STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345421	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments The survey team entered the facility on 06/30/25 to conduct an unannounced recertification and complaint investigation survey and exited on 07/03/25. Additional information was obtained on 07/08/25. Therefore, the exit date was changed to 07/08/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SC1B11.	E0000		
F0000	INITIAL COMMENTS The survey team entered the facility on 06/30/25 to conduct an unannounced recertification and complaint investigation survey and exited on 07/03/25. Additional information was obtained on 07/08/25. Therefore, the exit date was changed to 07/08/25. The following intakes were investigated: NC00227503, NC00222812, NC00224034. 3 of the 6 complaint allegations resulted in deficiency.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to	F0550	The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is 7-19-2025. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Corrective Action: The facility will continue to maintain resident dignity by ensuring that residents are adequately clothed or shielded during personal care.	07/19/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further 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.

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

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F0550 SS = D	Continued from page 1 quality care regardless of diagnosis, 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 United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §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 reviews and Paramedic and staff interviews, the facility failed to maintain a resident's (Resident #117) dignity when her nude body was left uncovered until after Emergency Medical Services (EMS) arrived following a fall on the shower room floor. EMS covered the residents' body upon their arrival. A reasonable person would not want to be left with their nude body fully exposed and would have experienced feelings such as embarrassment or humiliation. This deficient practice affected 1 of 4 residents reviewed for dignity. The findings included: Resident #117 was admitted to the facility on 02/05/25. Resident #117's 5-day Minimum Data Set (MDS) assessment dated 02/11/25 indicated her cognition was intact. Resident #117 required moderate assistance with shower/bath and transfers.	F0550	Continued from page 1 Resident #117 no longer resides at the facility. Identification of others potentially at risk: Current residents that require assistance with personal care have the potential to be affected. Current residents that require assistance with personal care were observed during facility rounds on 7.16.25 by the nursing management team to ensure that residents were adequately clothed or shielded during personal care. No negative psychosocial outcome was identified relating to these observations. Systemic Changes: 100% of all nursing assistants and licensed nurses will be inserviced by the Assistant Director of Nurses (ADON) as of 7.18.25 on the facility policy for resident dignity and personal privacy. Newly hired c n a's and licensed nurses that are hired after 7.18.25 will be educated by the ADON on the same policy prior to working their first shift on the floor. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the Director of Nurses (DON) /designee beginning on 7.19.25. The DON/designee will randomly observe 3 residents on each shift 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then bi-weekly x 4 weeks to ensure that residents are adequately clothed or shielded during personal care. Variances will be corrected at the time of observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months beginning on 7.19.25 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program and through random observations. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues	

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F0550 SS = D	Continued from page 2 Resident #117's incident report dated 02/14/25 at 9:20 PM, completed by Nurse #6, indicated Resident #117 had a fall while being assisted by Nurse Aide (NA) #1 in the shower room when she lost consciousness and collapsed onto floor. Nurse #6 assessed Resident #117, she had no breath sounds, but faint pulse and she was unable to obtain vital signs. Resident #117 had a laceration to her right eyebrow with significant bleeding and bruising and a skin tear was noted to her right elbow. EMS were called. An interview was conducted with NA #1 on 07/02/25 at 3:26 PM. She stated she was assisting Resident #117 with her shower on 02/14/25 when Resident #117 suddenly took a large gasping breath and then went limp. NA #1 explained Resident #117 slid off the shower bench and onto the floor. NA #1 stated Nurse #6 came into the shower room and touched Resident #117's wrist, checking for a pulse and that she did have a faint pulse. She indicated Nurse #6 left the shower room but told her not to touch Resident #117 until she returned. NA #1 explained that she nor the nurse put a sheet or towel over her exposed body. She stated she did not think about covering the resident up. NA #1 indicated Resident #117 was lying on the floor in the same position that she was in when she fell, no one moved her, and no one covered her up until Emergency Medical Services (EMS) arrived. EMS Paramedic covered her with a sheet and transferred Resident #117 to the stretcher. A phone interview was conducted with Nurse #6 on 07/02/25 at 5:20 PM. She verified she was the nurse for Resident #117 on 02/14/25. She stated staff made her aware Resident #117 had went unresponsive and had a fall in the shower room. Upon entering she observed Resident #117 nude, lying on her left side, and her face and upper body were face down to the floor. Nurse #6 indicated she checked Resident #117's wrist for a pulse and she noted a faint pulse, so she asked someone to call 911 for her. She explained she did not cover Resident #117 with a towel or sheet because she did not think to do so. She further stated she should have covered her with a sheet or towel after her fall. She explained that the resident should have been covered so everyone was not looking at her nude body. The EMS report dated 02/14/25 indicated the 911 call was received at 9:21 PM and they arrived on the scene with the resident at 9:28 PM.	F0550	Continued from page 2 identified. Date of compliance: 7.19.25	

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F0550 SS = D	Continued from page 3 A phone interview was conducted on 06/30/25 at 9:05 AM with the Paramedic that responded to the call at the facility on 02/14/25. Upon entering the shower room Resident #117 lay face down on the shower room floor, she was nude and had no covering on her. Her skin was cold and pale and she had a laceration on her forehead. The Paramedic went on to say that there were 5 staff members in the shower room when he entered. He explained that he was embarrassed for the resident being left on the floor nude and uncovered. He stated that no one should be left like that. He reported that no one had covered her body up with a towel or sheet. He added that staff were just standing there. An interview was conducted with the Director of Nursing (DON) on 07/03/25 at 11:30 AM. The DON agreed that Resident #117 should have been covered with a covering to maintain dignity after the fall in the shower room. The DON indicated she expected staff to treat all residents with dignity.	F0550		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) level II referral was made after a resident was given new mental health diagnoses for 1 of 2 residents (Resident #68) reviewed for PASRR.	F0644	F644: The facility will continue to ensure that Level II PASRR screening is completed for residents with new mental health diagnoses. Corrective Action: Resident #28 had an updated PASRR screening application completed as of 7-2-25 by the Social Worker. No negative outcome was identified relating to this observation. Identification of others potentially at risk: Current residents with mental health diagnoses have the potential to be affected. All current residents with mental health diagnoses were reviewed as of 7.14.25 to ensure that Level II PASRR screening had been completed. No negative outcomes were identified relating to these observations. Systemic Changes: The Social Workers, MDS Coordinator, and MDS Assistant were inserviced on 7.9.25 by the Administrator on the facility policy for Level II PASRR screening. All residents will be reviewed quarterly according to MDS calendar, as well as the weekly Resident at Risk	07/19/2025

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F0644 SS = D	Continued from page 4 The findings included: Review of Resident #68's medical record revealed the resident was originally admitted to the facility on 04/04/24 and a PASRR level I was completed. A level II PASRR was halted on 5/21/24 due to dementia being the primary diagnoses without a diagnosis of mental illness. The resident was diagnosed with unspecified psychosis not due to a substance or physiological condition on 10/03/24. He had been placed on Nuplazid (an antipsychotic medication) 34 milligrams with a start date of 09/30/24. There was no documentation regarding a new level II PASRR request in Resident #68's chart after the new mental health diagnosis. Review of Resident #68's most recent comprehensive Minimum Data Set (MDS) dated 03/13/25 assessed the resident to be moderately cognitively impaired and revealed the resident was not coded for a level II PASRR. During an interview with the Social Worker (SW) on 07/02/25 at 12:45 PM she revealed a PASRR level II referral was supposed to have been completed when a resident had a significant change of condition or a newly added mental health diagnosis. It was further revealed by the SW Resident #68 should have been assessed after his mental health diagnosis for a possible level II, and the facility failed to do so. The SW indicated the facility had a lot of residents for her to keep up with, and she was not aware that Resident #68 needed to have level II PASRR determination. An interview was conducted with the Administrator on 07/03/25 at 11:58 AM, and he stated the Social Worker was new to her role. He indicated he needed to educate the SW to look at the PASRR level of the residents to make sure the PASRR was correct.	F0644	Continued from page 4 meeting and upon admission. Orders are being reviewed weekly on the dashboard by running a report by the Social worker. Spreadsheet is in place with effective date, expiration date and diagnosis to assist with review for when updates are needed. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the Social Worker/designee beginning on 7.14.25. The Social Worker/designee will randomly audit 5 resident medical records weekly x 8 weeks, then bi-weekly x 4 weeks to ensure that Level II PASRR screening is completed when indicated. Variances will be corrected at the time of audit and additional education or corrective action provided when indicated. Audit results will be reported to the Administrator weekly 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 QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 7.19.25	
F0684 SS = D	Quality of Care	F0684	F684:	07/19/2025

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F0684 SS = D	Continued from page 5 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with staff and Medical Director, the facility failed to thoroughly assess Resident #117, who had a do not resuscitate order and was prescribed an anticoagulant (blood thinner) daily for blood clot prevention, after she went unresponsive during a shower and after a fall that resulted in injury. On 02/14/25 Resident #117 was sitting on a bath bench in the shower room while Nursing Aide (NA) #1 was washing her hair. Resident #117 took a deep breath, her body suddenly went limp, and she went unresponsive. NA #1 laid Resident #117 onto the shower bench, ran approximately 13 feet away from her to yell for help, leaving Resident #117 with no staff support resulting in the resident falling off the shower bench. In the minutes after the medical event and fall and before emergency medical services (EMS) arrived, Nurse #6 did not perform a head-to-toe assessment, check vital signs including pulse from the carotid artery, check range of motion or assess pain. Resident #117 was not turned over after the fall and pressure was not applied to the laceration. Resident #117 sustained a laceration to her right eyebrow with significant bleeding and bruising and a skin tear to her right elbow. This deficient practice was for 1 of 5 residents reviewed for accidents. The findings included: Resident #117 was admitted to the facility on 02/05/25 and expired in the facility on 02/14/25. Her diagnosis included fracture of sacrum, aneurysm of the ascending aorta without rupture, and radiculopathy (a nerve root in the spine is compressed or irritated, causing pain, numbness, or weakness) to lumbar region. Resident #117's physician orders for February 2025 revealed the following orders:	F0684	Continued from page 5 The facility will continue to ensure that residents are thoroughly assessed in the event of a medical emergency. Corrective Action: Resident #117 no longer resides at the facility. Identification of others potentially at risk: Current residents that experience a medical emergency or a fall within the facility have the potential to be affected. The nursing management team and Medical Director audited medical records for all current residents as of 7.18.25 to ensure that any residents that have experienced a recent medical emergency or a fall were thoroughly assessed. No negative outcomes were identified relating to these audits. Systemic Changes: All licensed nurses were inserviced by the ADON for Medical Emergency Management and falls. Any newly hired licensed nurses hired after 7.18.25 will receive the same education by the ADON in general orientation prior to working their first shift on the floor. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 7.19.25. The DON/designee will interview 5 licensed nurses weekly x 4 weeks then 3 licensed nurses weekly x 4 weeks then 1 licensed nurse weekly x 4 weeks to ensure that licensed nurses are able to thoroughly assess a resident in the event of a medical emergency or a fall. Variances will be corrected at the time of interview and additional education or corrective action provided when indicated. Interview results will be reported to the Administrator weekly 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 observations and through the facility's Quality Assurance Program.	

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F0684 SS = D	Continued from page 6 -Enoxaparin Sodium Injection Solution Prefilled Syringe 40 milligrams (mg)/0.4 milliliter (ml). Inject 40 mg subcutaneously one time a day for blood clot prevention for 4 weeks. Resident #117 received this medication daily until 02/15/25. -No Cardiopulmonary Resuscitation/Do Not Resuscitate dated 02/05/25. Resident #117's care plan, dated 02/05/25, included a focus that she was at risk for abnormal bleeding/bruising related to medication use (Anticoagulant). The interventions included for staff to observe and report to physician signs/symptoms of complications: blood sudden severe headaches, nausea, lethargy, bruising, blurred vision, sudden changes in mental status, and significant or sudden changes in vital signs. A focus that Resident #117 was at risk for fall related injury and falls related to deconditioning, history of falls with fracture, and medication side effects. The interventions included for staff to observe for fatigue and/or unsteadiness and encourage rest periods as needed. Resident #117's 5-day Minimum Data Set (MDS) assessment dated 02/11/25 indicated her cognition was intact. Resident #117 required maximum assistance with toileting hygiene and moderate assistance with shower/bath and transfers. Resident #117's incident report dated 02/14/25 at 9:20 PM, completed by Nurse #6, indicated Resident #117 had a fall while being assisted by NA #1 in the shower room when she lost consciousness and collapsed onto floor. Nurse #6 assessed Resident #117, she had no breath sounds, but faint pulse and she was unable to obtain vital signs. Resident #117 had a laceration to her right eyebrow with significant bleeding and bruising and a skin tear was noted to her right elbow. Emergency Medical Services (EMS) was called. The physician, Director of Nursing, and family were notified. An interview was conducted with NA #1 on 07/02/25 at 3:26 PM. She stated she had Resident #117 sitting on a shower bench (approximately 1.5 feet (ft) deep x 2.5 ft in width, and 2.5 ft high and had no sides or railing) assisting her with her shower on 02/14/25 when Resident	F0684	Continued from page 6 Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 7.19.25	

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F0684 SS = D	Continued from page 7 #117 suddenly took a large gasping breath and then went limp. NA #1 explained she laid Resident #117 across the shower bench, turned the water off and ran to the door (approximately 10 ft) to get help. NA #1 explained she opened the shower room door and yelled a few times before someone heard her. NA #1 then explained when she turned around and witnessed Resident #117 sliding off the shower bench and onto the floor. The fall resulted in Resident #117 hitting her face on the floor which caused a laceration to her forehead. NA #1 then stated Nurse #6 came into the shower room and touched Resident #117's wrist, checking for a pulse and that she did have a faint pulse. NA#1 further explained that Nurse #6 did not have a stethoscope, did not take Resident #117's vital signs, listen for breath sounds, or perform any other type of assessment on Resident #117. She indicated Nurse #6 left the shower room but told her not to touch Resident #117 until she returned. She then explained that EMS arrived and transferred Resident #117 to the stretcher after they verified she did have a pulse. NA #1 explained that there was an emergency cord located at the shower stall that she and Resident #117 were in, but it was located behind her, and she did not think to utilize it. She stated she was thinking of getting help as fast as she could, which at the time was to yell for assistance. NA #1 did explain she should have pulled the emergency cord instead of leaving Resident #117 on the shower bench. A phone interview was conducted with Nurse #6 on 07/02/25 at 5:20 PM. She verified she was the nurse for Resident #117 on 02/14/25. Nurse #6 stated she was coming up the 400 hall from doing her medication pass when she heard someone shouting. When she got to the top of the hall she saw staff holding the door open to the shower room. Upon entering she observed Resident #117 nude, lying on her left side, head towards the door, her face and upper body were face down to the floor, and her legs/feet were behind her back. She stated she saw blood on the floor by her head, and she checked her wrist for a pulse. She did have a faint pulse, and she asked someone to call 911 for her. She explained she tried to turn Resident #117 over but could not do it by herself and other staff members would not assist her. When asked why the other staff members would not assist her in turning Resident #117 over she stated, "you know, they didn't want to touch her, you know". Nurse #6 stated she did not cover or apply pressure to the laceration on her forehead, did not obtain vital signs, and did not do any other assessments on her. Her body was limp, and she was not responding to her. She also stated she did not cover her up with anything because she did not have time.	F0684		

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F0684 SS = D	Continued from page 8 Nurse #6 explained that NA #1 told her she was giving Resident #117 a shower when suddenly Resident #117 took a large gasping breath and then went limp. Nurse #6 indicated NA #1 explained to her that she laid Resident #117 across the bench and ran to the door (approximately 10 ft) to get help. When NA #1 turned around Resident #117 was sliding off the shower bench and onto the floor resulting in Resident #117 hitting her face on the floor which caused a laceration to her forehead. She explained she checked Resident #117's wrist for a pulse and left out of the shower room to get more help. She asked another nurse to call 911 and she was gathering Resident #117's paperwork to be sent to the hospital. EMS showed up and were assessing Resident #117. They also had a faint pulse and took Resident #117 to the ambulance. Nurse #6 explained that the policy when a resident had a fall was to perform a head to toe assessment, check vital signs, check range of motion to extremities, ask about pain and then assist them to a safe position if the assessment was ok. A follow-up phone interview was conducted with Nurse #6 on 07/03/25 at 7:57 AM. When asked could she further explain what she meant when she said, "you know, staff doesn't want to touch her" she stated she thought it was because they "didn't know if she had broken bone or anything like that, you know?". She indicated she did not know exactly when EMS was called after the incident occurred. Multiple unsuccessful attempts were made to contact Nurse # 8. An interview was conducted with Nurse #7 on 07/03/25 at 9:15 AM. She stated she was working in the building on the 300 hall and top of 200 hall on 02/14/25. She stated Nurse # 8 was yelling and came to her while she was in a resident's room and stated they needed assistance in the shower room. Upon entering the shower room, Nurse #7 stated it "appeared" Resident #117 fell from the shower chair and that she was kind of on her side but face down on the floor and there was blood on the floor. Nurse #7 stated she did not stay in the shower room and did not assess Resident #117. She stated EMS showed up shortly after. The EMS report dated 02/14/25 revealed sinus bradycardia (heart rate below 60 beats a minute) reading from 12-lead (electrocardiogram) ECG (a	F0684		

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

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F0684 SS = D	Continued from page 9 non-invasive test that records the heart's electrical activity from 12 different viewpoints). Resident #117 was unresponsive, skin cold and pale, cardiac arrythmias, pulse rate 40, and laceration to right side of the head. Call received from the facility to 911 at 9:21 PM, dispatch notified at 9:22 PM, dispatched out at 9:26 PM, EMS in route 9:26 PM, EMS on scene at 9:26 PM, and EMS at the resident at 9:28 PM. The narrative read that EMS arrived at the facility and was led down the hall to the shower room at 400 Hall, right by the nurses' station where they were met by multiple staff members. It was unknown exactly how long Resident #117 was on the floor, but staff advised they called as soon as it happened. Nurse #6 advised they were unable to roll Resident #117 over as "the floor was slippery, and the residents' limbs were flaccid". Nurse #6 did confirm with EMS that she felt a pulse and noted she was not breathing. EMS made contact with Resident #117, who was noted to be prone (face down) on the floor, and her head turned slightly to the left, with her right arm bent behind her back on the floor of the shower room. Her skin was cold, and pale and she had a laceration on her forehead. Resident #117 did have a faint carotid pulse noted but was not breathing. Resident #117 was positioned on the stretcher and was taken to the ambulance. A phone interview was conducted on 06/30/25 at 9:05 AM with the Paramedic that responded to the call at the facility on 02/14/25. He stated staff directed him to the shower room on the 400 Hall. He explained that Nurse #6 advised him Resident #117 was being assisted by a staff member in the shower when she "slipped and fell" hitting her head during the fall. It was unknown how long the resident was on the floor and that Nurse #6 stated the Resident #117 had a pulse, but she was unable to roll her over. Her skin was cold, and pale and she had a laceration on her forehead. Resident #117 did have a faint carotid pulse. The Paramedic went on to say that there were 5 staff members in the shower room when he entered and it made him upset that Resident #117 was still in the position she was laying in when she fell. No one had turned her over or put pressure on the head injury. An interview was conducted with the Medical Director (MD) on 07/03/25 11:45 AM. She indicated she remembered Resident #117. She stated she would expect the nurse to do a basic assessment such as apply pressure to a laceration and obtain vital signs after a resident falls.	F0684		

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F0684 SS = D	Continued from page 10 A follow-up phone interview was conducted on 07/08/25 at 5:42 PM with the Medical Director (MD). The MD explained that she wasn't at the facility when the incident occurred so she did not want to speculate on what might have caused Resident #117 to go unresponsive, but she felt that Resident #117 did experience a medical event that caused her to go limp and unresponsive. Also, she felt there was always the potential for injuries when a resident was on blood thinners, but she felt it would also depend on where she hit her head, how she hit her head, and how much force was behind it. The MD then stated that it would be a hard call to make, and she did not want to speculate. An interview was conducted with the Director of Nursing (DON) on 07/03/25 at 11:30 AM. She stated after a resident falls she expected staff to do an assessment on them. The assessment should include obtaining vital signs, assessing pain, and checking for bleeding, deformities, or any other obvious injuries.	F0684		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation and interviews with staff and the Medical Director the facility failed to provide care safely to a dependent resident (Resident #117). On 02/14/25 Resident #117 was sitting on a bath bench in the shower room while Nursing Assistant (NA) #1 was washing her hair when Resident #117's body suddenly went limp, and she went unresponsive. NA #1 laid Resident #117 onto the shower bench, ran approximately 10 feet away from her to yell for help, leaving Resident #117 with no staff support resulting in the resident falling off the shower bench. Resident #117 sustained a laceration to her right eyebrow with	F0689	F689: The facility will continue to ensure that care is provided safely to dependent residents. Corrective Action: Resident #117 no longer resides at the facility. Identification of others potentially at risk: Current residents that are dependent on staff for care and current residents at risk for falls had care plan reviews completed by the Nursing Administration team as of 7.11.25 to ensure that interventions are in place for appropriate staff assistance, supervision, and assistive devices. No negative outcomes were identified resulting from this audit. Systemic Changes: All licensed nurses and certified nursing assistants will be educated by the ADON as of 7.18.25 on the facility Fall Management policy with an emphasis on ensuring that residents are in a secure location prior to receiving assistance. Any newly hired licensed	07/19/2025

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F0689 SS = G	Continued from page 11 significant bleeding and bruising and a skin tear to her right elbow. Resident #117 was prescribed an anticoagulant (blood thinner) daily for blood clot prevention. This deficient practice affected 1 of 5 residents reviewed for supervision to prevent falls. The findings included: Resident #117 was admitted to the facility on 02/05/25. Her diagnosis included fracture of sacrum, aneurysm of the ascending aorta without rupture, and radiculopathy (a nerve root in the spine is compressed or irritated, causing pain, numbness, or weakness) to lumbar region. Resident #117's physician orders for February 2025 revealed the following orders: -Enoxaparin Sodium Injection Solution Prefilled Syringe 40 milligrams (mg)/0.4 milliliter (ml). Inject 40 mg subcutaneously one time a day for blood clot prevention for 4 weeks. Resident #117 received this medication daily until 02/15/25. -No Cardiopulmonary Resuscitation/Do Not Resuscitate dated 02/05/25. Resident #117's care plan, dated 02/05/25, included a focus that she was at risk for abnormal bleeding/bruising related to medication use (Anticoagulant). The interventions included for staff to observe and report to physician signs/symptoms of complications: blood sudden severe headaches, nausea, lethargy, bruising, blurred vision, sudden changes in mental status, and significant or sudden changes in vital signs. Another focus was that Resident #117 was at risk for fall related injury and falls related to deconditioning, history of falls with fracture, and medication side effects. The interventions included for staff to observe for fatigue and/or unsteadiness and encourage rest periods as needed. Resident #117's 5-day Minimum Data Set (MDS) assessment dated 02/11/25 indicated her cognition was intact. Resident #117 required maximum assistance with toileting hygiene and moderate assistance with shower/bath and transfers.	F0689	Continued from page 11 nurses or certified nursing assistants hired after 7.18.25 will receive the same education by the ADON during general orientation prior to working their first shift on the floor. Monitoring: A QA monitoring tool will be utilized by the DON/designee beginning on 7.19.25 to ensure ongoing compliance. The DON/designee will conduct random observations of staff providing care to ensure that appropriate staff assistance, supervision, and assistive devices are utilized, and that residents are being placed in a secure location prior to receiving assistance. The frequency of audit will be 5 observations weekly x 4 weeks, then 3 observations weekly x 4 weeks, then 3 observations bi-weekly x 4 weeks. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during the 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 Assurance Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 7.19.25	

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F0689 SS = G	Continued from page 12 Resident #117's incident report dated 02/14/25 at 9:20 PM, completed by Nurse #6, indicated Resident #117 had a fall while being assisted by NA #1 in the shower room when she lost consciousness and collapsed onto floor. Nurse #6 assessed Resident #117, she had no breath sounds, but faint pulse and she was unable to obtain vital signs. Resident #117 had a laceration to her right eyebrow with significant bleeding and bruising and a skin tear was noted to her right elbow. Emergency Medical Services (EMS) were called. An interview was conducted with NA #1 on 07/02/25 at 3:26 PM. She stated she had Resident #117 sitting on a shower bench (approximately 1.5 feet (ft) deep x 2.5 ft in width, and 2.5 ft high and had no sides or railing) assisting her with her shower on 02/14/25 when Resident #117 suddenly took a large gasping breath and then went limp. NA #1 explained Resident #117 was talking to her as she was washing her hair saying how good it felt when suddenly she took a large gasping breath and then went limp. NA #1 then explained she laid her body across the bench, turned the water off, and ran to the door (approximately 10 ft) to get help. NA #1 explained she opened the shower room door and yelled a few times before someone heard her. NA #1 then explained when she turned around and witnessed Resident #117 sliding off the shower bench and onto the floor. The fall resulted in Resident #117 hitting her face on the floor which caused a laceration to her forehead. NA #1 explained that there was an emergency cord located at the shower stall that her and Resident #117 were in, but it was located behind her, and she did not think to utilize it. She stated she was thinking of getting help as fast as she could, which at the time was to yell for assistance. NA #1 did explain she should have pulled the emergency cord instead of leaving Resident #117 on the shower bench. An observation of the shower room was conducted on 07/02/25 at 3:26 PM. The shower room was located at the top of the 400 Hall, across from the nurses' station. The shower stall that NA #1 utilized when she assisted Resident #117 with her shower was approximately 3.5 feet (ft) wide. The shower bench (approximately 1.5 feet (ft) deep x 2.5 ft in width, and 2.5 ft high and had no sides or railing) was positioned against the shower stall wall long ways. The emergency call bell was located on the wall at the same shower stall and a divider curtain was in front of the call bell. The door leading out of the shower room was approximately 10 ft from the shower stall that they were utilizing.	F0689		

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F0689 SS = G	Continued from page 13 A phone interview was conducted with Nurse #6 on 07/02/25 at 5:20 PM. She verified she was the nurse for Resident #117 on 02/14/25. Nurse #6 stated she was coming up the 400 hall from doing her medication pass when she heard someone shouting. When she got to the top of the hall, she saw the staff was holding the door open to the shower room. Upon entering she observed Resident #117 nude, lying on her left side, head towards the door. Her face and upper body were face down to the floor, legs and feet were towards her back. She stated she saw blood on the floor by her head. Nurse #6 explained that NA #1 told her she was giving Resident #117 a shower when suddenly Resident #117 took a large gasping breath and then went limp. Nurse #6 indicated NA #1 explained to her that she laid Resident #117 across the bench and ran to the door (approximately 10 ft) to get help. When NA #1 turned around Resident #117 was sliding off the shower bench and onto the floor resulting in Resident #117 hitting her face on the floor which caused a laceration to her forehead. An interview was conducted with the Medical Director on 07/03/25 11:45 AM. She stated she remembered Resident #117. She stated she would expect staff to make sure the residents were in a safe position prior to leaving their side. She stated she wasn't at the facility when the incident occurred so she couldn't speculate on what might have caused the resident to go unresponsive, but she felt that something had to of occurred. Also, she felt there was always the potential for injuries when a resident was on blood thinners, but she felt it would also depend on where she hit her head, how she hit her head, and how much force was behind it. That would be a hard call to make, and she did not want to speculate. An interview was conducted with the Director of Nursing (DON) on 07/03/25 at 11:30 AM. She stated she expected staff to make sure a resident was in a safe position prior to walking away from them to prevent a fall or other injuries. The DON indicated NA #1 should not have laid Resident #117 across the shower bench prior to walking away from her and that she should have placed her on the floor.	F0689		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition	F0693	F693: The facility will continue to administer water flushes via a tube feeding at the physician ordered flow rate	07/19/2025

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F0693 SS = D	Continued from page 14 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and staff interviews, the facility failed to administer water flushes via a feeding tube at the physician ordered flow rate for 1 of 1 resident reviewed with tube feedings (Resident #101). The findings included: Resident #101 was originally admitted to the facility on 5/8/25 with diagnoses that included unspecified severe protein-calorie malnutrition, cognitive communication deficit, dysphagia (difficulty swallowing) and presence of a feeding tube. A quarterly Minimum Data Set (MDS) assessment dated 5/13/25 indicated Resident #101 had moderate cognitive impairment with no behaviors noted. He was coded as receiving 51% or more of his total calories through a tube feeding and an average fluid intake of 501 cubic centimeters (cc) per day or more by tube feeding. Resident #101's active care plan, last reviewed 5/19/25, revealed a focus area for an enteral feeding tube to meet nutritional needs. The interventions included providing water as ordered.	F0693	Continued from page 14 Corrective Action: Resident #101 tube feeding pump was adjusted by the Unit Manager to administer the physician ordered water flush amount on 7.2.25. No negative outcome was identified relating to this observation. Identification of others potentially at risk: Current residents with physician orders for water flushes via tube feeding pump have the potential to be affected. All residents with physician orders for water flushes via tube feeding pump were audited by the Unit Managers on 7.2.25 to ensure that each was correct. No negative outcomes were identified relating to these observations. Systemic Changes: All licensed nurses were inserviced by the ADON as of 7.18.25 on the facility policy for ensuring that physician orders for water flushes via tube feeding pump are carried out as ordered. Any newly hired licensed nurses hired after 7.18.25 will receive the same education by the ADON in general orientation prior to working their first shift on the floor. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 7.19.25. The DON/designee will audit 3 residents with physician ordered water flushes via tube feeding pump 5x/week x 4 weeks then 3x/week x 4 weeks then weekly x 4 weeks to ensure that physician orders for water flushes via tube feeding pump are carried out as ordered. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program.	

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F0693 SS = D	Continued from page 15 Resident #101's active physician orders included an order dated 6/20/25 to flush the feeding tube with 200 cubic centimeters (cc) of water every 6 hours during continuous feedings. The daily total amount equaled 800 cc. An observation of Resident #101 on 7/2/25 at 3:50 PM, revealed his feeding tube was connected to a continuous bottle of formula with a standby bag of water. The water flush was observed to be running at 100 cc and the setting on the pump for frequency of the water flush was set at every 4 hours. The daily total amount equaled 600 cc. Resident #101's lips were not dry or cracked in appearance. An observation was made with Nurse #4 on 7/2/25 at 3:57 PM, of Resident #101's water flush setting on the tube feed pump. She acknowledged the settings for the water flush were set at a rate that was at 100 cc and the frequency of the water flush was set at every 4 hours. After reviewing the physician orders, she verified the water flush order was for 200 cc every 6 hours. She was unable to state why the rate was different than the physician's order but would correct it on the feeding tube pump. The Director of Nursing was interviewed on 7/3/25 at 10:58 AM and stated she expected water flushes to be at the prescribed rate.	F0693	Continued from page 15 Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 7.19.25	
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interviews, the facility failed to follow sterile technique when Nurse #5 failed to apply sterile gloves	F0695	F695 The facility will continue to ensure that tracheostomy care and suctioning is provided per facility policy and accepted standards of practice. Corrective Action: The licensed nurse received individual education on the facility policy for tracheostomy care by the ADON as of 7-14-25. No negative outcome resulted from this observation. Identification of others potentially at risk: Current residents with tracheostomies have the	07/19/2025

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F0695 SS = D	Continued from page 16 for suctioning while providing tracheostomy care for 1 of 2 residents observed for tracheostomy care (Resident #38). The findings included: Resident #38 was admitted to the facility on 9/20/19 with diagnoses of chronic respiratory failure, diffuse traumatic brain injury with loss of consciousness of unspecified duration, and tracheostomy. A review of the annual Minimum Data Set assessment tool dated 4/7/25 indicated Resident #38 was severely cognitively impaired. She was coded for using oxygen, a tracheostomy, and suctioning. A review of Resident #38's orders revealed an order dated 7/1/24 to deep suction the tracheostomy as needed for increased secretions and every shift. An observation was conducted on 7/2/25 at 10:50 AM of Nurse #5 as she provided suctioning and tracheostomy care for Resident #38. Nurse #5 washed her hands, applied clean gloves, and opened the sterile tracheostomy care kit on Resident #38's clean overbed table. She then removed the oxygen tubing from Resident #38's tracheostomy collar, removed her gloves, discarded them, and washed her hands. Nurse #5 then applied sterile gloves to both hands and picked up the unopened container that held the suction catheter that was lying on the overbed table outside of the sterile field. With both hands, Nurse #5 opened the packaging containing the suction catheter. Without washing her hands or applying a new sterile glove to her dominant hand, Nurse #5 then connected the suction catheter to the tubing using both hands. Nurse #5 then proceeded to use her dominant hand to advance the suction catheter, which was 40 centimeters long, into Resident #38's tracheostomy site. Once Resident #38 began to cough Nurse #5 applied suction with the catheter and withdrew it. After the task was completed, Nurse #5 replaced the inner cannula to Resident #38's tracheostomy and placed the oxygen tubing back to the tracheostomy collar, removed her gloves and washed her hands. Nurse #5 was immediately interviewed after performing suctioning and stated she was nervous being watched and forgot she needed to use sterile gloves to perform	F0695	Continued from page 16 potential to be affected. No negative outcomes resulted from this observation. Systemic Changes: All licensed nurses were inserviced by the ADON as of 7.18.25 on the facility policy for tracheostomy care and suctioning. All newly hired licensed nurses hired after 7.18.25 will be educated on the same policy by the ADON during general orientation prior to working their first shift on the floor. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON/designee beginning on 7.19.25. The ADON/designee will randomly observe licensed nurses providing tracheostomy care and/or suctioning 5x/week x 4 weeks then 3x/week x 4 weeks then 3x/bi-weekly x 4 weeks to ensure that tracheostomy care and suctioning is provided per facility policy. Variances will be corrected at the time of observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly 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 observations and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 7.19.25	

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F0695 SS = D	Continued from page 17 suctioning of a tracheostomy. She stated, "I had another pair lying right there." On 7/2/25 at 12:11 PM the Unit Manager was interviewed who stated Nurse #5 did not correctly follow sterile technique for suctioning a tracheostomy. She stated she had spoken with Nurse #5 who told her she was nervous. The Director of Nursing was interviewed on 7/2/25 at 2:50 PM who stated she expected the nurses to follow the infection control policy when providing tracheostomy care. The Infection Preventionist was interviewed on 7/3/25 at 11:09 AM who stated Nurse #5 should have opened the suction catheter with clean gloves and dumped the contents onto the sterile field, washed her hands, and then applied sterile gloves to suction the resident because suctioning a tracheostomy was supposed to be a sterile procedure.	F0695		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F0757	F757: The facility will continue to hold blood pressure medication as ordered by the physician. Corrective action: Resident #32 had a medication and vital sign review completed by the provider on 7-12-25. No negative outcome was identified relating to this review. Identification of others potentially at risk: Current residents prescribed medications with hold parameters have the potential to be affected. All current residents prescribed medications with hold parameters were audited by the provider as of 7.11.25 to ensure that appropriate medication and hold parameter orders were in place. No negative outcomes were identified relating to this audit. Systemic Changes: All licensed nurses were educated as of 7.18.25 by the ADON on the facility policy for medication administration, including following physician orders for hold parameters. Any newly hired licensed nurses	07/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345421	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2025

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

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F0757 SS = D	Continued from page 18 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, Nurse Practitioner and staff interviews, the facility failed to hold a blood pressure medication as ordered by the physician for 1 of 6 residents whose medications were reviewed (Resident #32). The findings included: Resident #32 was admitted to the facility on 7/31/18 with diagnoses that included hypertensive heart disease with heart failure. Review of Resident #32's physician orders included an order dated 7/20/24 for losartan potassium-hydrochlorothiazide (a medication for high blood pressure which is also a diuretic) 50-12.5 milligrams (mg) one tablet by mouth every day. Hold for systolic blood pressure (SBP-the top number in the blood pressure reading) less than 110. The March 2025 Medication Administration Record (MAR) was reviewed and revealed Resident #32 had received losartan potassium-hydrochlorothiazide, despite the SBP below 110 on the following dates: 3/4/25 SBP was 105 administered by Nurse #1. 3/9/25 SBP was 101 administered by Nurse #1. 3/12/25 SBP was 109 administered by Nurse #1. 3/13/25 SBP was 100 administered by Nurse #1. An annual Minimum Data Set (MDS) assessment dated 4/24/25 indicated Resident #32 had severe cognitive impairment. A review of the April 2025, May 2025 and June 2025 MARs indicated Resident #32 received losartan	F0757	Continued from page 18 hired after 7.18.25 will receive the same education by the ADON in general orientation prior to working their first shift on the floor. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning 7.19.25. The DON/designee will audit 3 guests prescribed medications with hold parameters weekly x 12 weeks to ensure that physician orders for hold parameters are followed. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 7.19.25	

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F0757 SS = D	Continued from page 19 potassium-hydrochlorothiazide, despite the SBP below 110 on the following dates: 4/3/25 SBP was 98 administered by Nurse #2. 5/19/25 SBP was 106 administered by Nurse #3. 5/22/25 SBP was 108 administered by Nurse #1. 6/14/25 SBP was 105 administered by Nurse #1. 6/30/25 SBP was 103 administered by Nurse #2. On 7/2/25 at 1:22 PM, an interview occurred with Nurse #1, who stated she was aware Resident #32 had parameters to hold the losartan potassium-hydrochlorothiazide further stating she took the blood pressure and recorded it on the MAR. Nurse #1 reviewed the March 2025, May 2025 and June 2025 MARs, verified the losartan potassium-hydrochlorothiazide was administered despite the SBP being below 110 when it should have been held and stated it was an oversight. Nurse #3 was interviewed on 7/2/25 at 2:22 PM. The May 2025 MAR was reviewed with him, but he was unable to recall why the losartan potassium-hydrochlorothiazide was administered outside the parameter other than to say it was an error on his part and the medication should have been withheld. Attempts to contact Nurse #2 were made without success. Nurse Practitioner #1 was interviewed via phone on 7/2/25 at 3:02 PM and didn't feel Resident #32 would have suffered any serious harm by receiving the losartan potassium-hydrochlorothiazide outside the parameter, however she would expected the nursing staff to follow the orders for the losartan potassium-hydrochlorothiazide parameter as written. The Director of Nursing was interviewed on 7/3/25 at 10:49 AM and stated she expected the nurses to follow physician orders including blood pressure medications with parameters to hold.	F0757		

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