

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

PRINTED: 07/01/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345421</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE LAURELS OF CHATHAM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>72 CHATHAM BUSINESS PARK</b> <b>PITTSBORO, NC 27312</b>		
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F 000	INITIAL COMMENTS  An unannounced complaint investigation survey was conducted on 6/1/21. 1 of 2 complaint allegations was substantiated and 1 of 2 complaint allegations was unsubstantiated. Event ID# D2G711.	F 000			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		6/21/21	

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

TITLE

(X6) DATE

Electronically Signed

06/17/2021

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

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F 609	<p>Continued From page 1</p> <p>by: Based on record review, observations and staff interviews, the facility failed to report an allegation of resident to resident abuse to the State Agency for 1 of 3 residents reviewed for allegations of abuse. (Resident #1)</p> <p>The findings include:</p> <p>Resident #1 was originally admitted to the facility on 6/12/19, with diagnoses including mild cognitive impairment, unspecified schizophrenia, major depressive disorder, recurrent, acquired absence of right leg, above the knee, epilepsy and anxiety disorder. According to the most recent Annual Minimum Data Set (MDS) dated 4/12/21, Resident #1 ' s cognition was intact with some confusion and he required extensive assistance in most areas of activities of daily living.</p> <p>Resident #5 was originally admitted to the facility on 7/3/20 and was readmitted on 2/6/21, with diagnoses including alzheimer ' s disease, psychotic disorder, depression and hypertension. According to the most recent Quarterly Minimum Data Set (MDS) dated 5/21/21, Resident #5 was cognitively impaired. Resident #5 required extensive assistance with most activities of daily living.</p> <p>Resident #4 was originally admitted to the facility on 4/12/21, with diagnoses including major depressive disorder, recurrent and anxiety disorder. According to the recent Admission Minimum Data Set (MDS) dated 4/19/21, Resident #4 ' s cognition was intact with some confusion. Resident # required limited to extensive assistance in different areas of</p>	F 609	<p>The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance date is June 18th, 2021.</p> <p>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.</p> <p>F609 Reporting Alleged Violations</p> <p>Corrective Action We have submitted for the plan of correction, a report to the State Agency regarding this alleged resident to resident abuse. In addition, we have submitted the investigation that was completed at the time resident #4 made the allegation.</p> <p>How the facility will identify those who have the potential to be affected At the time of the survey, the DON (Director of Nurses) and the Unit Managers reviewed any existing alleged violations to ensure they had been reported to the Administrator, and/or to other officials, to include the State Survey Agency. No other resident was found to be affected by this alleged deficient practice. Any resident that has an occasion to report an alleged violation has the potential to be affected</p>		

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F 609	<p>Continued From page 2 activities of daily living.</p> <p>During an interview on 6/1/21 at 3:54 PM, Resident #4 said he saw Resident #1 doing something promiscuous with a female resident, who did not know what was going on. Resident #4 stated Resident #1 was being inappropriate with Resident #5. He revealed he saw Resident#1 put his hand under Resident #5 ' s shirt and touched her breast. He revealed that Resident #1 also took Resident #5 ' s hand and put it on his crotch and he forced Resident #5 to play with his body parts. Resident #4 said Resident #1 could be Resident #5 ' s mother. He stated he reported what happened to the Administrator the next day. Resident #4 said Resident #1 found out about him reporting what happened to the Administrator and Resident #1 cursed him and fought him because he got caught.</p> <p>During an observation on 6/1/21 at 5:30 PM, Resident #1 was sitting in his wheelchair almost constant spastic involuntary movements with his right arm bent at the elbow extended up with involuntary spastic movement as he talked. Both of Resident #4 ' s arms and hands were contracted.</p> <p>During an interview on 6/1/21 at 5:30 PM, Resident #1 revealed he cursed out girls but there was nothing sexual going on with him and Resident #5. He said he played with grandma and he said he would not hurt anyone. He revealed Resident #4 got him in trouble and he did not fight anyone. Resident #1 said he did not have a fight with Resident #4, but he cursed at him. Resident #1 said he talked to the Unit Manager and he told her the truth.</p>	F 609	<p>by this alleged deficient practice.</p> <p><b>Systemic Changes</b> The Administrator and the Director of Nurses has been provided re-education regarding timely reporting of all alleged violations on June 1, 2021, by the Regional Director of Operations. This included the reporting of any and all alleged violations to the proper officials.</p> <p><b>Monitoring</b> The Regional Clinical Consultant, using a QA audit tool, will review all Reports of Alleged Violations monthly for three months, and then quarterly for two quarters, to determine if all Alleged Violations have been reported to the proper officials. The results of the QA tool will be reported by the DON, to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendation. The DON and Administrator will be responsible to follow-up on any recommendations from the QAPI committee.</p>		

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F 609	<p>Continued From page 3</p> <p>During an interview on 6/1/21 at 11:01 AM, the Unit Manager stated Resident #4 reported Resident #1 for being inappropriate with a female resident. The Unit Manager stated she reported the incident to the Director of Nursing (DON). She revealed an investigation was started by the Social Worker. She revealed she also spoke to the management team and they began an investigation right away. She stated the Social Worker interviewed Resident #5 and the resident was not interviewable. She revealed the Social Worker interviewed staff and they said they did not notice anything inappropriate. The Unit Manager revealed Resident #4 had been discharged and readmitted to the facility frequently and he tended to talk about sexual things. She stated Resident #4 said Resident #1 inappropriately reached over and groped a female ' s breast area. The Unit Manager stated Resident #4 told her he saw Resident #1 grab Resident #5 ' s hand to touch him in his crotch area.</p> <p>During an interview on 6/1/21 at 11:21 AM, the Director of Nursing (DON) stated Resident #4 tried to go into a female resident ' s room. She stated the next day Resident #4 alleged that Resident #1 had his hand rubbing Resident #5 ' s arm and touching Resident #5 inappropriately. The DON revealed Resident #4 did not tell the Nursing Assistant and Nurse on second shift what happened. She revealed the Nurse on second shift was sitting at the nurse ' s station desk with a Nursing Assistant, when the incident allegedly happened. She revealed that Resident #4 was sitting on the other side of the nurse ' s station and there was no way Resident #4 could have seen anything because the desk was there. The DON said Resident #1 and Resident #5 were</p>	F 609			

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F 609	<p>Continued From page 4</p> <p>sitting on the other side of the nurse ' s station. She stated Resident #1 and Resident #5 always sat together across from the nurse ' s station. The DON revealed Resident #5 liked to sit at the nurse ' s station to watch people go by and Resident #1 was everywhere. She stated Resident #1 saw Resident #5 as a mother figure. She stated Resident #4 did not like Resident #1. The DON revealed Resident #4 would fabricate stuff such as making up different allegations. She stated an investigation was completed but she dd not send the 24 hour and 5-day reports to the state agency because of Resident #4 ' s past behaviors.</p> <p>During an interview on 6/1/21 at 5:55 PM, the Director of Nursing (DON) revealed that her expectation would be to report abuse immediately, even if there was no harm and to interview residents about abuse and in-service staff on abuse. She stated abuse/neglect of any magnitude will be thoroughly investigated and turned into the state agency.</p> <p>During an interview on 6/1/21 at 11:41 AM, the facility Social Worker stated the incident was reported to the Director of Nursing (DON) and he said basically he talked to all parties involved. The Social Worker revealed Resident #1 was not sexually inappropriate. He said Resident #1 was known to do a lot of talking, but not overbearing. He revealed Resident #1 and Resident #4 were both followed by a Mental Health provider to address both mood and behaviors. The Social Worker stated Resident #4 claimed he saw a male resident over by the nurse ' s station with a female resident touching her inappropriately. The Social Worker wondered how did Resident #4 see what allegedly happened? He stated that no</p>	F 609			

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F 609	<p>Continued From page 5</p> <p>one could tell by the angle where Resident #4 was sitting, what was happening on the other side of the nurse ' s station where Resident #1 and Resident #5 were sitting. The Social Worker revealed Resident #4 fabricated information to get him the right attention. The Social Worker stated after talking to Resident #4 he talked to Resident #1 who said that he tried to be friends with Resident #5. The Social Worker revealed Resident #1 said he was not stupid, and he would not touch another resident. The Social Worker stated Resident #1 said Resident #4 was trying to get him in trouble. The Social Worker stated Resident #1 was always verbal but not physical. He revealed he was not aware of a fight between Resident #1 and Resident #4. The Social Worker revealed the female resident, Resident #5 was cognitively impaired and not interviewable.</p> <p>During an interview on 6/1/21 at 3:04 PM, Nursing Assistant (NA) #1 who worked on 2nd shift the night of the incident stated Resident #4 was on the 400-hall side of the nursing station facing the activity board where Resident #1 and Resident #5 were sitting. She revealed Resident #1 talked to Resident #5 every evening. NA#1 stated Resident #5 rubbed Resident #1 ' s arm up and down on the arm rest. She stated it kept Resident #5 occupied so that she would not get up and try to walk. NA#1 said Resident #4 was sitting on the other side of the nurse ' s station and there was no way he could have seen anything. She said Resident #4 did not go past where he was sitting. She revealed Resident #4 liked to make himself known. She stated Resident #4 did not report anything specifically to her. NA #1 stated she made sure Resident #1 and Resident #5 did not do anything inappropriate.</p>	F 609			

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F 609	<p>Continued From page 6</p> <p>During an interview on 6/1/21 at 3:30 PM, Nurse #1 revealed her medication cart was parked on the 300 hall. She stated Resident #1 talked to Resident #5 and that was something they did every day. She stated she had been observing Resident #1 and Resident #5.. Nurse #1 stated Resident #4 did not report anything to her.</p> <p>During an interview on 6/1/21 at 4:19 PM, the Director of Nursing (DON) revealed there was no fight between Resident #1 and Resident #4. She stated they did not like each other. She stated an investigation was completed, but a 24 hour and 5-day report were not done because of Resident #4 ' s behavior of fabricating information and being accusatory. She stated as soon as she heard about the incident, she said none of it happened. She said that was the reason she did not complete a 24 hour and 5-day report.</p> <p>During another interview on 6/1/21 at 5:55 PM, the Director of Nursing (DON) revealed that her expectation would be to report abuse immediately, even if there was no harm and to interview residents about abuse and in-service staff on abuse. She stated abuse/neglect of any magnitude will be thoroughly investigated and turned into the state agency.</p>	F 609			