 1 for proposition of the hidiseases and moder maximum assistance of 1 for proposition of the hidiseases. Resident #92 's action of the hidiseases and moder maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 2 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition was behaviors or rejection maximum assistance of 1 for proposition wa	stated he saw her last in the essed her skin where the een on the right leg and didn't ds, but she did have several so present. He further stated had a bad fracture to the right eage and fragility ement with a knee essen. She was at a high risk and had asked that the splint ene purposes as well as skin admitted to the facility on the posis that included proteus of bacteria that infects the uman body) as the cause of the essen eage of the saw and had asked that the splint ene purposes as well as skin admitted to the facility on the posis that included proteus of bacteria that infects the uman body) as the cause of the essen eage of the essen	F6	86		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345421	B. WING _				C 17/2024
	ROVIDER OR SUPPLIER			72 CHATHAI	PRESS, CITY, STATE, ZIP CODE  M BUSINESS PARK  O, NC 27312	<u>  04/</u>	17/2024
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	included for staff to for policies/protocols for impaired skin integrity. A wound provider proceeded an open are heel was healed and prep every shift for proceeding and was noted.  A nursing progress not the Wound Nurse reviseen by wound care provider, stage 4 wou and wound has been up or treatments need A review of Resident 04/11/24 to 04/16/24 prep to right heel.  An interview was con AM with Resident #90 ulcers had healed as allow observation of his there was nothing the applying anything to in An interview was con PM with the Wound Nound consultation in for skin prep every shift orders are noted on thowever, she stated order. She verified the discontinued order for the wound order for the woun	sollow facility the prevention/treatment of y.  Igress note dated 04/11/24 that to Resident #92 's right a recommendation for skin totection for at least 7 days  Interest of the dated 04/11/24 written by the dated 04/11/24 written by the dated Resident #92 was provider. Per wound care and to right heel has healed, the resolved. No further follow ded at this time.  #92's physician orders from the revealed no order for skin  ducted on 04/16/24 at 10:20 2. He stated his pressure of last week and refused to his right heel. He stated there to look. He denied staff tt.  ducted on 04/16/24 at 2:33  Jurse. She verified the tote had a recommendation the for protection for at least the also verified all new the wound care consult note, she must have missed the	F	886			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
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		345421	B. WING			04/	17/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 756 SS=D	AM with the Director stated the Wound Nutranscribing all orders the Wound Care Phy was unaware the ord Drug Regimen Revie CFR(s): 483.45(c)(1)  §483.45(c) Drug Reg §483.45(c)(1) The drug the reviewed at licensed pharmacist.  §483.45(c)(2) This resof the resident's med facility's medical direct and these reports musically in the section for (ii) Any irregularities including that meets the condition of the resident of the reside	inducted on 04/17/24 at 10:46 of Nursing (DON). She arse was responsible for skrecommendations noted by sician Assistant (PA). She er had not been transcribed. W, Report Irregular, Act On (2)(4)(5) imen Review.  ug regimen of each resident least once a month by a view must include a review ical chart.  armacist must report any stending physician and the corrand director of nursing, ast be acted upon. Ide, but are not limited to, any criteria set forth in paragraph an unnecessary drug. In the documented on a cort that is sent to the and the facility's medical of nursing and lists, at a cort in the cord that the identified. If yesician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in		686 756			5/8/24

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345421	B. WING		C 04/17/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	, , , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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)	BE COMPLÉTION
F 756			F 756	3	
	maintain policies and drug regimen review limited to, time frame the process and step when he or she iden requires urgent actio This REQUIREMEN' by:  Based on staff, Phys Pharmacist interview Consultant Pharmac of documentation for effects for a resident medications. This was residents reviewed for The findings included Resident #173 was cumulative diagnose dementia with behave Review of Resident a orders included an orange Zyprexa (antipsycho 6 hours as needed for days until 8/27/23.  Resident #173 was orisk for adverse react to receiving multiple which included an arthe antipsychotic inc sedation, headaches tremors, orthostatic hextrapyramidal (impaeffects to include akaren sedation).	cility must develop and disprocedures for the monthly that include, but are not as for the different steps in as the pharmacist must take tifies an irregularity that in to protect the resident. This not met as evidenced sician and Consultant as and record review, the ist failed to identify the lack the monitoring of side prescribed antipsychotic as for 1 (Resident #173) of 7 for unnecessary medications. It is admitted on 8/13/23 with as of Alzheimer's Disease, iors, and Bipolar Disease.  #173's admission Physician reder dated 8/13/23 for ticc) 2.5 milligrams (mg) every or psychotic disorder x 14  Eare planned on 8/14/23 for a tions and side effects related psychotropic medications intipsychotic. Interventions for luded to observed for a diziness, diarrhea, anxiety, hypotension, blurred vision, aired motor control) side athisia (inability to stay still) iia (involuntary muscle		F756: The Consultant Pharmacist will continue to identify the need for monitoring of seffects for residents prescribed antipsychotic medications.  Resident #173 no longer resides in the facility. No negative outcome was identified relating to this observation.  Current residents prescribed antipsych medications have the potential to be affected. All current residents prescribed antipsychotic medications were audite ensure that orders for monitoring for seffects are in place. No negative outcomes were identified relating to the observations.  The Consultant Pharmacist was educed as of 5.2.24 by the clinical manager or ensuring that residents prescribed antipsychotic medications have orders monitoring for side effects in place.  A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. Toon/designee will audit 3 guests	notic ped d to ide ese ated n

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345421	B. WING _		o	4/17/2024	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
THELALI	DELC OF CHATHAM			72 CHATHAM BUSINESS PARK			
THE LAU	RELS OF CHATHAM			PITTSBORO, NC 27312			
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F 756		nge 45 ardive dyskinesia (chronic ts in involuntary, sudden,	F 7	prescribed antipsychotic me weekly x 12 weeks to ensur			
	irregular movement of the face body or both).  Review of a Consultant Pharmacist medication			for monitoring for side effect Variances will be corrected observation and additional of	at the time of		
	review of a Consultant Pharmacist medication review note dated 8/15/23 read there was nothing "inconsistent with customary, accepted clinical approaches to providing pharmaceutical products or services or that could reasonably be expected to impede or interfere with the achievement of the intended or reasonably expected outcomes."			corrective action provided w	vhen indicated.		
				Observation results will be reported to Administrator weekly for the months beginning on 5.15.2 concerns will be reported to Assurance Committee during	e next 3 24 and the Quality		
	Review of another Physician order dated 8/16/23 for Seroquel (antipsychotic) 25 mg twice a day for bipolar disorder and a current manic episode. There were no orders or adverse side effect monitoring.  Review of Resident #173's behaviors monitoring documentation read she had the following behaviors on the follow days for August 2023: 8/13/23-aggressive behavior 8/15/23-wandering 8/17/23 inappropriate language 8/19/23-wandering 8/22/23-wandering x 2 8/23/23-wandering and aggressive			meetings.  Continued compliance will be through random observation the facility's Quality Assurar	ne monitored		
				Compliance will be monitore Committee for 3 months or and additional education/tra provided for any issues ider	until resolved aining will be		
	behavior 8/24/23-agg 8/26/23-wa 8/28/23-wa behaviors 8/29/23-agg 8/31/23-agg	gressive behavior ndering ndering and aggressive gressive behavior x 2 gressive behavior					
	medication adminis	t #173's nursing notes and stration record (MAR) for ot include any documentation					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		OATE SURVEY COMPLETED
		345421	B. WING _			C <b>04/17/2024</b>
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	<b>'</b>	041112024
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F 756	Continued From page 46		F 7	756		
		#173's September 2023 luded an order dated 9/5/23 mg at bedtime.				
	review note dated 9/ "inconsistent with cu approaches to provio or services or that co to impede or interfere	ant Pharmacist medication 7/23 read there was nothing stomary, accepted clinical ding pharmaceutical products ould reasonably be expected e with the achievement of the only expected outcomes."				
	following behaviors of September 2023:	tation read she had the on the follow days for we behavior, rejection of care, we behavior of care sive behavior of care ing on of care x 2 ing on of care ing				
	Review of Resident #173's nursing notes and MAR for September 2023 did not include any documentation of monitoring of adverse side effects.					
	indicated Resident#	um Data Set dated 9/18/23 173 had severe cognitive bited physical and wandering				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		NSTRUCTION		PLETED
		345421	B. WING			1	C <b>17/2024</b>
	ROVIDER OR SUPPLIER	1		72 CI	ET ADDRESS, CITY, STATE, ZIP CODE HATHAM BUSINESS PARK SBORO, NC 27312	1 04/	11/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 756	behaviors.  Review of Resident of documentation read behaviors on the foll 10/4/23-rejection 10/5/23-wander  Review of Resident of MAR for October 20 documentation of meeffects.  Review of a Consult review note dated 10 "inconsistent with cuapproaches to provie or services or that conto impede or interfer intended or reasonal Review of Resident 8/13/23 to 10/8/23 documentation regain presenting over sed and interview was conputed by the facility. Unit Manage at the facility, Reside wandered into other frequently refused he in worsening of her bany occasion where arouse or appeared.	#173's behaviors monitoring she had the following ow days for October 2023: In of care ing #173's nursing notes and 123 did not include any onitoring of adverse side ant Pharmacist medication 10/5/23 read there was nothing stomary, accepted clinical ding pharmaceutical products ould reasonably be expected e with the achievement of the bly expected outcomes." #173's nursing notes from id not include any roding any observations of her ated or difficult to arouse. Impleted on 4/15/24 at 3:45 er #1. She recalled Resident is admitted from a sister r #1 stated while she resided ent #173 was combative, residents rooms and er medications with resulted behaviors. She did not recall Resident #173 was difficult to	F	756			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345421	B. WING				C 1 <b>17/2024</b>	
	ROVIDER OR SUPPLIER			72	REET ADDRESS, CITY, STATE, ZIP CODE CHATHAM BUSINESS PARK ITSBORO, NC 27312	1 04/	17/2024	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 756			F	756				
	resided there. She st was admitted, readm psychotropic medical	at the time Resident #173 ated whenever a resident itted or newly prescribed a tion, there had to be an order nonitoring and side effect						
	AM with the Physicia #173 was admitted, her care so he prescription increase to the Serocanticonvulsant. The Fresident was prescrib	Physician stated anytime a ped an antipsychotic perative for staff to monitor cts such as tardive						
	AM with Nurse #12. S Resident #173. She s was prescribed an ar monitoring of adverse sedation and sympto An interview was con PM with Nursing Ass Resident #173 refuse combative during car	Inpleted on 4/16/24 at 9:10 She stated she did not recall stated anytime a resident ntipsychotic, there should be a side effects like tremors, ms of tardive dyskinesia.  Inpleted on 4/16/24 at 2:10 istant (NA) #10. She stated at her medications and was a e. NA #10 did not recall any dent #173 appeared over arouse.						
	at 3:55 PM with the C stated he should hav or documentation of effects related to Res medications. He state	was completed on 4/16/24 Consultant Pharmacist. He e noted there were no orders monitoring for adverse side sident #173's antipsychotic ed it was an oversight due to ity attempts to regulate						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345421	B. WING _			04/	17/2024
	ROVIDER OR SUPPLIER			72	TREET ADDRESS, CITY, STATE, ZIP CODE  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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758 SS=D	AM with the Director of Regional Nurse Constant Stated the should have identified ensure Resident #173 adverse side effects a antipsychotic medical Free from Unnec Psy CFR(s): 483.45(c)(3)( §483.45(c)(3) A psychaffects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehensident, the facility models with the side psychotropic drugs are unless the medication specific condition as continuous in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral intervention	appleted on 4/17/24 at 11:00 of Nursing (DON) and the ultant. The Regional Nurse Consultant Pharmacist If the need for observation to If was not experiencing any associated with taking tions. Inchotropic Meds/PRN Use If (e)(1)-(5) If (e)(1)-(6) If (e)(1)		756			5/8/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345421	B. WING		C 04/47/2024
	ROVIDER OR SUPPLIER	1 00.2		STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	04/17/2024
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 758	Continued From page	<b>∋</b> 50	F 75	8	
	unless that medication	ursuant to a PRN order on is necessary to treat a condition that is documented			
	are limited to 14 days §483.45(e)(5), if the aprescribing practition appropriate for the Pl beyond 14 days, he days	RN order to be extended or she should document their ent's medical record and			
	drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of	rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication.  is not met as evidenced			
	Based on staff and F record review, the factories of documentation for effects for a resident medications. This wa	Physician interviews and cility failed to identify the lack the monitoring of side prescribed antipsychotic s for 1 (Resident #173) of 7 or unnecessary medications.		F758: The facility will continue to ensure tha residents prescribed antipsychotic medications are monitored for side effects.  Resident #173 no longer resides in th facility. No negative outcome was	
	cumulative diagnoses dementia with behavi Review of Resident #	admitted on 8/13/23 with s of Alzheimer's Disease, fors, and Bipolar Disease.		identified relating to this observation.  Current residents prescribed antipsyc medications have the potential to be affected. All current residents prescribential antipsychotic medications were audited.	bed
	Zyprexa (antipsychot	ic) 2.5 milligrams (mg) every r psychotic disorder x 14		ensure that orders for monitoring for seffects are in place. No negative	

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STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345421	B. WING			04/	17/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TUE I ALIE	RELS OF CHATHAM			72	2 CHATHAM BUSINESS PARK		
THE LAUP	CELS OF CHAIRANI			Р	ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	e 51	F	758			
	days until 8/27/23.			outcomes were identified relating to observations.		ese	
	Resident #173 was c	are planned on 8/14/23 for a					
		ions and side effects related			100% of licensed nurses were educate	d	
		osychotropic medications			as of 5.7.24 on ensuring that residents		
		tipsychotic. Interventions			prescribed antipsychotic medications	ata	
		for sedation, headaches, nxiety, tremors, orthostatic			have orders for monitoring for side effe in place.	CIS	
		vision, extrapyramidal			iii pidoc.		
		ol) side effects to include			A QA monitoring tool will be utilized to		
	, , ,	stay still) restlessness,			ensure ongoing compliance by the		
	, ,	muscle contractions) and			DON/designee beginning on 5.8.24. T	he	
		nronic condition that results n, irregular movement of the			DON/designee will audit 3 guests prescribed antipsychotic medication		
	face body or both).	i, irregular movement of the			weekly x 12 weeks to ensure that order	rs	
	lace body of bothly.				for monitoring for side effects are in pla		
	Review of another Ph	nysician order dated 8/16/23			Variances will be corrected at the time		
		chotic) 25 mg twice a day for			observation and additional education o		
		a current manic episode.			corrective action provided when indicate	ed.	
		s or adverse side effect			Observation regults will be reported to	tha	
	monitoring.				Observation results will be reported to Administrator weekly for the next 3	ıne	
	Review of Resident #	173's behaviors monitoring			months beginning on 5.15.24 and		
	documentation read s	•			concerns will be reported to the Quality	,	
	behaviors on the follo 8/13/23-aggressi	ow days for August 2023:			Assurance Committee during monthly meetings.		
	8/15/23-wanderir	ng			meetings.		
	8/17/23 inapprop	• •			Continued compliance will be monitore		
	8/19/23-wanderir	•			through random observations and through		
	8/22/23-wanderir	ig x z ering and aggressive			the facility⊡s Quality Assurance Progra	IIII.	
	behavior	omig and aggicosive			Compliance will be monitored by the Q	A	
		essive behavior			Committee for 3 months or until resolve		
	8/26/23-wand				and additional education/training will be	9	
		ering and aggressive			provided for any issues identified.		
	behaviors	popiya babayiar y 2					
		essive behavior x 2 essive behavior					
	0/3 1/23-aggre	SSIVE DELIAVIOI					

Facility ID: 923099

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345421	B. WING				C 47/2004
	ROVIDER OR SUPPLIER	0.0.2.		72	TREET ADDRESS, CITY, STATE, ZIP CODE  2 CHATHAM BUSINESS PARK  PITTSBORO, NC 27312	1 04/	17/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	medication administra August 2023 did not i of monitoring of adve  Review of Resident # Physician orders inclu to add Seroquel 100  Review of Resident # monitoring document following behaviors o September 2023:	ation record (MAR) for include any documentation rese side effects.  ation order dated 9/5/23 and at bedtime.  ation read she had the in the follow days for the behavior of care in the care of care of care in the care of care of care in the care in the care of care in the care in t	F	758			
	MAR for September 2	173's nursing notes and 2023 did not include any nitoring of adverse side					
	indicated Resident #1	um Data Set dated 9/18/23 173 had severe cognitive oited physical and wandering					
	Review of Resident # documentation read s	173's behaviors monitoring she had the following					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345421	B. WING				C <b>17/2024</b>
	ROVIDER OR SUPPLIER		•	7	STREET ADDRESS, CITY, STATE, ZIP CODE 22 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	10/4/23-rejection 10/5/23-wanderin Review of Resident # MAR for October 202 documentation of mo effects.  Review of Resident # 8/13/23 to 10/8/23 did documentation regard presenting over seda An interview was com PM with Unit Manager #173 stating she was facility. Unit Manager at the facility, Resider wandered into other in frequently refused he in worsening of her brand occasion where francuse or appeared of An interview was com AM with Nurse #11. Sworking at the facility resided there. She stawas admitted, readming psychotropic medicate for target behaviors in monitoring.  An interview was com AM with the Physician #173 was admitted, here	and days for October 2023: a of care and a 173's nursing notes and a 3 did not include any nitoring of adverse side a 173's nursing notes from a not include any ding any observations of her and ted or difficult to arouse.  Inpleted on 4/15/24 at 3:45 ar #1. She recalled Resident admitted from a sister admitted from a sister and #173 was combative, residents rooms and ar medications with resulted and the haviors. She did not recall a Resident #173 was difficult to over sedated.  Inpleted on 4/16/24 at 8:30 Bhe stated she was not at the time Resident #173 atted whenever a resident atted or newly prescribed a ation, there had to be an order anonitoring and side effect and the stated when Resident are behaviors were impeding aribed Seroquel, made an	F	758			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		,	c
		345421	B. WING			04/	17/2024
	ROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE  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)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	anticonvulsant. The Fresident was prescrib medication, it was implor adverse side effect dyskinesia and over serious An interview was com AM with Nurse #12. Seesident #173. She seesident #173. She seesident and sympton An interview was com AM with the Director of Regional Nurse Consultant stated the identified the need for Resident #173 was not side effects associated medications.  Resident Records - In CFR(s): 483.20(f)(5), \$483.20(f)(5) Resident (ii) The facility may not resident-identifiable to accordance with a coagrees not to use or dexcept to the extent the do so.  §483.70(i) Medical re §483.70(i) (1) In accordance professional standard	Physician stated anytime a sed an antipsychotic perative for staff to monitor its such as tardive sedation.  Inpleted on 4/16/24 at 9:10 She stated she did not recall stated anytime a resident tipsychotic, there should be side effects like tremors, ms of tardive dyskinesia.  Inpleted on 4/17/24 at 11:00 of Nursing (DON) and the ultant. The Regional Nurse facility should have sobservation to ensure of experiencing any adverse d with taking antipsychotic dentifiable Information 483.70(i)(1)-(5)  Int-identifiable information that is the public. Itelease information that is an agent only in intract under which the agent disclose the information ine facility itself is permitted cords.		758			5/8/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345421	B. WING		C <b>04/17/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	1 04/11/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 842	all information contaregardless of the for records, except when (i) To the individual, representative when (ii) Required by Law (iii) For treatment, poperations, as perm with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial an law enforcement pupurposes, research medical examiners, a serious threat to help by and in compliance \$483.70(i)(3) The farecord information and unauthorized use.	mented; ole; and organized  cility must keep confidential nined in the resident's records, or or storage method of the or their resident e permitted by applicable law; or; ayment, or health care itted by and in compliance	F 84	<u>'</u>		
	(ii) Five years from there is no requirem (iii) For a minor, 3 ye legal age under Sta	ears after a resident reaches				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345421	B. WING _		C <b>04/17/2024</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	71772024
				72 CHATHAM BUSINESS PARK		
THE LAUF	RELS OF CHATHAM			PITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTI  CROSS-REFERENCED TO TI  DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 842	Continued From page	e 56	F8	842		
F 042	(i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have complete and accurate medical records in the areas of wound care (Residents #273 and #274). This was for 2 of 7 closed records reviewed.		F8	F842: The facility will continue to maintain complete and accurate medical records the areas of wound care.  Residents #273 and #274 no longer		
	Treatment Administra wound care to the lef	ent #273's February 2024 tion Record (TAR) revealed t great toe amputation site		was identified relating to the observations.  Current residents with orde	rs for wound	
	resident on 2/8/24 an			care have the potential to b Medical records for current orders for wound care were	residents with reviewed by	
	A phone interview was completed with Nurse #6 on 4/16/24 at 2:51PM. She was assigned to care for Resident #273 on 2/8/24. Nurse #6 stated she recalled completing wound care as ordered for Resident #273 but must have gotten busy and forgot to sign off as completed.			the Unit Managers between ensure that wound care was appropriately. No negative were identified relating to the observations.	s documented outcomes	
	A phone interview oc 4/16/24 at 9:11 AM, v Resident #273 on 2/1	curred with Nurse #7 on who was assigned to care for 5/24. Nurse #7 stated she re to her left great toe area		100% of licensed nurses we by the ADON as of 5.7.24 or policy for ensuring that med for wound care are accurate	on the facility dical records	
		have forgotten to sign off as		A QA monitoring tool will be	utilized to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345421	B. WING _			C	
NAME OF D	ROVIDER OR SUPPLIER	J+J+Z I	B: Willo _	QTE	REET ADDRESS, CITY, STATE, ZIP CODE	1 (	04/17/2024
NAME OF PI	ROVIDER OR SUPPLIER				, , ,		
THE LAUF	RELS OF CHATHAM				CHATHAM BUSINESS PARK TTSBORO, NC 27312		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	COMPLETION DATE
F 842	Continued From page	e 57	F8	342			
	complete.				ensure ongoing compliance by the		
					DON/designee beginning on 5.8.24.	Γhe	
	On 4/17/24 at 10:03			DON/designee will randomly audit wo	und		
	conducted with the D	irector of Nursing (DON)			care documentation for 5 residents		
	1	cted documentation to be			5x/week x 2 weeks, then 5 residents		
	complete and accura	te.			3x/week x 2 weeks, then 5 residents		
					weekly x 4 weeks, then 5 residents		
	2) A rayiaw of the Ar	wil 2022 to July 2022			biweekly x 4 weeks to ensure that documentation for wound care is		
		oril 2023 to July 2023 ation Records (TARs)			accurate. Variances will be corrected	at	
	revealed the wound	` ,			the time of audit and additional education		
	extremity pin sites wa				or corrective action provided when		
		by Resident #274 on			indicated.		
		3/24, 4/15/24, 4/21/23,					
	6/19/23, 6/25/23, 7/1				Audit results will be reported to the		
					Administrator weekly for the next 3		
	A phone interview oc	curred with Nurse #6 on			months beginning on 5.15.24 and		
	I .	She was the nurse assigned			concerns will be reported to the Qualit		
		re to Resident #274 on			Assurance Committee during monthly		
		d providing wound care to			meetings.		
		sites on her leg but must			Continued compliance will be president	l	
	have forgotten to sigi	n it oπ as completed.			Continued compliance will be monitore		
	On 4/17/24 at 9:43 A	M. an interview was			through random medical records audit and through the facility ☐s Quality	.5	
	I .	ound nurse. She had been			Assurance Program.		
		Resident #274 on 4/12/23					
		ated she always made sure			Compliance will be monitored by the C	QΑ	
	I .	t must have gotten busy and			Committee for 3 months or until resolv		
	forgot to sign it off as				and additional education/training will be provided for any issues identified.	e	
	Multiple phone calls	were made to Nurse #9			-		
	during the survey with no return call received.						
	I .	ssigned to provide wound					
	care to Resident #27	4 on 4/13/23 and 6/25/23.					
	Multiple phone calls were made to Nurse #8						
		no avail. She was the nurse					
	assigned to provide work on 4/11/23, 4/15/23, 0	wound care to Resident #274 6/19/23 and 7/17/23.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED
			7 50.25				С
		345421	B. WING			04/	/17/2024
	ROVIDER OR SUPPLIER			72	REET ADDRESS, CITY, STATE, ZIP CODE CHATHAM BUSINESS PARK ITSBORO, NC 27312		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	e 58	F	842			
	conducted with the D	AM, an interview was irector of Nursing (DON) cted documentation to be te					
F 867 SS=D	QAPI/QAA Improvem CFR(s): 483.75(c)(d)		F	867			5/8/24
	monitoring. A facility must establi policies and procedul collections systems, adverse event monitorial.	feedback, data systems and sh and implement written res for feedback, data and monitoring, including bring. The policies and ude, at a minimum, the					
	systems to obtain and from direct care staff, resident representative information will be us	w maintenance of effective d use of feedback and input other staff, residents, and wes, including how such sed to identify problems that lume, or problem-prone, and rovement.					
	systems to identify, c information from all d not limited to the facil §483.70(e) and include	w maintenance of effective collect, and use data and departments, including but lity assessment required at ding how such information op and monitor performance					
	and evaluation of per	ology and frequency for such					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345421	B. WING _			C <b>04/17/2024</b>	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	<b>!</b>	O-111/202-1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 867	including the method systematically identically analyze and use data adverse events in the facility will use the daprevent adverse events in the facility will use the daprevent adverse events in the facility will use the daprevent adverse events in the facility will be facility and track performant implementing those and track performant improvements are results. The facility is a service of the facility will be designed to elevel to prevent qual safety problems; and (iii) How the facility work of its performance in ensure that improve \$483.75(e) Program \$483.75(e) Program \$483.75(e) (1) The facility work of its performance improve the facility of its performance improved the incidency of problems in those	y adverse event monitoring, its by which the facility will fy, report, track, investigate, a and information relating to e facility, including how the ata to develop activities to ints.  systematic analysis and acility must take actions ee improvement and, after actions, measure its success, and its ealized and sustained.  acility will develop and didressing: a systematic approach to g causes of problems tems; relop corrective actions that affect change at the systems ity of care, quality of life, or divill monitor the effectiveness approvement activities to ments are sustained.	F8	67			

AND DI AN OF CORRECTION IDENTIFICATION NUMBER			TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345421	B. WING			C <b>04/17/2024</b>	
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF CHATHAM			STREET ADDRESS, CITY, STATE, ZIP COI 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	DE	04/11//2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIAT	COMPLETION DATE	
F 867	resident events, analimplement preventive that include feedback facility.  §483.75(e)(3) As parimprovement activitied distinct performance number and frequence conducted by the fact and complexity of the available resources, assessment required Improvement project annually a project that problem-prone areas collection and analys (c) and (d) of this section are quired under the following as a governing body, or defunctioning as a governing body, or defunctioning as a governing body activities, including in program required under (ii) Develop and implication to correct iden (iii) Regularly review data collected under	mance improvement medical errors and adverse yze their causes, and a actions and mechanisms and learning throughout the at of their performance as, the facility must conduct improvement projects. The cy of improvement projects ility must reflect the scope a facility's services and as reflected in the facility at §483.70(e). In the facility at services on high risk or a identified through the data is described in paragraphs stion.  In the facility's services and as reports to the facility's esignated person(s) arrived as the facility's esignated person(s) arrived as the facility's esignated person(s) arrived as through the data in the facility's esignated person(s) arrived as the facility's esignated person(s) arrived as through the data is described in paragraphs to the facility's esignated person(s) arrived as the facility as the facility is esignated person(s) arrived as the facility is esignated as the facility	F	867			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		3) DATE SURVEY COMPLETED		
345421			B. WING			С		
		345421	D. WING _		•	4/17/2024		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE			
THE LAUF	RELS OF CHATHAM			72 CHATHAM BUSINESS PARK				
				PITTSBORO, NC 27312				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 867	Continued From pa	ge 61	F 8	67				
	available data to ma This REQUIREMEN by:	ake improvements. NT is not met as evidenced						
	Based on observat	ions, record review and staff ity's quality assurance (QA)		F867				
	process failed to im as needed the action recertification surves achieve and sustain recited deficiencies 4/14/24. The defici- dignity (550), activitation ulcer, and accurate continued failure du record shows a pation	plement, monitor, and revise on plan developed for the ey dated 2/9/23 in order to a compliance. This was for on a recertification survey on encies were in the areas of ies of daily living, pressure medical records. The uring two federal surveys of tern of the facility's inability to quality assurance program.		The facility will continue to en QAPI Committee implements and revises action plans as rorder to achieve and sustain.  The facility will continue to princontinence care on night statement of the dependent residents.  The facility will continue to	s, monitors, needed in compliance. rovide timely hift for			
	The findings include	ed:		understand what to expect.  The facility will continue to pi	rovide a			
	This tag is cross-ref			dignified dining experience b residents with regular plates	y providing			
	staff and resident in provide stool incont dependent resident	cord review, observation, and atterviews, the facility failed to inence care on night shift for a which caused him to feel		The facility will refrain from reresidents as feeders.	-			
	with a resident. A rebe provided communderstand what to deficient practice af	9) and failed to communicate easonable person expects to inication during care and expect (Resident #15). This fected 2 of 3 residents		The facility will continue to el dependent residents nails ar and clean, and assistance is shaving facial hair and wash	e trimmed provided with ing hair.			
	2/9/23, the facility fa	recertification survey on ailed to provide a dignified by providing residents with		The facility will continue to en assistance is provided with both the facility will continue to en skin integrity underneath spli	pathing.			
	during three observ resident who neede	ntainers and plastic utensils ed meals and referring to a ed assistance with meals as a for 3 of 9 residents reviewed		The facility will continue to el protective skin care orders a				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED		
		245424	345424 R WING			С		
	345421 B. WING				04/17/2024			
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE			
THE LAUF	RELS OF CHATHAM			72	2 CHATHAM BUSINESS PARK			
	(220 01 011) (111) (111)			Р	ITTSBORO, NC 27312			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 867	Continued From pag	e 62	F 8	367				
	for dignity. Based on	the reasonable person			per physician orders.			
	concept residents wo	ould expect to utilize regular						
	plates and utensils re	egardless of how fast they			The facility will continue to ensure that	t		
		pect to be identified as a			alternating pressure reducing air			
	"feeder." Requiring a	resident to utilize disposable			mattresses are set according to			
	food containers and	plastic utensils while other			resident□s weight.			
	residents were not or							
	the potential for a reasonable person to				The facility will continue to maintain			
	experience a negativ			complete and accurate medical record the areas of wound care.	ls in			
	F677: Based on reco							
	staff and resident into			Current residents have the potential to	be			
	provide dependent residents nail care (Resident				affected. See specific plans of correct	tion		
	#s 59 and 92) and failed to provide hair care and				under F550, F677, F686, and F842.			
	facial hair shaving (R							
		or activities of daily living.			The Administrator and DON consulted with Alliant QIO on 4.30.24.			
		ecertification survey on						
	2/9/23, the facility fail				The QAPI Committee completed a roo			
	1 -	nails (Residents #66, #28,			cause analysis for each repeat deficie	ncy		
		#58) and failed to assist with			on 5.1.24.			
		34). In addition, the facility						
	I .	dent with bathing (Resident			The facility's quality assurance commit			
	1	of 12 residents reviewed for			was inserviced by the Regional Clinica	al		
	Activities of Daily Living (ADLs).				Coordinator on the procedures for	iata		
	E696: Basad on roca	ord reviews, observations and			developing and implementing appropri plans of action to correct identified qua			
		•			concerns on 5.1.24. Education include	-		
	interviews with the Orthopedic Physician Assistant, Orthopedic Nurse, Wound Physician				determining the root cause of the	eu		
		· · · · · · · · · · · · · · · · · · ·			identified concerns, and identifying,			
	Assistant, Medical Director, Hospice Aide, and staff, the facility failed to assess Resident #102's				implementing, and monitoring the			
	skin under an immobilizer used following a				corrective action plan and recognizing			
	fractured distal femur (the area of the leg just				when an action plan may need to be			
	above the knee joint). This resulted in the				revised.			
	development of an unstageable (full thickness							
	skin and tissue loss in which the extent of tissue				A QA monitoring tool will be utilized to			
	damage within the ulcer cannot be confirmed				ensure ongoing compliance for by the			
		ped is obscured by eschar			Administrator/designee beginning on			
	(dry, dark scab of dead skin), slough (yellow				5.8.24. The Administrator/designee w	ill		

AME OF PROVIDER OR SUPPLIER  THE LAURELS OF CHATHAM  (YA) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 867  Continued From page 63 tissue that is stringy and thick) and granulation tissue (part of the healing process in which lumpy, pink tissue containing new connective tissue and capillaries form around the edges of the wound) pressure ulcer to the right inner ankle. The facility also failed to transcribe and provide protective skin care to a recently healed pressure ulcer (Resident #92). This deficient practice affected 2 of 7 residents reviewed for pressure ulcers.  During the previous recertification survey on 2/9/23, the facility failed to ensure the alternating pressure reducing air mattress was set according	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED		
THE LAURELS OF CHATHAM    STREET ADDRESS, CITY, STATE, ZIP CODE   72 CHATHAM BUSINESS PARK   PITTSBORO, NC 27312							С			
THE LAURELS OF CHATHAM  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 867  Continued From page 63 tissue that is stringy and thick) and granulation tissue (part of the healing process in which lumpy, pink tissue containing new connective tissue and capillaries form around the edges of the wound) pressure ulcer to the right inner ankle. The facility also failed to transcribe and provide protective skin care to a recently healed pressure ulcers.  During the previous recertification survey on 2/9/23, the facility failed to ensure the alternating  STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312  STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312  STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312  STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312  SUMMARY STATEMENT OF DEFICIENCY)  F 867  F 867			345421	B. WING _				1		
PITTSBORO, NC 27312   PITTSBORO, NC 27312   PROVIDER'S PLAN OF CORRECTION (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PREFIX TAG	NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
PITTSBORO, NC 27312				72	2 CHATHAM BUSINESS PARK					
F 867  Continued From page 63 tissue that is stringy and thick) and granulation tissue (part of the healing process in which lumpy, pink tissue containing new connective tissue and capillaries form around the edges of the wound) pressure ulcer to the right inner ankle. The facility also failed to transcribe and provide protective skin care to a recently healed pressure ulcer (Resident #92). This deficient practice affected 2 of 7 residents reviewed for pressure ulcers.  During the previous recertification survey on 2/9/23, the facility failed to ensure the alternating  PREFIX TAG  PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 867  F 867  F 867  F 867  F 867  F 867  A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will randomly observe 5 residents weekly x 12 weeks to ensure	THE LAUR	RELS OF CHATHAM			Р	ITTSBORO, NC 27312				
F 867  Continued From page 63 tissue that is stringy and thick) and granulation tissue (part of the healing process in which lumpy, pink tissue containing new connective tissue and capillaries form around the edges of the wound) pressure ulcer to the right inner ankle. The facility also failed to transcribe and provide protective skin care to a recently healed pressure ulcer (Resident #92). This deficient practice affected 2 of 7 residents reviewed for pressure ulcers.  EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  PREFIX TAG  F 867  F 867  F 867  randomly observe 5 staff to resident interactions weekly x 12 weeks to ensure that the facility is in compliance with the elements of F550. Variances will be corrected at the time of observation and additional education provided when indicated.  A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.8.24. The DON/designee will randomly observe 5 residents weekly x 12 weeks to ensure	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
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2/9/23, the facility failed to ensure the alternating residents weekly x 12 weeks to ensure		During the provious	recordification our roy on							
					1					
pressure reducing an mattress was set according					· · · · · · · · · · · · · · · · · · ·					
to the resident's weight for 3 of 12 residents elements of F677. Variances will be							10			
reviewed for pressure ulcers.		_	=				nd			
additional education provided when		Torrow of process								
F842: Based on record review and staff indicated.		F842: Based on reco	ord review and staff			_				
interviews, the facility failed to have complete and		interviews, the facility	y failed to have complete and							
accurate medical records in the areas of wound  A QA monitoring tool will be utilized to						A QA monitoring tool will be utilized to	)			
care (Residents #273 and #274). This was for 2 ensure ongoing compliance by the		care (Residents #27	3 and #274). This was for 2			ensure ongoing compliance by the				
of 7 closed records reviewed. DON/designee beginning on 5.8.24. The		of 7 closed records r	eviewed.			DON/designee beginning on 5.8.24. T	The			
DON/designee will randomly audit 5						DON/designee will randomly audit 5				
During the previous recertification survey on resident records and observe skin										
2/9/23, the facility failed to provide a dignified condition weekly x 12 weeks to ensure						1				
dining experience by providing disposable food that the facility is in compliance with the						T	ne			
containers and referring to a resident as a feeder, elements of F686. Variances will be			•							
failed to provide nail care, facial hair shaving, and corrected at the time of observation and			•				nd			
bathing, failed to assure the pressure reduction additional education provided when						· ·				
		mattress was correctly set, and failed to maintain				indicated.				
accurate medical records for wound care.		accurate medical red	ords for wound care.			A Q A it t   ill     t				
A QA monitoring tool will be utilized to		Op 4/17/24 at 12:20			_					
On 4/17/24 at 12:30 pm an interview was ensure ongoing compliance by the DON/designee beginning on 5.8.24. The							Tho			
Administrator stated the facility had hired more DON/designee beginning on 5.8.24. The DON/designee will randomly observe 5										
staff to address the need for activities of daily  staff to address the need for activities of daily  resident medical records weekly x 12			•			1	J			
living which affected the resident's dignity and weeks to ensure that the facility is in										
care and the resident that acquired the pressure compliance with the elements of F842.		_				· ·	,			
ulcer from the splint has had an improvement in Variances will be corrected at the time of										

					TE SURVEY MPLETED			
		345421 B. WING				C		
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF CHATHAM			J. Willed	72	TREET ADDRESS, CITY, STATE, ZIP CODE 2 CHATHAM BUSINESS PARK	1 0	04/17/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 867	her wound. The facilicare company to mar and a new medical st manage the medical nurse practitioner 5 whad no comment regarding the records. The facility lassurance/performant that meets once a momembers include the Director, Director of Nheads. Plans of corre	ontinued From page 64 er wound. The facility had hired a new wound are company to manage the facility's wounds and a new medical staff management firm to anage the medical care and would provide a aurse practitioner 5 weekdays. The Administrator and no comment regarding the inaccurate aredical records. The Administrator had no comment regarding the inaccurate medical accords. The facility has a quality assurance/performance improvement committee and meets once a month and as needed. The arembers include the Administrator, Medical irrector, Director of Nursing, and all department and seads. Plans of correction are presented at the inonthly meetings by the Director of Nursing.		867	audit and additional education provided when indicated.  A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Nurse beginning on 5.8.24. The Regional Clinical Coordina will attend the facility quality assurance committee meeting monthly x 3 months ensure committee is developing and implementing appropriate plans of active to correct quality concerns. Variances be corrected and/or additional education provided when indicated.  Audit results will be reported to the Regional Clinical Nurse monthly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings.  Continued compliance will be monitored through random audits and through the facility's Quality Assurance Program.  Compliance will be monitored by the Quality Committee and the Regional Clinical Nurse for 3 months or until resolved an additional education/training will be provided for any issues identified.	ator es s to on will on		