STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345421	A. BUILDING _____ B. WING _____	C 11/21/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with residents and staff the facility failed to keep a resident covered while being taken to and from the shower room to maintain dignity for 1 of 4 residents (Resident #69) reviewed for dignity. Findings included: Resident #69 was admitted on 9/5/10 with diagnoses that included anxiety and quadriplegia. The quarterly Minimum Data Set (MDS) dated 10/21/13 indicated Resident #69 was cognitively intact and was totally dependent with bathing, having impairment of both upper and lower extremities. On 11/18/13 at 4:25 pm Resident #69 was observed being transported in a shower chair, by Nurse Aide (NA) #4, from the shower room to his room. He was unclothed but covered with a blanket from front to back. The resident's buttocks were showing due to the blanket being open in the back. NA #4 was interviewed and asked about his exposure. She indicated she had not been aware of his exposure but verified he was exposed and stated, "This is a new shower chair."	F 241	F241 Resident #69: Upon becoming aware of the observation, the CNA adjusted the blanket to fully cover the resident. Residents requiring transport to the shower room have the potential to be affected. The Administrator and ADON observed other residents being transported in shower chairs and did not find any other residents that were not properly covered. The identified staff member who transported the resident has been re-educated. All nursing assistants have been in-serviced regarding properly covering residents while being transported to the shower rooms. Using an audit tool, random rounds will be conducted by the DON and/or her designee daily for (2) weeks, then randomly each week for two months, to observe for compliance. Variances will be corrected at the time of observation and additional education will be provided as	12/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/19/2013

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F 241	Continued From page 1 During an interview on 11/20/13 at 4:45 pm, Resident #69 stated, "On Monday, the aide was taking me back to the room from the shower and one of the surveyors said to her that my butt was exposed. The aide said it was a new chair, but it has happened before. Last week, when I was going to the shower, [Nurse #4] said, ' I see your butt. ' An aide had me at the nurse's station and I felt like everyone there probably saw. I was embarrassed then and I was embarrassed on Monday." During an interview with Nurse #4 on 11/20/13 at 5:41 pm, she indicated the previous week she said she could see his upper leg, but not his buttocks. That she has not seen him exposed. During an interview with NA #4 on 11/21/13 at 9:25am, she indicated on 11/18/13 she was taking Resident #69 out of shower room and back to his room. A surveyor stated she could see the resident ' s buttocks. She looked and found the resident ' s bottom was exposed and she had not realized it. She indicated she was using the new shower chair that had a larger opening in the back and that was the reason for the exposure. She further indicated the previous procedure was to undress a resident in their room and wrap a blanket across them from front to back on a resident. [Since the date of his exposure on 11/18/13] the procedure is now to use two blankets - one wrapped front to back, one wrapped back to front - to ensure privacy. During an observation on 11/21/13 at 9:33 am, two shower chairs were noted in the unit 2 shower room. NA #4 indicated one chair was the "old chair." It had a 1 inch open space at the	F 241	necessary. The QA committee will review the findings of the audits during the monthly QA committee meeting x two months, or until resolved, to monitor for on-going compliance .The administrator will ensure that any additional education and monitoring will be initiated for any identified concerns. Continued compliance will be monitored through routine observation of care and transports and through the facility□s quality assurance program.	

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F 241	Continued From page 2 bottom edge of the back of the chair. She indicated one chair was the "new chair." It had a 9 inch open space to the bottom edge of the back of chair. During an interview on 11/21/13 at 9:50 am Nurse #5, the Unit Coordinator, stated, "Everyone should be covered completely going to and from the shower and in the hallway. That is my expectation and the facilities' expectation." During an interview on 11/21/13 at 3:41pm the Director of Nursing stated, "Residents should be covered completely when going back and forth to the shower."	F 241		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to apply splints to one of two sampled residents with splints. Resident #29 The findings included: Resident #29 was admitted to the facility on 9/15/07 with diagnoses of stroke and right sided	F 318	F318 Resident #29 has been rescreened by Rehab. The resident□s splints are being applied as scheduled and the care plan has been updated. No negative outcome resulted from the observations. Current residents with orders for splints have the potential to be affected.	12/24/13

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F 318	Continued From page 3 hemiparesis. The care plan dated 2/8/13 addressed a problem of contractures and pain related to contractures. There were no approaches for contracture management. The Minimum Data Set dated 9/25/13 assessed Resident #29 as having limitation in range of motion of both upper extremities, requiring total assistance with transfer, toileting, dressing and hygiene. Resident #29 had short and long term memory impairments. Review of the occupational therapy evaluation and plan of treatment signed by the MD on 4/2013 included treatment for contracture of joint; multiple sites. The long term goals were for the patient to tolerate wearing bilateral upper extremity (BUE) resting hand orthotic devices for 4 hours daily without skin irritation or complaints of pain in order to maintain optimal joint and skin integrity. Establish a restorative nursing program (RNP) with restorative nursing assistants (RNAs) demonstrating 100% accuracy with joint mobilization and stretch of BUE in all planes in order to assist the patient with grooming tasks and ability to wear orthotic devices daily as specified for joint integrity. Resident # 29 was discharged from therapy May 2013. Observations of Resident #29 on 11/19/13 at 9:00 AM, 11:34 AM and 2:36 PM revealed no splints were on either hand. Observations on 11/20/13 at 11:52 AM revealed Resident #29 did not have splints on her hands or upper extremities.	F 318	Residents who are identified to wear splints have been reviewed by the DON and her designee to ensure that the care plan and care cards address the need and schedule for the splints, and that splints are being worn as ordered. No other resident was found to not be wearing their splint as ordered. The nursing and rehab staff has been in-serviced on the process when a resident is transferred from rehab services to a restorative nursing program and then to nursing services when a resident is to utilize splints. The process includes updating the plan of care and care cards, and entry of the splint application order on the MAR. Using an audit tool rounds will be conducted by the DON and/or her designee, daily for 2 weeks, then randomly each week for two months, to observe that splints are being applied as ordered. Variances will be corrected at the time of observation and additional education and/or administrative action will be initiated when indicated. The QA committee will review the findings of the audits during the monthly QA committee meeting x two months, or until resolved, to monitor for on-going compliance. Continued compliance will be monitored through routine round observations, routine review of MARs, care plans and care cards and through the facility□s	

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F 318	Continued From page 4 Interview with the nurse supervisor for restorative on 11/20/13 at 11:15 AM revealed Resident #29 was not on the restorative caseload. Resident #29 had been discharged from restorative. The aides on the floor were supposed to apply the splints.Continued interview revealed the RNAs were teaching floor aides to apply the splints to both upper extremities An interview was conducted on 11/20/13 at 11:50 AM with aide #1 who was providing care for Resident #29. In the interview, she stated she had not been instructed on application of splints. She further explained the restorative aides apply the splints and she provided no restorative nursing care for Resident #29. Aide #1 was asked how she would know what care to provide to Resident #29. Aide #1 stated a care card was located inside the closet door with instructions. An interview was conducted with the nurse supervisor for restorative on 11/20/13 at 12:15 PM. Further information was provided indicating Resident #29 had a discharge from restorative on 9/25/13. The restorative plan was discussed with the aides on the floor to do range of motion, apply splints to maintain ROM and check for skin integrity. The nurse supervisor for restorative was informed the aide working with Resident #29 was not aware she was responsible for application of the splints, and had not been instructed on how to apply the splints. Observations on 11/20/13 at 3:30 PM of the care card information posted inside the resident's closet indicated bilateral splints were used on both hands. The restorative portion was blank. Observations on 11/21/13 at 9:16 AM revealed	F 318	quality assurance program. The administrator will ensure that additional education and monitoring will be initiated for any identified concerns.	

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F 318	Continued From page 5 Resident #29 had bilateral splints on both hands. Interview with aide #1 on 11/21/13 at 9:24 AM revealed she had not applied the splints. Aide #1 was asked who applied the splints, and she stated " must have been a restorative aide. " Interview on 11/21/13 at 9:40 AM with the nurse supervisor for restorative revealed the RNA had trained 2 aides on splint application, but they were no longer here (employed at the facility). The process for monitoring for splints included a written order on the Medication Administration Record (MAR). The nurse supervisor for restorative explained she was not aware it was her responsibility to write the orders and ensure it was on the MAR. Once it was brought to her attention there was not a written order, she completed the order on 11/20/13 and updated the MAR.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to implement interventions to reduce fall risk for 1 of 4 residents identified with falls in the facility.	F 323	F323 Corrective Action: Resident #186 has been reassessed for interventions by the interdisciplinary team	12/24/13

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F 323	Continued From page 6 (Resident #186) The findings included: Resident #186 admitted to the facility on 5/20/13 with the diagnosis of dementia and depression. The Care Plan initiated 5/30/13 and updated 11/14/13 indicated that Resident #186 was at risk for fall related injury related to impaired mobility and history of falls. The interventions implemented on 5/30/13 included to lock wheel on wheelchair prior to transfers, keep bed in low position. New interventions were added to the care plan on 6/14/13 to assist guest back to bed when observed to be tired and leaning in wheelchair, on 7/7/13 to place mat beside bed, on 11/12/13 educate staff to hold on to guests shoulder when transporting, on 11/20/13 refer to PT (Physical Therapy) for wheelchair positioning. The Minimum Data Set (MDS) dated 11/11/13 revealed that Resident #186 cognition was severely impaired and required extensive assistance and total dependence of staff for Activities of Daily Living (ADL). Review of the fall incident investigation for 6/14/13 at 12:00PM indicated that Resident #186 had a witnessed fall from the wheelchair to floor in the corridor and obtained a laceration above left eye and abrasion to right knee and lip was bleeding. Resident #186 was being taken to lunch by (NA) Nursing Aide #5 and Resident #186 fell forward out of wheelchair. The care plan was updated 6/14/13 to assist guest back to bed when observed to be tired and leaning in wheelchair. During an interview with NA#5 on 11/21/13 at	F 323	and the care plan and care card has been updated. The resident is being observed by the charge nurses to ensure identified interventions are in place. Residents with the potential for or a history of falls were reviewed at the time of the survey by the ADON and Administrator to ensure care plans and interventions were in place and appropriate. The Nursing staff has been re-educated by the Director of Nurses and/or her designee regarding our falls program, to include interventions. Interventions will be placed on the care cards in the closet for ready access to staff. Using an audit tool, random observations of identified residents will be conducted by the DON and/or her designee daily for 2 weeks then weekly for two months to ensure interventions are in place as identified in the plan of care. Variances will be corrected at the time of observation and additional education and/or administrative action will be initiated when indicated. The QA committee will review the findings of the audits during the monthly QA committee meeting x two months, or until resolved, to monitor for on-going compliance. Continued compliance will be monitored through review of incidents during the morning clinical meeting, routine round	

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F 323	Continued From page 7 10:24AM revealed that on 6/14/13 she was taking Resident #186 to the dining room in her wheelchair and she was leaning forward, before she could catch her she fell forward. NA #5 further indicated that she received education that day to watch for resident leaning and make sure leg rest were on the chair. Review of fall incident investigation for 7/7/13 at 7:30PM indicated that Resident #186 was found on floor beside of bed and obtained a hematoma and tiny laceration above left eye. The care plan was updated 7/7/13 to place mat beside bed on floor. Review of fall incident investigation for 11/12/13 at 10:30PM indicated that Resident #186 had a witnessed fall from the wheelchair at station 2 lounge. NA #4 was pushing Resident #186 back to room and resident leaned forward and fell out of wheelchair and hit her head and obtained a frontal laceration. The immediate intervention was to educate staff to hold on to resident shoulder while transporting and the care plan was updated 11/12/13. During an interview with NA #4 on 11/21/13 at 9:00AM indicated that on 11/12/13 she was getting Resident #186 ready to get her shower and pushed her wheelchair from the TV room to take her to the shower and she fell over face first on the floor, she tried to catch her, but she fell. She indicated that on 11/12/13 after the fall she received education to hold the resident by the shoulder when pushing her wheelchair and from that day forward she makes sure that Resident #186 has her feet on the foot rest and one hand on her shoulder and one hand on the wheelchair.	F 323	observations, and reviews of care plans and care cards and through the facility□s quality assurance program. The administrator will ensure that additional education and monitoring will be initiated for any identified concerns.	

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F 323	Continued From page 8 Review of the physician progress notes dated 11/12/13 indicated a visit after a fall out of her wheelchair this afternoon. She was being pushed in her wheelchair and slumped forward and fell hard unto her face. She is lethargic and not answering questions, no recent illness per staff. Has vertical laceration right frontal region. Chronic sedation/lethargy with unfortunate fall unto her face despite being directly supervised. Refer to emergency department for evaluation and laceration repair. On 11/19/13 at 10:53AM Resident #186 was observed lying in bed with a forehead laceration covered with steri-strips. The bed was in low position and no mats were on the floor next to resident ' s bed. On 11/20/13 at 2:00PM Resident #186 was observed to be lying in bed with eyes closed. The bed was in low position and no mats were on the floor next to resident ' s bed. During an interview with the DON on 11/21/13 at 9:30AM confirmed that mats should have been placed next to Resident #186 ' s bed.	F 323		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to provide 3 of 3 residents (Resident #43, #118, and #120) with	F 369	F369 Corrective Action: Residents' #43, 118, and 120 are being	12/24/13

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F 369	Continued From page 9 physician orders for adaptive equipment/assistive devices recommended by occupational therapy for dining. The findings included; 1. Resident # 43 was admitted to the facility on 5/18/13. The Residents documented diagnosis included Alzheimer ' s, dementia, Depression, debility, and difficulty walking. Review of Resident #43 most recent Minimum Data Set (MDS) dated 9/12/13 revealed the resident required extensive assistance to complete Activities of Daily Living (ADL ' s). The MDS further revealed the resident was on a mechanically altered, therapeutic diet. A 7/31/12 physician order documented, " Please add inner lip plate to trays. " Review of Resident #43 ' s care plan reviewed 9/9/13 indicated the resident was at nutritional and dehydration risk due to therapeutic diet, use of psychotropic ' s and abnormal labs. Interventions included; Provide diet as ordered, Provide adaptive equipment as needed (Inner lip plate/Sippy cup) provide assistance with eating and/or drinking as needed, monitor tolerance to diet and liquids served, and restorative feeding program. Observation on 11/18/2013 at 12:35 pm revealed resident #43 being assisted by Nursing Assistant (NA) #6 with meal set up. Two regular glasses with thickened liquids were placed in front of Resident #43. NA#6 was observed to prompt Resident #43 to use the regular glasses during the meal. Observation of Resident #43 ' s meal	F 369	provided with adaptive equipment for meals as ordered. The Dietary Manager has updated the identified residents□ tray tickets to reflect the type of adaptive equipment that is to be utilized for every meal. Current residents with orders for adaptive equipment have the potential to be affected. The ADON, UM□s and Dietary Manager have reviewed all residents with orders for adaptive equipment to ensure the need for the adaptive equipment is identified in the plan of care, the care card and dietary tray card. Variances were corrected when identified. The DON and/or her assistant has re-educated the nursing staff regarding the need to ensure that adaptive equipment is provided as ordered. The Dietary Manager has re-educated the dietary staff regarding providing the proper adaptive equipment during meals. The rehab department will generate orders for adaptive equipment and send information to the dietary and nursing departments, so that the dietary department can place the equipment on the tray ticket and the nursing department can update the plan of care and care card. Using an audit tool, meal observations will be conducted by the DON/Dietary Manager and designees daily for 2 weeks,	

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F 369	Continued From page 10 card indicated the use of a nosey cup and inner lip plate as adaptive dining needs. Nosy cups were not observed during the residents dining experience. Observation on 11/19/13 at 8:20 am revealed resident #43 being assisted by NA #6. Two regular glasses with thickened liquids were placed in front of Resident #43. NA#6 was observed to assist the resident with consuming liquids from regular glasses throughout the dining experience. Observation of Resident #43 ' s meal card indicated the use of a nosey cup and inner lip plate as adaptive dining needs. Observation on 11/19/13 at 12:40 pm revealed resident #43 being assisted by NA#6. Two regular glasses with thickened liquids were placed in front of Resident #43. NA #6 was observed to assist the resident with prompting to consume liquids from regular glasses throughout the dining experience. Observation of Resident #43 ' s meal card indicated the use of a nosey cup and inner lip plate as adaptive dining needs. Observation on 11/20/13 at 8:12am revealed Resident #43 being assisted by NA#6 with dining. Two regular glasses with thickened liquids were place in front of Resident #43. NA #6 was observed to assist resident with prompting to consume liquids from regular glasses. Observation of Resident #43 ' s meal card indicated the use of a nosey cup and inner lip plate as adaptive dining needs. During a continuous observation on 11/20/13 at 12:00 pm revealed NA#6 retrieving two nosey cups from the cabinet in the main dining room. The NA put Resident #43 ' s thickened liquids into	F 369	then randomly each week for two months, to observe for compliance. Variances will be corrected at the time of observation. The QA committee will review the findings of the audits during the monthly QA committee meeting x two months, or until resolved, to monitor for on-going compliance Continued compliance will be monitored through routine meal observations, review of new orders during the morning clinical meeting, routine review of care plans and care cards and through the facility□s quality assurance program. The administrator will ensure that additional education and monitoring will be initiated for any identified concerns.	

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F 369	Continued From page 11 the nosey cups and assisted the resident with consuming its contents. Resident #43 was observed to drink the liquids from the nosey cups without refusal. Interview with NA#6 on 11/20/13 at 12:05 pm revealed residents diet consistency and adaptive dining equipment are located on the resident meal cards. NA#6 stated the reason she did not supply the resident with a Nosy Cup was due to the resident refusing to use them. NA#6 indicated that the resident would not use them if staff remove the liquid from a regular glass and place them in a Nosy Cup. 3. Resident #120 was admitted to the facility on 11/6/13. The documented diagnosis included dementia, hyperlipidemia, renal insufficiency, seizure disorder, Hypertension, and Congestive Heart failure. Resident #120 ' s most recent MDS dated 10/28/13 revealed the resident required extensive assistance to complete ADL ' s in the area of eating with one person physical assistance. The MDS further revealed the resident was on mechanically altered, therapeutic diet. Review of Resident #120 occupational therapy discharge summary dated 2/20/13 indicated the resident was discharged on 1/23/13. The short term goal #4.1 identified, " Patent will perform self feeding task with use of Adaptive equipment as needed/determine in order to increase self feeding. " Comments included; " patient continues to vary with feeding task and requires max cues to initiate tasks. " Review of Resident #120 ' s care plan dated	F 369		

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	345421	A. BUILDING _____ B. WING _____	C 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 369	Continued From page 12 10/15/13 indicated a problem of, " Resident #120 was at nutritional and dehydration risk related to therapeutic diet, mechanically altered diet, use of psychotropic, and dementia. The approaches included; assess tolerance to diet and liquids served, assess meal intake and offer alternative as needed, provide assistance with eating and/or drinking as needed, provide adaptive equipment as needed, and provide diet per order. A 11/15/13 physician order documented, " Decrease diet to puree. " Physician order dated 1/10/13 documented, " OT clarification order for Adaptive Equipment at meals: 1) plate guard (applied to Left side). " Review of Resident #120 ' s nutritional assessment dated 11/12/13 indicated current nutrition prescription: Mechanical soft diet, super nutrition program and ensure TID. During a continuous Observation on 11/19/13 at 12:26 pm revealed resident #120 being provided assistance by NA #8 with dining. NA #8 was observed to provide Resident #120 with extensive physical assistance for dining. Resident #120 ' s meal was observed on a regular plate with no plate guard present. Observation of Resident #120 ' s meal card indicated the use a plate guard for adaptive dining needs. No plate guard was present during the dining experience. Resident did not attempt to self feed. During a continuous observation on 11/20/13 at 8:12 am revealed Resident #120 being provided extensive assistance by NA staff. Resident #120 ' s meal was observed on a regular plate with no plate guard present. Observation of Resident #120 ' s meal card indicated the use of a plate	F 369		

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F 369	Continued From page 13 guard for adaptive dining needs. No plate guard was present during the dinning experience. Resident did not attempt to feed himself. During a continuous observation on 11/20/13 at 12:29 pm revealed Resident #120 being provided extensive assistance by NA#7. Resident #120 had a plate guard placed underneath his plate. Interview with NA#7 on 11/20/13 at 12:29pm indicated she was aware of the resident ' s adaptive needs in dining by reviewing the resident ' s meal card. NA#7 indicated the resident ' s plate was sent out by dining with the plate guard underneath the plate. NA#7 stated she was unaware of how to apply the plate guard. Interview with Assistant Dietary manager on 11/20/13 at 11:30 am revealed staff are aware of resident adaptive eating needs by what was dictated on the residents meal cards. The assistant dietary manager indicated staff that provide assistance in the dining room were to retrieve their own adaptive equipment. The adaptive equipment was located in the dining area cabinet. The Assistant Dietary manager further revealed changes are made to resident meal cards upon a new order provided by occupational therapy or speech therapy. Changes to resident ' s adaptive needs are immediately placed on the resident meal card to ensure staff were aware of the changes. The Assistant dietary manager indicated she updated resident ' s adaptive needs in a binder every Monday. The binder with resident information was located in the cabinet that the adaptive equipment for staff access. Interview with Rehab Service Director in	F 369		

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F 369	Continued From page 14 conjunction with the Occupational Therapist on 11/20/13 at 2:44pm indicated adaptive equipment needs are placed on a physician order form. A copy of the order is made and provided to nursing and dietary management to ensure the adaptive equipment needs are transcribed onto the resident ' s meal card. No discharge orders could be located. It was the expectation that adaptive equipment be utilized until the device was discontinued by Rehab services. Interview with Speech Therapist (ST) on 11/20/13 at 3:15 pm revealed adaptive equipment needs are transcribed on a physician order sheet. The information is provided for any restorative needs and to the dietary department. ST indicated staff should report refusals to nursing or rehab to ensure necessary revisions to staff training or adaptive equipment could be made. ST recalled previous observations of Resident #43 in which staff utilize equipment implemented. ST could not recall any refusals of the adaptive equipment or communications from staff indicating refusals. The Speech Pathologist indicated it was her expectation that residents continue to utilize any implemented adaptive devices until they are discontinued. Interview with Director of Nursing (DON) 11/21/13 at 4:42 pm revealed it was her expectation that residents that had been assessed by Occupational Therapy or Speech Therapy utilized recommended adaptive equipment. The DON further reveled it was her expectation that rehab equipment is screen periodically to determine if the resident still needs the equipment.	F 369		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		12/24/13

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F 425	Continued From page 15 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to order and have available an inhaler for one of one residents receiving inhalers. Resident #224 The findings included: Resident #224 was admitted to the facility on 11/15/13 with diagnoses of asthma and chronic lung disease. Review of the physician ' s admission orders dated 11/15/13 included an inhalant (Symbicort) one puff every day at 8:00 AM.	F 425	F425 Resident #224 is receiving the inhaler as ordered. Nurse #3 has been re-educated on the process for ordering therapeutic interchange medications. Education also included that when a medication is not available the nurse will call the pharmacy and/or back up pharmacy to obtain the medication. The DON and ADON reviewed all current residents□ medication administration records to ensure recommended	

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F 425	Continued From page 16 Review of the pharmacy " Therapeutic Exchange " notification dated 11/16/13 revealed the medication ordered on admission was to be discontinued. An exchange medication for a different inhaler was recommended by pharmacy. A hand written date of 11/16/13 and " faxed " was in the lower right hand corner of the " Therapeutic Exchange " notification. There were no initials of the nurse who had sent the fax or where it had been faxed. Review of the Medication Administration Record (MAR) for November 2013 revealed documentation for the doses of the inhaler (Symbicort) ordered on admission. The nurses ' initials were circled for 11/18-11/21/13 by the same nurse. Interview on 11/21/13 at 9:00 AM with nurse #3 revealed the medication had not been given to the resident. Nurse #3 was not able to find the inhaler during med pass observations. Nurse #3 went to the computerized back up medication system and obtained the pharmacy recommended exchange inhaler for the morning dose on 11/21/13. Interview on 11/21/13 at 1:00 PM with the Director of Nursing revealed the pharmacy notification for drug exchanges had been agreed to by the physicians. The physicians would not be required to respond to a fax by the nurses for an order for the drug exchange. The nurse would write a telephone order, send the order to the pharmacy and the drug would be sent to the facility. The medication had not been sent because a telephone order had not been written. She expected residents to have their medications	F 425	therapeutic interchange medications had been ordered and available. No other variances were identified. The ADON has re-educated licensed nursing staff regarding the ordering of medications and the time frame to have medications started. The medication exchange process will be included in the nurse orientation program as well as the process for obtaining medications from the pharmacy and/or back up pharmacy when medications are not found in the medication cart. Using an audit tool the UM□s/designees will review therapeutic exchange recommendations to ensure orders have been obtained and medications are available daily for 2 weeks then weekly for two months then randomly thereafter. Variances will be promptly corrected. The QA committee will review the findings of the audits during the monthly QA committee meeting x two months, or until resolved, to monitor for on-going compliance. Continued compliance will be monitored through routine MAR and order reviews and through the facility□s quality assurance program. The administrator will be ensure that additional education and monitoring will be initiated for any identified concerns.	

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F 425	Continued From page 17 available for administration within 24 hours after the order was written. Interview on 11/21/13 at 1:30 PM with nurse #3 revealed she had not written the telephone order, but was working the days of 11/18 to 11/21/13 and the inhaler medication had not been given. This nurse gave an explanation of how to use the drug exchange system. Nurse #3 explained she had not written the telephone order and given the inhaler dose because " it was overlooked ", because she had " gotten busy. "	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		12/24/13

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F 441	Continued From page 18 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to disinfect/sanitize shared glucometers (blood glucose monitoring) after obtaining a blood glucose sample. Observations were made of two nurses during medication pass observations. The residents receiving finger stick blood sugar monitoring were Resident #99 and #133. The findings included: 1. During continuous observations on 11/20/13 at 4:21 PM of nurse #1, a finger stick blood sugar was obtained for Resident #. After obtaining the reading, nurse # removed the glucometer from the resident ' s room and returned it to the top of the med cart. At 4:45 PM nurse #1 used a (brand name) sanitizer wipe and cleaned the face of the glucometer, and then placed the glucometer on top the clean lancets inside the med cart. The opening for the test strip was not cleaned, and the glucometer was not left visibly wet for two	F 441	F441 No negative outcome resulted for Resident #99 or Resident #133. Current residents with orders for blood sugar checks have the potential to be affected. Nurse #1 and Nurse #2 have received additional education by the DON/designee relating to the facility□s policy for cleaning glucometers. All Licensed Nurses have received additional education by the DON/designee relating to cleaning glucometers per facility policy. New nurse orientees will be educated on the facility□s glucometer cleaning policy during the orientation process. Using an audit too, the DON and designees will conduct accu check	

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F 441	Continued From page 19 minutes. Interview on 11/20/13 with nurse #1 revealed she was not aware of the directions on the (brand name) wipes for disinfecting/sanitizing the glucometer. The directions were pointed out to the nurse and she read the instructions to clean the glucometer and leave it visibly wet for two minutes. Interview with the Director of Nursing on 11/21/13 at 3:00 PM revealed the nurses were to clean the glucometers with the wipes and leave it wet for two minutes. The entire glucometer should have been wiped down and left to air dry before placing it in the med cart. 2. During continuous observations on 11/21/13 at 4:51 PM of Nurse #2 revealed a finger stick blood sugar was obtained for Resident #80. After obtaining the reading, the glucometer was brought to the med cart. Nurse #2 was observed preparing for the next resident ' s blood sugar testing. During continuous observations, nurse #2 took the shared glucometer into Resident #133 ' s room, wiped the resident ' s finger with an alcohol prep wipe, put the test strip into the glucometer and picked up the lancet to stick the resident ' s finger. The surveyor stopped nurse #2 and asked if she had cleaned the glucometer. Nurse #2 stated " no. " Nurse #2 left Resident #133 ' s room with the equipment, cleaned the glucometer according to manufacturer ' s recommendations and returned to perform the finger stick blood sugar. Interview on 11/21/13 at 3:00 PM with the Director of Nursing revealed the glucometer should have been sanitized after it was used. Nurse #2	F 441	observations daily for 2 weeks, then randomly each week for two months, to observe for compliance. Variances will be corrected at the time of observation.. The QA committee will review the findings of the observations during the monthly QA committee meeting x two months, or until resolved. Continued compliance will be monitored through random accu check observations and through the facility□s quality assurance program. The administrator will ensure that additional education and monitoring will be initiated for any identified concerns.	

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F 441	Continued From page 20 should have used the (brand name) wipes, thoroughly cleaned the glucometer, let it remain wet for two minutes and then the next resident ' s blood sugar could be tested.	F 441		

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K 000	INITIAL COMMENTS This Life safety Code(LSC) survey was conducted as per The Federal Register, using the Existing Health Care section of the LSC and its referenced publications. This building is type V (111)) construction , one story with a complete automatic sprinkler system.	K 000	The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. 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.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1, 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 12/18/2013 the following was observed; a. there was no componant location map and wiring diagiam under glass near the FACP. b. the staff did not know about the master release switch at the nurses station. c. the exterior exit door from did not a release switch with in three (3) feet of the door d. the fire doors near room 401 failed to release when pressure was appiled to the release devise. 42 CFR 483.70 (a)	K 038	K 038 A component locations map to include a wiring diagram has been placed at the fire panel. Staff members responsible for not knowing about the master switch for the magnetic locks have been re-educated . The exterior kitchen door has had a switch installed. The fire doors near room 401 have been adjusted to release when pressure applied. No other area was identified as requiring a device map with wiring diagram. The Administrator and Director of Maintenance asked other	1-17-14
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 12/18/2013 the med.	K 147		

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

John Farrell — Administrator — 12/26/13

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

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K 147	Continued From page 1 refrigerator at nurses #1 was not plugged into an emergency circuit. 42 CFR 483.70 (a)	K 147	staff present about the master switch upon notification. No other staff was identified as not knowing about the switch. The Administrator and Director of Maintenance reviewed all other doors and did not find any exit door in need of a switch. The Administrator and Director of Maintenance reviewed all other corridor fire doors and did not find any to have an issue with opening upon applying pressure. Upon placing the map with wiring diagram and installing the special lock for the exterior kitchen door, there will be no further action required. The Director of Maintenance has placed on his monthly fire drills to also quiz staff regarding the special locks master switch and to review the corridor fire doors for proper release. Staff has been re-educated regarding the special locking mechanisms and will be educated about them during orientation. Using an audit tool, rounds will be conducted by the Director of Maintenance daily for one week, then weekly for 4 weeks and monthly for two months to observe if staff are properly aware of the master locking switch and to determine if the corridor smoke doors are properly releasing when pressure is applied. The Director of	

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K 147	Continued From page 1 refrigerator at nurses #1 was not plugged into an emergency circuit. 42 CFR 483.70 (a)	K 147	Maintenance has been re-educated regarding the use of the weekly preventative maintenance program tools. The QA committee will review the findings of the audits during the monthly QA committee meeting x 2 months, or until resolved, to monitor for on-going compliance. Continued compliance will be monitored through the preventative maintenance program, and through the facility's monthly Quality Assurance program. The Administrator will ensure that additional education and monitoring will be initiated for any identified concerns. K 147 The med room refrigerator has been placed on the emergency electrical system. The other med room was reviewed by the Administrator at the time of survey and found the refrigerator to be in compliance with electrical compliance. When this issue has been corrected, there will not be the need for further systemic changes. Using an audit tool, rounds will be conducted by the Director of	1-10-14

(2 B)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 1 refrigerator at nurses #1 was not plugged into an emergency circuit. 42 CFR 483.70 (a)	K 147	Maintenance weekly for 4 weeks and monthly for two months to observe if the med room refrigerator is plugged into the emergency outlet. The QA committee will review the findings of the audits during the monthly QA committee meeting x 2 months, or until resolved, to monitor for on-going compliance. Continued compliance will be monitored through the preventative maintenance program, and through the facility's monthly Quality Assurance program. The Administrator will ensure that additional education and monitoring will be initiated for and identified concerns.	

(2C)