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 03/17/2022

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

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E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted on 03/14/22 through 03/17/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #HJXJ11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 03/14/22 through 03/17/22. Event ID# HJXJ11. 11 of the 11 complaint allegations were not substantiated. The following intakes were investigated: NC00187042, NC00186511, NC00186591, NC00186424, NC00185852, NC00184315, NC00178625.	F 000		
F 644 SS=E	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 (PASARR) 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	F 644		4/7/22

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

Electronically Signed | 04/04/2022

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 644	Continued From page 1 a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to refer residents with newly evident mental illness for Pre-Admission Screening and Resident Review (PASARR) Level II screening for 2 of 3 residents reviewed for PASARR (Resident #35, Resident #96). The findings included: 1. Resident #35's PASARR documentation revealed a Level I screening was completed on 06/05/20. A Level II screening was not completed. Resident #35 was admitted to the facility on 09/08/20 with diagnoses that included chronic obstructive pulmonary disease and major depressive disorder. Diagnoses were added on 09/24/21 for psychosis and schizoaffective disorder. A physician's order dated 09/15/20 indicated a psychiatry consult for medication review and aggressive behaviors. Active medication orders included olanzapine 5 milligrams (mg) twice daily for psychosis and mood disorder and Depakote 500 mg twice a day for mood disorder. Resident #35's care plan dated 02/28/22 revealed focus areas for mood fluctuations, psychotropic medication use, and behavioral problems. Interventions included administered medications as ordered, behavioral health consultation, observed for symptoms of psychosis and mood	F 644	The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is April 7th, 2022. 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 regulator requirements. F644 Coordination of PASARR and Assessments The Laurels of Chatham provides for the coordination of pre-admission screening and resident review. Corrective Action When notified at the time of survey, Resident #35 and Resident #96 was referred for Pre-Admission Screening and Resident Review (PASARR) Level ll screening. Corrective Action for those having the potential to be affected All residents that are originally admitted with a Level 1 PASARR screening that have additional diagnoses added that require a Level II PASARR and go through the required Minimum Data Set (MDS)	

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F 644	Continued From page 2 fluctuations, and provided positive interactions. A progress note by social worker #1 dated 03/02/22 revealed Resident #35 had fluctuating moods and behaviors of yelling out and use of inappropriate language. She was being seen by in-house mental health services for mood and behaviors. The significant change Minimum Data Set (MDS) dated 03/08/22 revealed Resident #35 was cognitively impaired. She expressed verbal behavioral symptoms directed toward others and received antipsychotics on a routine basis. 2. Resident #96's PASARR documentation revealed a Level I screening was completed on 12/14/18. A level II screening was not completed. Resident # 96 was admitted to the facility on 04/18/19 with diagnosis that included type 2 diabetes mellitus and psychosis. A diagnosis for schizophrenia was added on 10/26/21. A physician's order dated 10/28/21 indicated a psychiatry consult for diagnoses of psychosis, narcissistic personality disorder, and impulsiveness. Active medications included Depakote 500 mg twice a day for mood disorder, chlorpromazine 100 mg twice a day for psychosis, and Zoloft 25 mg daily for depression. A progress note dated 02/11/22 by social worker #2 revealed Resident #96 was reviewed for behaviors of manipulation and attention seeking. Her medications were reviewed.	F 644	assessment, are at risk for this alleged deficient practice and are identified through the MDS care plan process. An audit of all residents has been completed by the Admission and Care Plan team by 3/26/22, with any additional identified resident requiring a Level 2 PASARR applied for. Systemic Changes The Director of Social Workers, the Director of Admissions, has been educated by the Regional Social Worker on 3/28/22, regarding the process for when to obtain a Level II PASARR. In addition, a quick sheet has been developed for this team to include when a resident gets a new diagnosis that requires a Level II PASARR. All current guests will be reviewed in the weekly resident at risk meeting and the quick sheet completed for any identified guests. All new residents will be reviewed in The interdisciplinary team meeting (IDT) morning meeting following admission. The Director of Marketing will initiate any PASARR changes as needed. Monitoring The Administrator/designee will perform audits weekly times one month, then bi-weekly for one month and then monthly for one month, of all residents that have been given new diagnoses that meets the requirement of a level II PASARR, and then with the Director of Marketing to determine if the Level II has been applied	

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F 644	Continued From page 3	F 644		

Resident #96's care plan dated 02/17/22 revealed focus areas for receiving psychotropic medications, mood fluctuations, and behavior problems. Interventions included administered medications as ordered, observed for medication side effects, observed for changes in mood and behavior, and psychiatric consultation.

The annual MDS dated 02/17/22 revealed the resident was cognitively intact. She had verbal behavioral symptoms directed towards others and received antipsychotic and antidepressant medications. Antipsychotic medications were received on a routine basis.

An interview was conducted with social worker #2 on 03/15/22 at 2:50 PM. He revealed he worked with the admission coordinator on PASARR updates. Social worker #2 provided PASARR documentation for Resident #35 and Resident #96.

An interview was conducted with the admission coordinator on 03/15/22 at 4:00 PM. She explained the facility's PASARR process. The admission coordinator stated PASARR information was checked upon a resident's admission. A PASARR was applied for if the resident didn't have one. If a Level II was needed, information was requested from the physician for submission. The MDS nurse notified her when diagnoses changed. She had not been notified of Resident #35 or Resident #96 needing updated PASARRs or rescreened.

In an interview with the MDS nurse on 03/15/22 at 4:10 PM, she stated the MDS nurse would notify the admission coordinator of changes in residents' diagnoses. The MDS nurse reviewed

for. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.

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F 644	Continued From page 4 Resident #35 and Resident #96's diagnoses and PASARR information. She revealed both residents should have been reevaluated when the diagnoses changed. An interview was conducted with the director of nursing (DON) on 03/16/22 at 12:40 PM. She stated admissions, MDS, and social services departments were responsible for the PASARR process. Resident changes were reviewed in clinical meetings. MDS would typically update orders and review changes of resident conditions. PASARR Level IIs were not completed for Resident #35 and Resident #96.	F 644		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff and physician	F 688	F688 Increase/Prevent Decrease in	4/7/22

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F 688	Continued From page 5 interviews, and record review, the facility failed to apply splints as ordered for 1 of 2 residents reviewed for contractures and limited range of motion (Resident #30). The findings included: Resident #30 was initially admitted to the facility on 8/31/13 with diagnoses that included persistent vegetative state, brain damage, and multiple contractures. An order dated 8/11/21 stated provide good hygiene to the left and right elbow creases, provide passive range of motion (PROM) to the upper extremities, and apply bilateral elbow extension splints in the morning. Resident #30's care plan dated 2/28/22 revealed a focus area for risk for further contracture development. Interventions included preformed range of motion (ROM) to extremities during morning and afternoon care, referred to occupational therapy (OT) as needed, and rolled washcloths and towels to bilateral hands and elbows every shift. A physician's order dated 3/1/22 revealed an extension of OT services for Resident #30. The order stated treatment would be provided five times per week and included therapeutic exercises, orthotic fitting, training, and management. An additional order stated Resident #30 would be discharged from skilled OT services after his treatment on 3/3/22. The OT discharge summary dated 3/3/22 revealed nursing staff were educated on Resident #30's splinting program. The resident was to have	F 688	ROM/Mobility The Laurels of Chatham provides care to increase/prevent Decrease in ROM/Mobility. Corrective Action Resident # 30 is having splints applied as ordered and are placed on the resident by licensed staff each day. The nurse responsible for not donning the splints has been re-educated by the Assistant Director of Nurses (ADON) Corrective Action for those having the potential to be affected All residents that have orders to have splints placed or taken off are at risk for this alleged deficient practice and are identified through the MDS care plan process. An audit of all residents has been completed by the Care Plan team by 3/26/22, with any additional identified resident requiring splint order clarification completed by the assessment nurse, with the plan of care updated, along with the administration record. Systemic Changes A 100% re-education of licensed staff has been completed regarding completing and following orders for splinting. In addition, new nurses will be educated during their onboarding orientation. All nurses will be reminded through the Point Click Care (PCC) charting Point Click Care	

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F 688	Continued From page 6 bilateral elbow extension splints applied for 4-6 hours with no adverse effects to prevent further contractures. Education was provided to nursing staff for PROM. Pictures were provided to help nursing staff with splint placement. The significant change Minimum Data Set (MDS) dated 3/7/22 revealed Resident #30 received OT services. He was totally dependent on staff for activities of daily living (ADLs). A restorative nurse program was not indicated for splints or ROM. A review of the resident's medication administration record (MAR) revealed staff documented bilateral elbow extension splint applications at 9:00 AM and splint removals at 1:00 PM on 03/14/22 - 03/15/22. In an interview with nurse aide (NA) #13 on 3/14/22 at 10:55 AM, she had just finished Resident #30's morning care. NA #13 stated nurses were responsible for any splints that should be placed on the resident. An observation on 3/14/22 at 11:00 AM revealed Resident #30 had bilateral upper extremity contractures. There was a splinting program folder at the resident's bedside. The "Restorative Program Therapy to Nursing Communication" plan stated the resident was to have bilateral upper extremity splints applied for four hours after morning care. Resident #30 was not wearing splints. There were splints on the resident's bedside table. An observation on 3/14/22 at 2:00 PM revealed the resident was not wearing bilateral upper arm splints. The splints were on his bedside table.	F 688	dashboard through the next quarter, by the DON and/or her nurse managers, to place splints at prescribed times. Monitoring The Director of Nurses, and/or her nurse manager, will perform audits 5 times a week for one week, then 3 times a week for one week, then weekly times two weeks, bi-weekly for one month and then randomly for two months of all residents that wear splints utilizing an audit tool. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 688	Continued From page 7	F 688		

An observation on 3/15/22 at 8:24 AM revealed splints were not applied to Resident #30. There were rolled washcloths and towels on his elbows and hands.

In an interview with Nurse #3 on 3/15/22 at 12:36 PM, she revealed therapy services had worked with Resident #30 regarding splints. She indicated splints were to be applied after morning care was provided and nurses were responsible for applying Resident #30's splints. Nurse # 3 stated she had applied Resident # 30's splints at 7:30 am and removed them at 10:00 AM. Nurse #3 explained the splints were usually applied between 9:00 AM and 1:00 PM. She indicated the resident's contractures had gradually worsened. Nurse #3 explained OT staff had trained nursing staff on Resident #30's splint application. Splint application was documented on the resident's MAR.

An observation on 3/15/22 at 12:40 PM revealed Resident # 30's splints were not applied.

On 03/15/22 at 1:51 PM, an interview was conducted with the rehab director. She stated OT services were provided to Resident #30 for splinting. The most recent dates of service included 1/31/22 - 3/3/22. Resident #30's goals were to have PROM tolerance, prevent further contractures and skin breakdown, bed positioning, and to tolerate bilateral splints for 4-6 hours. He was tolerating his splints and they were not new to him. He had used them in the past. The rehab director indicated the resident's splints were a good fit and nursing took over his splint application on 3/3/22. Education and training were provided to nursing staff regarding Resident # 30's splints and PROM. Pictures and

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F 688	Continued From page 8 instructions on Resident #30's splinting program were available at the nurse's station and in the resident's room. In an interview with Physician #1 on 03/16/22 at 3:16 PM, she stated the expectation was that staff would apply Resident #30's splints as ordered. During an interview with the director of nursing (DON) and Nurse #2 on 3/16/22 at 4:25 PM, Nurse #2 stated Resident #30 wore bilateral splints on dayshift and received PROM. The therapy department reassessed Resident #30 periodically and his splints were adjusted as needed. Nurses were responsible for the splint application. Resident #30 was not capable of refusing his splints or interventions. The DON indicated staff were cross trained to ensure splints were applied and nurses helped each other when new staff were on the unit. The DON further explained splinting was an area that had been identified for improvement. She indicated there was a good working relationship with the therapy department. In an interview with the MDS Nurse and DON on 3/17/22 at 10:13 AM, the MDS Nurse stated she typically pulled orders daily and updated care plans accordingly. Resident #30 should have had a splints intervention added to the care plan, but she was out of the facility during the time it was ordered. The DON explained there was not a backup person during the time the MDS nurse was away from the facility because MDS staff were pulled to the unit to help with staffing issues.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		4/7/22

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F 690	Continued From page 9 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with staff and physicians, the facility	F 690	F690 Bowel/Bladder Incontinence Care, Catheter, UTI	

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F 690	Continued From page 10 failed to 1) clarify a PRN (as needed) order for a condom catheter to determine the indication for use; 2) discontinue the use of a condom catheter as ordered by the physician; and 3) maintain a urinary drainage bag below the level of the urinary bladder to prevent a backflow or urine for 1 of 1 resident reviewed for urinary catheter (Resident #28). Findings included: 1. Resident #28 was readmitted on 4/16/21 with diagnoses that included Wilson's disease (a genetic disorder causing excessive copper accumulation in the liver, brain, and other organs), and neuromuscular dysfunction of urinary bladder. 1a. Review of the physician orders dated 4/16/21 read in part "may use condom catheter PRN (as needed) for coccyx [a triangular arrangement of bone that makes up the very bottom portion of the spine commonly referred to as the tailbone] wounds". Review of the annual Minimum Data Set (MDS) assessment dated 1/7/22 revealed the Resident #28 was assessed as cognitively intact. Assessment indicated the resident had an external catheter and was always incontinent for urinary bladder and bowel. The resident had no pressure ulcers but was assessed as at risk for pressure ulcers. Review of the care plan dated 1/13/22 revealed Resident #28 was care planned for Urinary Tract Infection (UTI) and urinary catheter related trauma. The resident uses a condom catheter as needed (PRN).	F 690	The Laurels of Chatham ensures that a resident who is continent of bowel and bladder upon admission receives services to maintain continence unless due to a clinical condition, continence is not possible to maintain. Corrective Action As the order for the condom catheter had dropped off after a recent hospital admission, a clarification order has been written to apply the condom catheter each morning and remove it at night when guest lies down. Resident #28 likes to sit up for extended periods and the condom catheter allows for this, as the resident is continually incontinent. The incontinent device we use has a backflow device that prevents any backflow of urine, but we are mounting it to the frame of the bed and the frame of the wheelchair for gravity flow. Corrective Action for those having the potential to be affected Any resident that is requiring an external condom catheter for PRN use are at risk for this alleged deficient practice and are identified through the MDS care plan process. An audit of all orders for those that use a condom catheter was completed at the time of notification. No other clarification order was found to be necessary. Systemic Changes	

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F 690	Continued From page 11 Review of the physician notes dated 1/25/22 revealed the resident was followed up on chronic conditions regarding primary diagnoses of Wilson's disease. In the physician notes there was no mention of the condom catheter. On 2/23/22 Resident #28's physician's order (initiated on 4/16/21) for a condom catheter PRN for coccyx wounds was discontinued. Review of the physician notes dated 2/25/22 revealed the resident was followed up on chronic conditions regarding primary diagnoses of Wilson's disease. In the physician notes there was no mention of the condom catheter. Physician Orders dated 3/14/22 read in part "may use condom catheter as needed ". This order included no instructions for staff that specified the indications for PRN use. Resident #28 was observed on the following dates and times with condom catheter in use: - 3/14/22 at 11:35 and 12:45 PM - 3/15/22 at 8:15 AM, and 11:21 AM, - 3/16/22 at 12:45 PM and 2:00 PM - 3/17/22 at 4:00 PM During an interview on 3/15/22 at 2:00 PM, Nurse #4 indicated was assigned to the Resident #28. Nurse #4 stated the resident had orders to use condom catheter as needed. Nurse #4 indicated the Nurse Aides (NAs) utilized the condom catheter in the morning as the resident had a tendency of holding his urine in the bladder and when voided he had a high volume of urine. Nurse #4 stated the NAs assisted with replacing the catheter and emptying the catheter drainage	F 690	A 100% re-education of licensed staff has been completed by the Assistant Director of Nurses by 3/31/22 regarding having a complete order for a PRN condom catheter, to include indication of when to use it and to keep it below the level of the bladder. In addition, new nurses will be educated during their onboarding orientation. All nurses will be reminded through the Point Click Care (PCC) charting dashboard through the next quarter, by the DON and/or her nurse managers, to check their condom catheters for position of the drainage bag. Monitoring The Director of Nurses, and/or her nurse manager, will perform audits weekly times one month, then bi-weekly for one month and then monthly for one month, of all residents that have PRN orders for condom catheters, utilizing an audit tool and reviewing for proper orders, as well as placement of drainage bag. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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bag. Nurse #4 indicated Resident #28 was dependent on staff for Activities of Daily Living (ADL) care. Nurse #4 confirmed the NAs utilized condom catheter on a regular basis due to high urine volume.

During an interview on 3/16/22 at 10:51 AM, Nurse #5 stated she was the Unit Manager for Station 1, the hallway that Resident #28 resided. Nurse #5 stated the resident had a condom catheter with an order to use on as needed basis. Nurse #5 indicated the nursing staff utilized the condom catheter as needed. Nurse #5 was unsure how the staff decided when to use the condom catheter.

During an interview on 3/16/22 at 12:55 PM, NA #4 indicated she was frequently assigned to Resident #28. NA #4 further indicated the staff utilized the condom catheter for Resident #28 daily during the day and did not utilize it at night. NA #4 stated the second shift (3PM - 11PM) staff usually removed the condom catheter when the resident was laid to bed. The condom catheter was applied on the resident daily in the morning by the third shift (11 PM - 7 AM) staff after early morning incontinent care or by the first shift (7AM- 3PM) after morning bath/shower.

During an interview on 3/16/22 at 1:45 PM, NA #10 stated she was assigned to Resident #28 multiple times and was aware of resident's needs. The resident was bladder incontinent and had a high urine volume. NA #10 indicated the staff utilized the condom catheter for Resident #28 daily, mostly during the day.

On 3/17/22 at 3:53 PM during an interview, Nurse #6 stated she was usually assigned to Resident

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#28. Nurse #6 stated the resident had an order for condom catheter as needed. Nurse #6 further stated the staff utilized the condom catheter for Resident #28 during the day and the staff removed the condom catheter at night, prior to the resident lying to sleep. Nurse #6 indicated the resident had no urinary tract infection or any perineal or penis skin wound. The condom catheter was used because the resident had high urine volume. She was unable to explain why the PRN order for the condom catheter was utilized daily.

On 3/17/22 at 4:03 PM, during an interview, NA #11 stated she was assigned to the Resident #28 during the second shift (3 PM - 11 PM). NA #11 stated the resident had a condom catheter during the day and it was removed when the resident went to bed at night. NA #11 indicated the resident was always bladder incontinent and had a high urine volume.

On 3/16/22 at 3:20 PM, during an interview, Physician #1 indicated that she did not give the order for condom catheter as needed for the Resident #28. In general, the indication for an as needed condom catheterization could be due to presence of local wounds, which the Physician could not find in the chart. She expected the staff to call the physician on call for condom catheter application.

On 3/16/22 at 4:20 PM, during a telephone interview, Physician #2 indicated that he did not know the reason for order of the condom urinary catheter as needed. In general, it could be done for the short time, related to doctors' appointment outside of facility. He was unable to explain why the facility staff utilized the condom catheter daily

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for Resident #28.

On 3/17/22 at 4:30 PM, during an interview, the Director of Nursing (DON) indicated Resident #28 was care planned for a condom catheter. The condom catheter was utilized for Resident #28 when going out of the facility for appointments and leave of absence. DON indicated the resident was admitted with the condom catheter. The order was discontinued on 2/23/22. The DON stated on 3/14/22, the Unit Manager was conducting an audit related to catheters when she realized that the resident did not have an order for use of condom catheter, and that the condom catheter was still being utilized. The DON stated the physician was contacted and a new order obtained on 3/14/22 to use the condom catheter as needed. The DON reiterated that the condom catheter was used by the resident when he had an appointment and had to go out of facility or for leave of absence (LOA).

1b. Review of the annual Minimum Data Set (MDS) assessment dated 1/7/22 revealed the Resident #28 was assessed as cognitively intact. Assessment indicated the resident had an external catheter.

Review of the care plan dated 1/13/22 revealed Resident #28 was care planned for Urinary Tract Infection (UTI) and urinary catheter related trauma. The resident used a condom catheter as needed (PRN). Interventions included positioning the urinary catheter drainage bag and tubing below the level of the bladder.

During an observation on 3/14/22 at 11:35 AM, Resident #28 was observed lying in bed with his urinary catheter in place and catheter drainage

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F 690	Continued From page 15 bag on bed, between resident legs at the same level as the bladder. During an interview on 3/14/22 at 11:50 AM, the Nurse Aide (NA) #4, assigned to the Resident #28, stated the resident had a condom catheter. NA stated she just gave the resident a bath and emptied the catheter drainage bag. During an interview on 3/16/22 at 3:20 PM, Physician #1 stated she preferred to have Resident #28's urinary drainage bag attached to his leg when awake and to the bed frame when lying in bed below the bladder. On 3/16/22 at 4:20 PM, during an interview, Physician #2 confirmed that the position of the urinary drainage bag on the bed, was not appropriate. The drainage bag must be mounted on the bed frame for gravity. The Physician #2 was not sure if the facility had standing order for the urinary catheter care and preferred to leave this determination on facility's administration. On 3/17/22 at 4:30 PM, during an interview, the Director of Nursing (DON) stated the catheter drainage bag and tubing should be placed below the bladder level and properly secured to the bed or wheelchair, depending on where the resident was located.	F 690		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs.	F 805		4/7/22

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F 805	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to provide pureed diet, according to physician orders for 1 of 6 residents (Resident # 18) during dining observation. Findings included: Resident # 18 was readmitted to the facility on 10/22/20 with diagnoses that included protein-calorie malnutrition, dysphagia, and congestive heart failure. Review of the significant change Minimum Data Set (MDS) assessment, dated 3/1/22, indicated Resident # 18 was assessed as severely cognitively impaired. The assessment indicated the resident received mechanically altered diet. Review of the physician's orders for Resident #18 dated 3/14/22 read in part " regular diet, pureed texture, and thin consistency". During a dining observation on 3/16/22 at 12:20 PM, Resident # 18 was observed in her room, sitting in her bed, and staring at her meal tray. Resident had not touched her tray and did not seem interested in the food. Review of the resident's meal ticket revealed the resident was on pureed diet. Review of the meal tray revealed the resident received regular texture diet which consists of carrots, chicken, and scalloped potatoes. The staff was alerted, the tray was removed, and the resident was provided pureed diet. During an interview on 3/16/22 at 12:45 PM, the Nurse aide (NA)# 3 indicated she was unsure	F 805	F805 Food in Form to Meet Individual Needs The Laurels of Chatham ensures that each resident receives, and the facility provides food designed to meet individual needs. Corrective Action Resident #18, although this time received the incorrect consistency, has been and is receiving the correct meal consistency. Corrective Action for those having the potential to be affected Any resident that is on a mechanically altered diet is at risk for this alleged deficient practice and will be identified through the MDS care plan process. A 100% audit was completed by the DON and/or her nurse managers, of all other guests with mechanically altered diets for a meal, to ensure proper diets were served. The dietary staff member that plated the tray has been re-educated. All nursing staff have been re-educated regarding identification of the meal being served and the diet ordered. Systemic Changes All nursing staff re-education has been completed by the Assistant Director of Nurses regarding the importance of the correct consistency to be delivered. All dietary staff has been re-educated	

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F 805	Continued From page 17 who had served Resident #18 her lunch tray. Nurse aide stated it was the responsibility of all staff to check the resident's meal tray for accuracy (diet and texture) before serving tray to the residents. During an interview on 3/16/22 at 12:50 PM, NA # 4 indicated she was assigned to the Resident #18 but had not served the resident her lunch tray. NA #4 stated she was assisting residents in the dining room and other staff had assisted with serving trays to residents eating in their rooms. During an interview on 3/16/22 at 1:00 PM, NA #5 indicated that she had assisted in serving meal trays to residents in hallway but had not served meal tray to Resident #18. She further indicated she was unsure who served the resident her lunch tray. During an interview on 3/16/22 at 1:10 PM, the dietary manager indicated the tray line had 3 dietary staff. One dietary aid read out the meal ticket, the cook platted the meal, and another dietary staff checked the trays before placing the tray in the insulated tray cart. Dietary manager indicated a NA usually come to the dining room prior to start of tray line and reviewed the tray tickets. Meal tickets of all residents who plan to eat in the dining area were removed and kept aside by the NA. Dietary Manager stated the NA came in late to review the meal tickets and the tray line had already been started. The dietary staff had already started plating resident meals to be sent to the hallway. There was some confusion and the tray line had to be stopped. The Dietary Manager indicated this was a very rare incident, and unsure how the dietary staff had made an error and wrong meal was served to	F 805	regarding ensuring the correct consistency is plated. The tray ticket system has been enhanced to provide a picture of the patient, and it is now highlighted for meals that are any consistency other than regular. Monitoring The Director of Nurses, and/or her nurse manager, will perform audits 5 times weekly x 1 week, then 3 x weekly x 1 week, then weekly x 2 weeks, then bi-weekly for one month and then randomly for a month of all residents that have mechanically altered diets. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 805	Continued From page 18 the resident. During an interview on 3/16/22 at 1:20 PM, the Director of Nursing (DON) stated she was not sure who had served the resident her lunch tray. DON further stated the resident was supervised at eating and needs a lot of encouragement to eat. Resident #18 was assisted with feeding as needed. The resident's diet was recently changed from mechanically soft diet to pureed diet to encourage resident to consume her meals. DON stated the dietary staff, and the nursing staff should check the tray for accuracy before serving trays to the residents.	F 805		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		4/7/22

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F 812	Continued From page 19 Based on observations, interviews and record review the facility failed to keep the "Cook's" reach-in refrigerator clean, failed to label and date foods in the "Line's" reach-in refrigerator and 3 of the 3 nourishment refrigerators (station 1, memory unit and station 2 nourishment refrigerators). The facility failed to maintain food in the walk-in freezer without freezer burn. The facility failed to maintain the ice machine clean. Findings included: 1.Observation of the "Cook's" reach-in refrigerator on 3/14/22 at 9:30 AM revealed yellow colored dried food stains and bluish/ blackish stains on the inside walls of the refrigerator. Review of the cleaning schedule revealed the small reach in refrigerators should be cleaned inside out and dates on items should be checked daily. During an interview on 3/14/22 at 9:35 AM, the dietary manager indicated that black marks on the inside of the refrigerator was that of food labels. The dietary manager stated staff should be cleaning the reach-in refrigerators daily, on regular basis. Dietary manager indicated that the dietary cooks were responsible for cleaning the Cook's reach-in refrigerators. He further stated that the dietary assistant manager was in the process of cleaning the refrigerator that morning. 2. Observation of the "Line" reach- in refrigerator on 3/14/22 at 9:45 AM revealed 2 plastic pitchers half filled with brownish colored liquid. The plastic pitchers were not labeled or dated.	F 812	F812 Store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The facility ensures that food is stored and distributed in accordance with professional standards. Corrective Action The Cook’s reach-in refrigerator has been cleaned, the items in the Line’s reach-in, and the 3 nourishment rooms have been labeled and dated, and items with any freezer burn in the walk-in freezer have been discarded, all by the dietary staff. The ice machines have been cleaned as well. Corrective Action for those having the potential to be affected All areas of food storage that contain items that are left over or contain prep foods, as well as ice machines, have the potential to be affected by this alleged deficient practice and are identified during daily rounds performed by the dietary department. All these items have been reviewed by the Dietary Manager and have been corrected. Systemic Changes The dietary staff has been re-educated by the dietary manager regarding assigned duties of the cooks and aides for cleaning, labeling, and discarding items. Signs have been posted on each refrigerator to	

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F 812	Continued From page 20 During an interview on 3/14/22 at 9:45 AM, the dietary manager indicated the brown colored liquid in the plastic pitchers was apple juice. The dietary manager stated he was unsure when these pitchers were used. The dietary manager further stated all food placed in the refrigerators should be labeled and dated. 3a. Observation of the nourishment refrigerator#1 (station1) on 3/14/22 at 9:50 AM revealed a half-filled 1.4 quarts bottle of thickened iced tea with date 2/28 written on the bottle cap. The dietary manager was interviewed, and he indicated the date on the cap was the date the bottle was received from the vendor. The dietary manager stated that any thickened liquid bottles that were opened should be labelled and discarded after 24 hours of opening. He stated he was unsure when the thickened liquid bottle was opened. 3b. Observation of the nourishment refrigerator #2(memory unit) on 3/14/22 at 9:55 AM revealed a clear take-out container with pie slices and a plastic container containing a slice of pie that were not labeled and dated, a half-filled plastic pitcher with brown colored liquid that had no label and date. The refrigerator also contained a 3.5-ounce (oz) of store brought yogurt, 20 oz sports drink and 7.5 oz of soda can that was not labeled. The refrigerator also contained 5 cups of pudding dated "3/9". The nourishment freezer contained a Styrofoam cup of drink from a fast-food restaurant. There was also a Styrofoam cup with ice cubes and cream color solid in it. During an interview on 3/14/22 at 9:58 AM the dietary manager stated the clear plastic take-out container contained pie slices that were served	F 812	remind everyone what can be stored in it and the timeframe that the item can be in there and when it needs to be discarded. The Maintenance Director has been re-educated by the administrator regarding the cleaning schedule of the ice machines. Monitoring The Director of Nurses, and/or her nurse managers, will perform audits 5 times weekly x 1 week, then 3 x weekly x 1 week, then weekly x 2 weeks, then bi-weekly for one month and then randomly for a month of the refrigerators in the nourishment rooms, on their assigned units. The Dietary Manager will perform audits of the refrigerators and freezer in the kitchen, and the ice machine, 5 times weekly x 1 week, then 3 x weekly x 1 week, then weekly x 2 weeks, then bi-weekly for one month and then randomly for a month. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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for resident's dinner meal. These slices were removed from the resident's tray to be served to the residents later at night. The dietary manager further stated the yogurt, soda can, and sports drink stored in the refrigerator were brought in by resident's family members. Any food brought in by the resident's family members should be labelled with resident's name and dated. He indicated any staff accepting the resident's food brought in by family should label and date the food. The dietary manager indicated the 5 cups of pudding were sent out as snack on 3/9/22. This was prepared by the kitchen staff and should be consumed within 3 days. Prepared food should be discarded after 3 days. The dietary manager stated he usually checks all nourishment refrigerators in the morning and discard any unused and expired food. Dietary manager indicated staff should not be placing any personal food in the nourishment refrigerator.

3c. Observation of the nourishment refrigerator#3 (station2) on 3/14/22 at 10:02 AM revealed a half-filled 1.4 quarts bottle of thickened iced tea with date 3/8 written on the bottle cap. The dietary manager indicated the date on the cap indicated the date the bottle was received from the vendor. The dietary manager stated that any thickened liquid bottles that were opened should be labelled and discarded after 24 hours of opening. He stated he was unsure when the thickened liquid bottle was opened.

4. Observation of the walk-in freezer on 3/14/22 at 9:35 AM revealed food stacked on the shelves were overloaded and did not allow proper circulation. There were four (4} clear bags of raw meat in the bottom shelf which had freezer burn and ice crystals on them. One clear bag

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containing food wrapped in aluminum foil, labelled "Pork loin 1/23" filled ice crystals in it. One clear bag with raw meat, labelled "chicken legs 2/25" with freezer burn and ice crystals inside the bag.

During an interview on 3/14/22 at 9:38 AM, the dietary manager indicated that the four clear bags of raw meat was marinated chicken. Dietary manager stated the aluminum foil contained left-over food that was frozen and could be kept in the freezer for 6 months. He further stated he was unsure how there were ice crystals inside the bags and meat had freezer burn.

5. Observation of the ice machine on 3/14/22 at 9:47 AM revealed a plastic bag filled with ice resting on top of the ice

During an interview on 3/14/22 at 9:48 AM, the dietary manager stated the dietary staff usually filled a plastic bag with ice for residents in COVID unit. The bag was filled and placed on ice inside the ice machine, until it was ready to be placed on the cart that was sent to the COVID unit.