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 02/09/2023

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/6/23 through 2/9/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# HZHR11.	E 000		
F 000	INITIAL COMMENTS A recertifiction and complaint investigation survey was conducted from 2/6/23 through 2/9/23. Event ID# HZHR11. The following intakes were investigated NC00189390, NC00191909, NC00191905, NC00195448, NC00195560, NC00189304, NC00190831, NC00197736 and NC00197870. 9 of the 29 complaint allegations resulted in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		3/3/23

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

Electronically Signed | 02/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide a dignified dining experience by providing residents with disposable food containers and plastic utensils during three observed meals (Resident #89 and Resident #31) and referring to a resident who needed assistance with meals as a "feeder" (Resident #75). This was for 3 of 9 residents reviewed for dignity. Based on the reasonable person concept residents would expect to utilize regular plates and utensils regardless of how fast they eat and would not expect to be identified as a "feeder." Requiring a resident to utilize disposable food containers and plastic utensils while other residents were not or being labeled a "feeder" has the potential for a reasonable person	F 550	The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is March 3, 2023. 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. F550 Resident Rights/Exercise of Rights:	

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F 550	Continued From page 2 to experience a negative psychosocial outcome. The findings included: 1. Resident #89 was admitted to the facility on 03/06/2020 with diagnoses which included unspecified dementia and hypertension. The quarterly Minimum Data Set (MDS) assessment dated 01/27/23 indicated Resident #89's cognition was coded as rarely/never understood and required supervision with eating by one person. A record review revealed no order indicating Resident #89 needed to utilize disposable food containers or plastic utensils. On 02/06/23 at 11:53 AM Resident #89 was observed to be utilizing disposable food containers and plastic utensils in the dining room while her other 3 tablemates were utilizing regular plates and utensils. On 02/07/23 at 11:47 AM Resident #89 was observed to be utilizing disposable food containers and plastic utensils in the dining room while her other 2 tablemates were utilizing regular plates and utensils. On 02/0/23 at 11:51 AM Resident #89 was observed to be utilizing disposable food containers and plastic utensils in the dining room while her other 2 tablemates were utilizing regular plates and utensils. During an interview with Nurse Aide #8 on 02/08/23 at 12:00 PM revealed Resident #89 "eats slowly" so the facility gave her disposable food containers and plastic utensils, so they do	F 550	The facility will continue to ensure that residents are provided a dignified dining experience. Corrective Action: Residents #89, #31, and #75 will continue to be provided with a dignified dining experience as evidenced by staff providing meals using standard dishes and silverware and not using labels to describe the level of assistance required with eating. No negative psychosocial outcome was identified relating to these observations. How the facility will identify those who have the potential to be affected: Current residents that require assistance with eating have the potential to be affected and are identified through the careplan process. . Current residents that require assistance with eating were observed during mealtime on 2.21.22 by the Director of Nurses (DON) and Unit Manager to ensure that they are being provided with a dignified dining experience. No negative psychosocial outcome was identified relating to these observations. Systemic changes: 100% of all nursing assistants will be inserviced by the Assistant Director of Nurses (ADON) as of 2.28.23 on ensuring that residents that require assistance with eating are provided with a dignified dining experience. Newly hired staff Certified Nursing Assistants (c n a)'s and agency c n a 's that are hired after 2.28.23 will be educated by the ADON on the facility	

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F 550	Continued From page 3 not have to keep the meal cart on the floor. On 02/08/23 at 12:05 PM the Dietary Manager was interviewed. He stated he was told by facility staff Resident #89 was a "late riser" and was instructed by staff to provide her with disposable food containers and plastic utensils for all meals. He indicated he requested speech therapy to obtain an order for these items. The Rehab Director was interviewed on 02/08/23 at 1:10 PM. She stated utilizing disposable food containers and plastic utensils were not a speech therapy treatment or intervention. This would not have been ordered by speech therapy. A joint interview with the Director of Nursing (DON) and the Administrator on 02/09/23 at 1:23 PM revealed Resident #89 should not have had disposable food containers or plastic utensils because this was a dignity concern. 2. Resident #31 was admitted to the facility on 05/22/21 with diagnoses that included unspecified dementia with other behavior disturbance and hypertension. The annual Minimum Data Set (MDS) dated 01/30/23 indicated Resident #31's cognition was severely impaired and was independent with eating requiring setup assistance. She was coded as not having hallucinations, delusions, or experienced physical or verbal behaviors. There was no documentation in Resident #31's Electronic Medical Chart indicating the rationale for Resident #31's needing disposable food containers or plastic utensils.	F 550	policy on ensuring that residents that require assistance with eating are provided with a dignified dining experience. Monitoring: A Quality Assurance (QA) monitoring tool will be utilized to ensure ongoing compliance by the Unit Manager beginning on3.1.22. The Unit Manager will randomly observe staff assisting 3 residents with eating at each meal 3x/week x 4 weeks then weekly x 4 weeks then randomly x 4 weeks. Variances will be corrected at the time of observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified. will be corrected at the time of observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored	

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F 550	Continued From page 4 On 02/06/23 at 11:53 AM Resident #31 was observed to be utilizing disposable food containers and plastic utensils in the dining room while her other 3 tablemates were utilizing regular plates and utensils. On 02/07/23 at 11:47 AM Resident #31 was observed to be utilizing disposable food containers and plastic utensils in the dining room while her other 2 tablemates were utilizing regular plates and utensils. On 02/0/23 at 11:51 AM Resident #31 was observed to be utilizing disposable food containers plate and plastic utensils in the dining room while her other 2 tablemates were utilizing regular plates and utensils. During an interview with Nurse Aide #8 on 02/08/23 at 12:00 PM revealed Resident #31 "eats slowly" so the facility gave her disposable food containers and plastic utensils, so they do not have to keep the meal cart on the floor. On 02/08/23 at 12:05 PM the Dietary Manager was interviewed. He stated he was told by facility staff Resident #31 was a "late riser" and was instructed by staff to provide her with disposable food containers and plastic utensils for all meals. He indicated he requested speech therapy to obtain an order for these items. The Rehab Director was interviewed on 02/08/23 at 1:10 PM. She stated utilizing disposable food containers and plastic utensils were not a speech therapy treatment or intervention. This would not have been ordered by speech therapy. A joint interview with the Director of Nursing	F 550	through the facility's Quality Assurance Program Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified. The Administrator will be responsible to ensure any recommendations from the QA committee are carried out.	

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F 550	Continued From page 5	F 550		

(DON) and the Administrator on 02/09/23 at 1:23 PM revealed Resident #31 should not have had disposable food containers or plastic utensils because this was a dignity concern.

3. Resident #75 was admitted to the facility on 07/02/21 with diagnoses which included Unspecified dementia, hypertension, and anxiety.

The quarterly Minimum Data Set dated 01/19/22 indicated Resident #75's cognition was coded as rarely/never understood and had no hallucinations, delusions, or rejection of care. Resident #75 required extensive assistance with 1 person with dressing, eating, toilet use, and personal hygiene.

During observation on 02/06/23 at 11:53 AM, Nurse Aide #9 was observed in the dining room of the memory care unit assisting with meal pass. Nurse Aide #9 stated Resident #75 was a "feeder." The statement could be heard throughout the entire dining room where other residents were present.

During an interview on 02/07/23 at 12:19 PM Nurse Aide #9 stated she remembered identifying Resident #75 as a "feeder." She stated she called her a "feeder" because she needed help being fed her meals. She stated she called all residents "feeders" if they need assistance with meals.

A joint interview with the Director of Nursing (DON) and the Administrator on 02/09/23 at 1:23 PM revealed it was their expectation that staff never utilize labels such as "feeder" to describe a resident and staff were to say a resident required assistance with eating.

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F 551	Continued From page 6	F 551		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under	F 551		3/3/23

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F 551	Continued From page 7 State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews with staff, Responsible party, the facility failed to transfer a resident to the hospital when the Responsible Party's (RP) made the request for 1 of 1 (Resident #119) reviewed for choices. The findings included: Resident #119 was admitted to the facility on 1/9/2023 with diagnosis that included dementia and fracture after a fall. The resident's admission Minimum Data Set (MDS) dated 1/13/2023 indicated the resident	F 551	F551 Rights Exercised by Representative The facility will continue to ensure that residents are transferred to the hospital when the Responsible Party makes the request. Corrective Action: Resident #119 no longer resides at the facility. How the facility will identify those who have the potential to be affected: Current residents that experience a change in condition which may result in consideration of hospital transfer have the potential to be affected. Current residents	

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F 551	Continued From page 8 was severely cognitively impaired and required extensive assistance with activities of daily living. The resident's medical record included a progress note dated 1/28/2023 by Nurse #10. The progress note indicated Resident #10 was found on the floor next to her bed. The nurse assessed the resident for injuries, notified the RP and the Medical Director, and placed the resident on neurological observations. Then at 2:35PM Nurse #10 documented a progress note that read in part, "guest with continued labored breathing yet no signs or symptoms of pain. MD notified of clinical situation and new orders were written for Ativan every 6 hours. A phone interview was conducted with the resident's RP on 2/8/2023 at 4:00PM. The RP stated when she reached the facility on 1/29/2023 during the evening. She did not recall what time. She stated the resident was in obvious distress breathing rapidly and crying. The RP spoke with Nurse #10 and asked what was being done to make the resident more comfortable because if they could not make her comfortable, she wanted the resident transferred to the hospital. The RP stated Nurse #10 reported giving the resident pain medications and stated she would call the physician on call for additional orders if needed. The RP stated the resident received pain medications on two separate occasions and continued to be in distress. The RP stated she approached Nurse #10 again and stated she would like the resident transferred to the hospital. At that point, Nurse #10 stated she would call the physician on call back. The nurse then asked the RP to speak with the physician on call. The RP	F 551	were reviewed on 2.21.23 for changes in condition. No negative outcome was identified relating to these observations. Systemic changes: 100% of all licensed nurses will be inserviced by the ADON as of 2.28.23 on ensuring that residents are transferred to the hospital when the Responsible Party makes the request. Newly hired staff nurses and agency nurses that are hired after 2.28.23 will be educated by the ADON on the facility policy on ensuring that residents are transferred to the hospital when the Responsible Party makes the request. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 3.1.22. The DON/designee will review nursing documentation 5x/week x 12 weeks. Variances will be corrected at the time of observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.22 who will be responsible for reporting identified concerns to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled meetings or until resolved and additional education/training will be provided for any	

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F 551	Continued From page 9	F 551		

stated the physician asked her what her goal was in transferring the resident to the hospital. The RP stated she wanted the resident to be comfortable, she perceived the resident was in distress for several hours despite treatments provided by the facility. The RP told the physician that she would call 911 and have the resident transferred if the facility did not.

The resident's medical record contained a progress note dated 1/29/2023 6:45PM by Nurse #10 that read as follows: "Nurse assured family that comfort measures could be made at the facility and morphine and Ativan were comfort measures used in the plan of care."

Progress note dated 1/29/2023 at 8:50PM by Nurse #10 read in part, "daughter continues to request the resident be transferred." Received order to send resident out.

On 2/8/2023 at 2:47PM and interview was conducted with Nurse #10. She stated she recalled the resident's fall from bed. She stated she notified the physician on call and the Resident's RP. She began neurological assessments on the resident 1/28/2023 at 3:30PM. Nurse #10 stated she was in the facility and assigned to the resident on 1/29/2023 when she displayed a change in condition. Nurse #10 stated she did speak with the RP on several occasions that night and the RP did request the resident be transferred to the hospital. She stated she informed the RP the facility could provide comfort measures and keep the resident comfortable, but the daughter did not believe the resident was comfortable. Nurse #10 stated she called the physician on call and had her speak to the RP. The resident was transferred to the

issues identified.

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F 551	Continued From page 10 hospital around 9:00PM. The nurse stated the resident was not on hospice services and there was not an order for comfort care. On 2/9/2021 at 1:00PM and interview was conducted with the Director of Nursing (DON) and Administrator. The Administrator stated the resident should have been sent to the hospital when the RP requested.	F 551		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not	F 561		3/3/23

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 561	Continued From page 11 interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to honor a resident's choice related to showers (Resident #66) for 1 of 2 residents reviewed for choices. The findings included: Resident #66 was admitted to the facility on 12/8/20 with diagnoses that included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and muscle weakness. A quarterly Minimum Data Set (MDS) assessment dated 1/17/23 indicated Resident #66 was cognitively intact and displayed no behaviors or rejection of care. He required total assistance from staff for bathing and personal hygiene. Resident #66's active care plan, last reviewed 1/20/23, included a focus area for ADL self-care performance deficit and requires assistance with ADLs and mobility related to decline in mobility and dementia. A review of Resident #66's nursing progress notes from 9/1/22 to 1/8/23 revealed no refusals of showers documented. A review of the facility's shower schedule indicted Resident #66 was scheduled to receive a shower on Wednesday and Saturday evening shift (3:00 PM to 11:00 PM).	F 561	F561 Self-Determination The facility will continue to honor resident choices related to showers. Corrective Action: Resident #66 is receiving showers as scheduled per resident choice. No negative outcome was identified relating to this observation. How the facility will identify those who have the potential to be affected: Current residents have the potential to be affected. Current resident shower schedules were reviewed as of 2.24.23 to ensure that resident choices related to showers are being honored. No negative outcome was identified relating to these observations. Systemic changes: 100% of nursing assistants and licensed nurses will be inserviced by the ADON by 2.28.23 on ensuring that residents are receiving showers as scheduled and per resident choice. Newly hired staff and agency c n a's and staff and agency licensed nurses that are hired after 2.28.23 will be educated by the ADON on the facility policy on ensuring that residents are receiving showers as scheduled and per resident choice. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the Unit Manager/designee beginning on	

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 02/09/2023

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F 561	Continued From page 12 Resident #66's Nurse Aide Flow Record for December 2022, January 2023 and February 2023 were reviewed and revealed assistance with bathing was not documented as provided or refused by the resident on 12/31/22, 1/21/23 and 2/1/23. The form did not differentiate if showers or bed baths were provided to Resident #66. The form asked, "Did the resident receive a shower/bath/bed bath" and the answers were either yes, no, or not applicable. On 2/6/23 at 11:12 AM, an interview occurred with Resident #66 who stated he couldn't remember the last time he received a shower but would like one. He indicated staff provided him with a bed bath only. Resident #66 was clean and free from odors; however, his skin was dry and flaky in appearance at the time of the interview. An interview was conducted with Nurse Aide (NA) #3 on 2/8/23 at 11:36 AM who was familiar with Resident #66. Stated she has been working at the facility for the past two months and gave Resident #66 a shower when she first came to the facility. She recalled him saying he didn't like it, so she had never offered him a shower since. Stated on his scheduled shower days she provided him with a bed bath only. On 2/8/23 at 12:11 PM, an interview was held with NA #4 who was familiar with Resident #66 but stated she could not recall if she gave him a shower or bed bath on his scheduled shower days. NA #5 was interviewed on 2/8/23 at 2:52 PM and explained that in the past Resident #66 would often decline a shower when offered so she gave him a bed bath on his scheduled shower day. NA	F 561	3.1.23. The Unit Manager/designee will audit scheduled shower documentation and interview residents 6x/week x 4 weeks then 3x/week x 4 weeks then weekly x 4 weeks ensure that residents are receiving showers as scheduled and per resident choice. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.23, who will be responsible for reporting concerns to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified.	

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F 561	Continued From page 13 #5 denied asking him whether he would like a shower or not. She further explained the NA Flow Record for bathing didn't have a place to state which type of bath he received only whether he was bathed or not. Multiple attempts were made to contact NA #6 on 2/8/23 and 2/9/23, without success. She was the NA that had not marked if assistance with bathing was provided on 12/31/22 (Saturday), 1/21/23 (Saturday) or 2/1/23 (Wednesday). The Director of Nursing was interviewed on 2/9/23 at 1:01 PM and stated she would expect Resident #66 to be offered a shower on his scheduled shower day and if he refused then be provided with a bed bath. In addition, any refusals should be reported to the nursing staff so that documentation could be made in the nursing progress notes.	F 561		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of cognition (Residents #89, #87 & #19), pressure ulcer (Resident #114) and diagnoses (Resident #28) for 5 of 31 residents whose MDS were reviewed. Findings included:	F 641	F641 Accuracy of Assessments The facility will continue to code assessments to accurately reflect the resident's status. Corrective Action: Residents #87, #114, #28, #89, and #19 had MDS corrections completed by 2.9.23 by the Minimum Data Set (MDS Careplan coordinator). No negative outcome was identified relating	3/3/23

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F 641	Continued From page 14 1. Resident #87 was admitted to the facility on 3/25/20. The annual MDS assessment dated 1/24/23 indicated that Resident #87 had unclear speech, sometimes made self-understood and usually understood others. The Brief Interview for Mental Status (BIMS), used to screen and identify cognitive conditions, was noted as not completed because Resident #87 was rarely/never understood. The Social Worker (SW) Assistant was interviewed on 2/8/23 at 10:17 AM. The SW indicated that she was responsible for completing the BIMS assessment for the MDS assessment. She stated that she was new to the facility and was still learning the process. The MDS Nurse was interviewed on 2/9/23 at 10:50 AM. The MDS Nurse reported that Resident #87's speech was not clear, but he was able to understand. She stated that the BIMS interview should have been conducted for the resident by the SW. The Director of Nursing (DON) and the Administrator were interviewed on 2/9/23 at 12:58 PM. The DON stated that she expected the MDS assessments to be accurate. 2. Resident #114 was admitted to the facility on 11/17/22 and was readmitted on 1/12/23. Resident #114 had a physician's order dated 1/12/23 for zinc oxide based and water absorbing cream (provides a moist wound environment facilitating the debridement of devitalized tissue) to the deep tissue injury (DTI) on the left buttock every shift.	F 641	to these observations. How the facility will identify those who have the potential to be affected: Current residents with MDS assessments that are coded as BIMS not completed due to rarely/never understood and no staff interview completed, current residents with pressure ulcers, and current residents with diagnoses of Hypothyroidism and Atrial Fibrillation, have the potential to be affected. All current residents that meet these criteria were reviewed by 2.24.23 by the MDS Careplan Coordinator to ensure that assessments had been completed that accurately reflect each resident's status. No negative observations were identified. Systemic changes: The MDS Coordinator and Social Worker were inserviced by the Clinical Resource Specialist on 2.28.23 on completing assessments that accurately reflect the residents status. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 3.1.23. The DON/designee will randomly audit 5 resident MDS□s weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 4 weeks to ensure that MDS assessments are being completed that accurately reflect the residents status. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the	

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F 641	Continued From page 15 The Treatment Administration Records (TARs) for January 2023 revealed that Resident #114 had received treatment to the left buttock pressure ulcer from 1/12/23 through 1/24/23. The significant change in status Minimum Data Set (MDS) assessment dated 1/19/23 indicated that Resident #114 did not have a pressure ulcer. The Treatment Nurse was interviewed on 2/9/23 at 10:45 AM. She stated that Resident #114 was readmitted from the hospital with a DTI to her left buttock on 1/12/23. The MDS Nurse was interviewed on 2/9/23 at 10:50 AM. She reported that she was not aware that Resident #114 was readmitted with a pressure ulcer to her left buttock since there was no pressure ulcer assessment on admission. She stated that she didn't look at the orders nor the TARs when she completed the MDS assessment dated 1/19/23. The Director of Nursing (DON) and the Administrator were interviewed on 2/9/23 at 12:58 PM. The DON stated that she expected the MDS assessments to be accurate. 3. Resident #28 was admitted to the facility on 9/30/22. Resident #28 had physician's orders dated 9/30/22 for Levothyroxine 88 micrograms (mcg) 1 tablet by mouth daily for hypothyroidism and Apixaban 5 milligrams (mgs) 1 tablet by mouth twice a day for Atrial Fibrillation.	F 641	Administrator weekly for the next 3 months beginning on 3.8.23, who will be responsible for reporting concerns to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified.	

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 641	Continued From page 16	F 641		

The Medication Administration Records (MARs) for December 2023 revealed that Resident #28 had received Levothyroxine and Apixaban during the MDS look back period.

Resident #28's significant change in status Minimum Data Set (MDS) assessment dated 12/6/22 did not indicate that the resident had diagnoses of Hypothyroidism and Atrial Fibrillation.

The MDS Nurse was interviewed on 2/9/23 at 10: AM. She reviewed the physician's orders and the Medication Administration Records (MARs) for Resident #28 and verified that the resident had received Levothyroxine and Apixaban during the MDS look back period. The MDS Nurse indicated that she missed noting Hypothyroidism and Atrial Fibrillation on the 12/6/22 MDS assessment.

The Director of Nursing (DON) and the Administrator were interviewed on 2/9/23 at 12:58 PM. The DON stated that she expected the MDS assessments to be accurate.

4. Resident #89 was admitted to the facility on 03/06/20 with diagnoses that included unspecified dementia, anxiety disorder, and hypertension.

The quarterly Minimum Data Set (MDS) assessment dated 01/27/23 indicated Resident #89 had unclear speech, was sometimes understood, and sometimes understands. The Brief Interview for Mental Status (BIMS, used to screen and identify cognitive conditions) was noted as not completed because Resident #89 was rarely/never understood, and the staff

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 641	Continued From page 17	F 641		

assessment had not been completed.

There were no Social Worker notes indicating any additional attempts had been made to interview Resident #89.

An interview was conducted with Resident #89 on 02/07/23 at 11:30 AM. Resident #89 had mumbled speech and was slow to respond to questions. She was able to state her first name, how she was doing, and was able to sing a song.

An interview was conducted with the SW Assistant on 02/08/23 at 10:17 AM. The SW Assistant revealed that she had attempted the BIMS assessment with Resident #89, but Resident #89 was not able to answer the questions; therefore, she indicated Resident #89 was rarely/never understood. She stated she attempted the assessment several times during the same interview, but Resident #89 did not respond. She stated she did not know she should have completed the staff interview or attempt the interview at 3 different times. She further stated she knows how to assess residents for cognition status but was new to MDS assessment process. The SW Assistant stated the MDS was coded inaccurately because Resident #89 could sometimes understand.

The MDS Nurse was interviewed on 02/08/23 at 10:54 AM. She stated the SW Assistant did attempt to complete the interview several times with Resident #89. She stated Resident #89 was often confused and did not respond to questions appropriately. She stated the assessment should have been attempted 3 different times, and then the staff assessment should have been completed.

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 641	Continued From page 18	F 641		

A joint interview with the Director of Nursing (DON) and Administrator at 02/09/23 1:15 PM revealed it was their expectation for the MDS to be coded accurately.

5. Resident #19 was admitted to the facility on 07/23/21 with diagnoses that included type 2 diabetes, congestive heart failure, and hypertensive heart and chronic kidney disease.

The quarterly Minimum Data Set (MDS) assessment dated 01/22/23 indicated Resident #19 had clear speech, was understood by others, and able understand others. The Brief Interview for Mental Status (BIMS, used to screen and identify cognitive conditions) was noted as not completed because Resident #89 was rarely/never understood, and the staff assessment had not been completed.

There were no Social Worker notes indicating any additional attempts were made to interview Resident #19.

An interview was conducted with Resident #19 on 02/06/23 at 11:18 AM. Resident #19 was alert, oriented, and had clear speech. She could answer questions accurately and without difficulty.

An interview was conducted with the SW Assistant on 02/08/23 at 10:20 AM. The SW Assistant revealed that she had attempted the BIMS assessment with Resident #19, but Resident #19 refused to answer the questions and told her to "go away;" therefore, she indicated Resident #19 was rarely/never understood. She stated she did not return to re-interview Resident

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 641	Continued From page 19 #19. She stated she did not do a staff interview, nor did she write a note addressing Resident #19's refusal. She stated she knew how to assess residents for cognitive status but was new to MDS assessment process. The SW Assistant stated the BIMS assessment was coded inaccurately as Resident #19 could understand and be understood. MDS Nurse was interviewed on 02/08/23 at 10:56 AM. She stated Resident #19 is cognitively intact, able to understand and be understood. The BIMS interview should have been completed by the SW Assistant and should have been attempted 3 different times. She stated SW Assistant was new to MDS and was still learning how to complete MDS assessments. A joint interview with the Director of Nursing (DON) and Administrator at 02/09/23 1:15 PM revealed it was their expectation for the MDS to be coded accurately.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to transcribe the correct medication administration route for 1 (Resident #87) of 4 residents reviewed for gastric feeding tube and with orders for nothing by mouth (NPO).	F 658	F658 Services Provided Meet Professional Standards The facility will continue to ensure that the correct medication administration route is transcribed for residents receiving gastric tube feeding with orders for nothing by	3/3/23

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 658	Continued From page 20 Findings included: Resident #87 was admitted to the facility on 3/25/20 with multiple diagnoses including dysphagia (difficulty swallowing) following cerebro vascular disease and severe protein calorie malnutrition. The annual Minimum Data Set (MDS) assessment dated 1/24/23 indicated that Resident #87 was receiving tube feeding. Resident #87 had a physician's order dated 11/10/22 for continuous enteral feeding at 60 milliliter (ml) per hour and "NPO". On 11/11/22, the resident had an order for Melatonin 3 milligrams (mgs) 1 tablet by mouth at bedtime for insomnia. On 2/4/23, the resident had an order for Fluconazole (used to treat fungal infections) 150 mgs 1 tablet by mouth for infection. Resident #87 was observed on 2/6/23 at 11:24 AM. He was in bed and a continuous tube feeding was infusing at 60 ml per hour. Nurse #4, assigned to Resident #87, was interviewed on 2/8/23 at 9:30 AM. The Nurse reported that Resident #87 was NPO, and all his medications were administered through Gastrostomy (G) tube. She reviewed the physician's orders and verified that the Melatonin and Fluconazole were ordered to be given by mouth. She indicated that the nurse who received these orders should have transcribed it to be administered through G tube and not by mouth. Nurse #4 was observed to change the orders for the Melatonin and the Fluconazole to be given through G tube. The Treatment Nurse was interviewed on 2/8/23	F 658	mouth. Corrective Action: Resident #87 had physician order corrections completed on 2.8.23 by the Unit Nurse Manager. No negative outcome was identified relating to this observation. How the facility will identify those who have the potential to be affected: Current residents that receive gastric tube feeding and have orders for nothing by mouth have the potential to be affected. Current residents meeting this criteria were audited on 2.21.23 to ensure that the correct medication administration route is transcribed for all ordered medications. No negative outcome was identified relating to these observations. Systemic changes: All licensed nurses will be inserviced by the ADON by 2.24.23 on the facility policy for ensuring that the correct medication administration route is transcribed for all ordered medications. Newly hired staff and agency nurses that are hired after 2.28.23 will be educated by the ADON on the facility policy for ensuring that the correct medication administration route is transcribed for all ordered medications. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON beginning on 3.1.23. Residents that receive gastric tube feeding and have orders for nothing by mouth will have order audits completed 3x/week x 4 weeks then weekly x 4 weeks	

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F 658	Continued From page 21 at 9:38 AM. The Wound Nurse verified that she received the order for the Fluconazole and transcribed it to the electronic records. She stated that the resident was NPO, and she should have transcribed it to be given through G tube, but she did not, it was a mistake on her part. The Nurse Unit Manager #1 was interviewed on 2/9/23 at 11:30 AM. The Unit Manager verified that Resident #87 was NPO, and all his medications should be ordered and administered through G tube. The Director of Nursing (DON) and the Administrator were interviewed on 2/9/23 at 12:58 PM. The DON stated that she expected nursing staff to transcribe the correct administration route for residents with G tube.	F 658	then bi-weekly x 4 weeks. Variances will be corrected at the time of the observation and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.23, who will be responsible for reporting concerns to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, family member, resident and staff interviews, the facility failed to trim and clean dependent residents' nails (Residents #66, #28, #114, #40, #116 and #58) and failed to assist with shaving (Resident #84). In addition, the facility failed to assist a resident with bathing (Resident #33). This was for 8 of 12 residents reviewed for Activities of Daily Living	F 677	F677 ADL Care Provided for Dependent Residents The facility will continue to ensure that dependent residents nails are trimmed and clean, and assistance is provided with shaving and bathing.	3/3/23

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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 677	Continued From page 22 (ADLs). The findings included: 1. Resident #66 was admitted to the facility on 12/8/20 with diagnoses that included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and muscle weakness. A quarterly Minimum Data Set (MDS) assessment dated 1/17/23 indicated Resident #66 was cognitively intact and displayed no behaviors or rejection of care. He required total assistance from staff for bathing and personal hygiene. Resident #66's active care plan, last reviewed 1/20/23, included the following areas of need: - ADL self-care performance deficit and requires assistance with ADLs and mobility related to decline in mobility and dementia. - Risk for impaired skin integrity/pressure ulcer related to decline in mobility, deconditioning, fragile skin. One of the interventions included to observe finger and toenails on shower days to see if they need to be trimmed. A review of Resident #66's nursing progress notes from 9/1/22 to 1/8/23 revealed no refusals of nail care documented. On 2/6/23 at 11:12 AM, an interview and observation of Resident #66 occurred while he was lying in bed. Fingernails to both hands were medium in length with dark substance noted under the nails to his right hand. Resident #66 stated his nails were longer than he like to have them.	F 677	Corrective Action: Residents #66, #28, #114, #40, #116, and #58 received assistance with trimming/cleaning nails at the time of discovery on 2.9.23, per c n a as directed by DON. Resident #33 is receiving assistance with bathing per schedule and resident choice. Resident #84 received assistance with shaving at the time of discovery on 2.9.23, per c n a as directed by DON. No negative outcome was identified relating to these observations. How the facility will identify those who have the potential to be affected: Current residents that require assistance with trimming/cleaning nails, shaving, and bathing have the potential to be affected. All current residents that require assistance with trimming/cleaning nails, shaving, and bathing were observed by the DON, ADON, and Unit Managers during adl care by c n a□s to ensure that each received assistance as needed. These observations were made between 2.20.23 and 2.24.23. No negative outcome was identified relating to these observations. Systemic changes: 100% of nursing assistants and licensed nurses were inserviced by the ADON by 2.28.23 on facility policy for providing assistance to residents that require assistance with trimming/cleaning nails, shaving, and bathing. Newly hired staff and agency c n a□s and newly hired staff and agency nurses that are hired after 2.28.23 will be educated by the ADON on the facility	

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 02/09/2023

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 677	Continued From page 23 Resident #66 was observed on 2/7/23 at 9:30 AM, lying in bed watching TV. His nails were unchanged from prior observation. On 2/8/23 at 8:45 AM, Resident #66 was observed lying in bed watching TV. His fingernails remained medium length with dark substance under the nails to the right hand. An interview occurred with Nurse Aide (NA) #2 on 2/8/23 at 9:55 AM. She was the NA assigned to care for Resident #66. She stated nail care was completed when there was a need during a shower or personal care. An observation occurred with the NA #2 of Resident #66's nails who stated they were longer than he liked to have them. NA #2 confirmed a dark substance was under the nails to the right hand and stated she had not noticed the need for nail care during his morning care. NA #1 was interviewed on 2/8/23 at 11:10 AM and stated that nail care was performed when there was a need. On 2/8/23 at 2:52 PM, an interview occurred with NA #5 who was familiar with Resident #66 but not assigned to care for him. She explained nail care should be completed when there was a need during personal care tasks. The Director of Nursing was interviewed on 2/9/23 at 1:01 PM and stated she was not aware of any refusals of nail care from Resident #66 or that nail care was needed. She added that she would expect fingernails to be observed on shower days and during personal care with nail care rendered as needed.	F 677	policy for providing assistance to residents that require assistance with washing hair, trimming/cleaning nails, and oral care. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the Unit Manager/designee beginning on 3.1.23. The Unit Manager/designee will randomly observe 5 residents 5x/weekly x 4 weeks, then 3x/weekly x 4 weeks, then weekly x 4 weeks to ensure that assistance is being provided to residents that require assistance with trimming/cleaning nails, shaving, and bathing. Variances will be corrected at the time of observation and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.23, who will be responsible for reporting concerns to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified.	

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 02/09/2023

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 677	Continued From page 24	F 677		

2. Resident #33 was admitted to the facility on 6/3/21 with diagnoses that included type 2 diabetes, dementia, and osteoarthritis.

A modification of a significant change in status Minimum Data Set (MDS) assessment dated 12/19/22 indicated Resident #33 had severe cognitive impairment but displayed no behaviors or rejection of care. He required total dependence on staff for personal hygiene and bathing.

Resident #33's active care plan, last reviewed 12/27/22, included an area of need for Activities of Daily Living (ADL) self-care performance deficit and required assistance with ADL's and mobility related to decondition and decline in mobility.

The nursing progress notes were reviewed from 12/1/22 until 2/8/23 and did not indicate any refusals of bathing assistance.

Per the Director of Nursing, Resident #33 was to receive a shower every Wednesday and Saturday on the evening shift (3:00 PM to 11:00 PM).

Resident #33's Nurse Aide Flow Record for December 2022, January 2023 and February 2023 were reviewed and revealed assistance with bathing was not documented as provided or refused by the resident on 12/3/22, 12/7/22, 12/10/22, 12/14/22, 12/31/22, 1/14/23, 1/18/23, 1/21/23, 1/25/23, 1/28/23, and 2/1/23. The form asked, "Did the resident receive a shower/bath/bed bath" and the answers were either yes, no or not applicable.

On 2/6/23 at 10:56 AM, a family member of

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 02/09/2023

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 677	Continued From page 25	F 677		

Resident #33 was interviewed and stated she was concerned that Resident #33 was not receiving a shower as scheduled or even consistent bathing but had not inquired about them.

On 2/6/23 at 10:56 AM, Resident #33 stated he wasn't offered a shower only received a "wash up" in the bed. Resident #33 was free from odors, but his skin was very dry in appearance at the time of interview.

A phone interview was conducted with Nurse Aide (NA) #3, who worked the evening shift, on 2/8/23 at 11:36 AM. She stated she didn't offer showers and only provided bed baths to Resident #33 because "he refuses everything". NA #3 was assigned to Resident #33 as follows:
- 1/14/23 (Saturday) and had marked Not Applicable on the NA flow record for bathing.
- 1/18/23 (Wednesday) and had marked Not Applicable on the NA flow record for bathing.
She explained if No or Not Applicable were marked on the NA flow record, she didn't provide a bath of any kind to Resident #33. She could not recall if she had reported Resident #33's refusal.

A phone interview was held with NA #4 on 2/8/23 at 12:11 PM, who worked the evening shift, and stated she couldn't recall if she had provided showers or bed baths to Resident #33. NA #4 was assigned to Resident #33 on 12/14/22 (Wednesday) and had marked no on NA flow record for bathing. NA #4 stated that if No or Not Applicable were marked on the NA flow record that meant she had not provided a bath of any kind to Resident #33.

On 2/8/23 at 2:52 PM, an interview occurred with

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 02/09/2023

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 677	Continued From page 26	F 677		

NA #5 who was familiar with Resident #33 and worked the evening shift. She stated she had worked at the facility for the past two months and stated Resident #33 wasn't listed on the shower scheduled so she marked Not Applicable for 1/25/23 (Wednesday) and 1/28/23 (Saturday). She stated Not Applicable would mean no shower or bed bath was provided by herself on those days.

A phone call was placed to NA #7 on 2/9/23 at 10:57 AM and was unable to leave a message. She was assigned to Resident #33 the evening shift on 1/18/23 (Wednesday) and had marked Not Applicable for bathing assistance.

A phone call was placed to NA #6 on 2/9/23 at 10:58 AM and was unable to leave a message. She was assigned to Resident #33 as follows:
- 12/31/22 (Saturday) and had not marked the NA flow record as a bath received.
- 1/21/23 (Saturday) and had not marked the NA flow record as a bath received.
- 2/1/23 (Wednesday) and had not marked the NA flow record as a bath received.

The Director of Nursing was interviewed on 2/9/23 at 1:01 PM and stated she expected all residents to be offered and receive a shower as requested and scheduled. If a resident refused, the NA should alert the nurse so a progress note could be written, and alternate means of a bath provided.

3. Resident #28 was admitted to the facility on 9/30/22 with multiple diagnoses including altered mental status. The significant change in status Minimum Data Set (MDS) assessment dated 12/6/22 indicated that Resident #28 had severe cognitive impairment and was totally dependent

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 02/09/2023

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 677	Continued From page 27	F 677		

on the staff for personal hygiene. The assessment further indicated that the resident had no behavior of rejection of care.

Resident #28's current care plan that was initiated on 9/30/22 revealed that the resident had activity of daily living (ADL) self-care deficit and she required assistance with ADL. The approaches included "resident requires extensive assistance with personal hygiene and to check nail length and trim and clean on bath day and as necessary".

Resident #28 was observed on 2/6/23 at 12:50 PM in bed. Her fingernails were long and jagged, at least 1 inch from the tips of her fingers. There were brown substances noted underneath her fingernails.

Resident #28 was again observed on 2/7/23 at 8:30 and 2:41 PM and her fingernails remained unchanged from the previous observation.

Nurse Aide (NA) #15, assigned to Resident #28, was interviewed on 2/7/23 at 2:42 PM. The NA stated that she had noticed resident's fingernails were long and dirty, but she knew she would refuse nail care. She added that nail care was done during shower days and if needed. The NA further indicated that she would trim and clean resident's nails when she has the time.

Resident #28 was observed on 2/8/23 at 8:50 AM. Her fingernails were short and clean.

The Nurse Unit Manager #1 was interviewed on 2/9/23 at 11:30 AM. She stated that nail care was done during shower days but if the nails were long and dirty, staff should trim and clean the

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 02/09/2023

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 677	Continued From page 28	F 677		

resident's nails and not to wait for shower days.

The Director of Nursing (DON) and the Administrator were interviewed on 2/9/23 at 12:58 PM. The DON stated that personal hygiene including nail care should be provided when needed.

4. Resident # 114 was admitted to the facility on 11/17/22 with multiple diagnoses including hemiplegia/hemiparesis following cerebral infarction affecting the left non dominant side. The significant change in status Minimum Data Set (MDS) assessment dated 1/19/23 indicated that Resident #114's cognition was intact, and she needed extensive assistance with personal hygiene. The assessment further indicated that the resident had no behavior of rejection of care.

Resident #114's current care plan that was initiated on 11/17/22 revealed that the resident had activity of daily living (ADL) self-care deficit and she required assistance with ADL. The approaches included "resident requires extensive assistance with personal hygiene".

Resident #114 was observed on 2/6/23 a 11:34 AM. Her fingernails were long and dirty, at least half an inch from the tips of her fingers. There were brown substances underneath her fingernails. She stated that she would like her nails short and clean. She reported that nobody had offered to trim and clean her nails and she was tired of asking.

Resident #114 was again observed on 2/7/23 at 8:35 AM and 2:41 PM. Her fingernails remained

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 02/09/2023

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 677	Continued From page 29	F 677		

the same from the previous observations.

Nurse Aide (NA) #15, assigned to Resident #114, was interviewed on 2/7/23 at 2:41 PM. She reported that Resident #114 needed extensive assistance with personal hygiene including nail care. She stated that the resident did not refuse care. She stated that she would trim and clean resident's nails later when she had the time.

Resident #114 was again observed on 2/8/23 at 8:51 AM. Her fingernails remained long and dirty. She stated that nobody had offered to trim and to clean them and she hate to keep asking the staff.

NA #15 was interviewed on 2/8/23 at 9:30 AM. The NA reported that she didn't get the chance to trim and clean resident's nails yesterday, but she passed it on to the next shift to trim and clean her nails but that was not done either.

The Nurse Unit Manager #1 was interviewed on 2/9/23 at 11:30 AM. She stated that nail care was done during shower days but if the nails were long and dirty, staff should trim and clean the resident's nails and not to wait for shower days.

The Director of Nursing (DON) and the Administrator were interviewed on 2/9/23 at 12:58 PM. The DON stated that personal hygiene including nail care should be provided when needed.

5. Resident # 84 was admitted to the facility on 11/25/19 with multiple diagnoses including persistent vegetative state. The quarterly Minimum Data Set (MDS) assessment dated

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 02/09/2023

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 677	Continued From page 30	F 677		

11/4/22 indicated that Resident #84 had a tracheostomy tube and a feeding tube in place.

Resident #84's current care plan that was dated 11/4/22 revealed that the resident had activity of daily living (ADL) self-care deficit and required total assistance with ADL. The approaches included "resident requires total assistance with personal hygiene".

Resident #84 was observed on 2/6/23 at 2:09 PM in bed and he was unshaven. The amount of facial hair seemed to be at approximately 3 days growth.

Another observation was made on 2/7/23 at 8:46 AM, and 1:50 PM. The resident was in bed and was still unshaven.

Nurse Aide (NA) #10, assigned to Resident #84, was interviewed on 2/7/23 at 1:51 PM. She reported that she provided AM care to the resident. When asked how often the resident should be shaved, she responded that she didn't know, she usually worked night shift and recently moved to day shift.

The Director of Nursing (DON) was observed to enter Resident #84's room on 2/7/23 at 1:52 PM. She observed the resident and agreed that the resident needed to be shaved.

The Director of Nursing (DON) and the Administrator were interviewed on 2/9/23 at 12:58 PM. The DON stated that personal hygiene including shaving should be provided when needed.

6. Resident #40 was admitted to the facility on

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 02/09/2023

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 677	Continued From page 31	F 677		

07/02/20 with diagnoses which included spinal stenosis, neuropathy, and chronic embolism and thrombosis of unspecified vein.

The quarterly Minimum Data Set (MDS) assessment dated 12/13/22 indicated Resident #40's cognition was moderately impaired and he required extensive assistance of one person with toilet use, bed mobility, and personal hygiene. He was not coded as having hallucinations, delusions, or rejection of care.

Resident #40's care plan dated 12/13/22 indicated, in part, he had an Activities of Daily Living (ADL) self-care performance deficit and required assistance with ADLs and mobility due to neuropathy, spinal stenosis, and reliance on staff for mobility. The goal included Resident #40 would improve current level of function in bed mobility, transfers, eating, dressing, and personal hygiene through the review date. Interventions included to encourage Resident #40 to participate to the fullest possible with each interaction and he required extensive assistance with personal hygiene and oral care. Staff were to check nail length and trim and clean on bath day and as necessary.

A review of the Shower Schedule Sheet indicated Resident #40 was to receive showers every Monday and Thursday on the 3 PM - 11 PM shift.

A review of the Nurse Aide Flow Record sheet documented Resident #40 refused a bath on 02/06/23.

There were no other nurse progress notes after 10/04/22 indicating Resident #40 refused ADL care.

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 02/09/2023

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 677	Continued From page 32	F 677		

An observation on 02/07/23 at 10:04 AM revealed Resident #40 had brown debris under all 10 of his nails. Resident #40 stated he would like his nails cleaned, but the staff have "not gotten around to it."

Another observation on 02/08/23 at 10:11 AM revealed Resident #40 continued to have brown debris under all 10 of his fingers. Resident #40 indicated he would like them cleaned.

An interview and observation occurred on 02/08/23 at 10:26 AM with Nurse Aide #11 (NA) revealed Resident #40 had brown debris under all 10 of his fingers. NA #11 stated she is familiar with Resident #40 and had developed a rapport with him. She indicated his nails had brown debris under them and she would clean his nails when he received a bath in the afternoon. She stated she bathed Resident #40 every day at 2 PM. She indicated she bathed Resident #40 on 02/07/23, but did not look at his nails because he told her to "hurry up." She stated Resident #40 refuses ADL care at times and she notified the nurse each time he refuses.

In an interview with Nurse #6 at 02/08/23 at 2:50 PM, he stated he was familiar with Resident #40 and his care needs. He indicated Resident #40 would refuse care often and the Nurse Aides would inform him of his refusals. He indicated he typically documented Resident #40 refusals of ADL care but did not document as much as he should.

A joint interview with the Director of Nursing and the Administrator on 02/09/23 at 1:08 AM revealed it was their expectation that residents'

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 02/09/2023

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 677	Continued From page 33	F 677		

nails should be checked during baths and as needed. Residents' nails should be kept clean to ensure cleanliness and good hygiene.

7. Resident #116 was admitted to the facility on 01/03/23 with diagnoses which included Parkinson's disease, hypertension, and dementia with agitation.

The 5-day Medicare Minimum Data Set (MDS) assessment dated 01/10/23 indicated Resident #116's cognition was moderately impaired and required extensive assistance with one person for bed mobility, dressing, eating, toilet use, and personal hygiene. He was coded as not having rejection of care.

Resident #116's care plan dated 01/03/23 indicated he had an Activities of Daily Living (ADL) self-care performance deficit and required assistance with ADLs and mobility due to deconditioning decline, Parkinson's dementia, and vision abilities would fluctuate according to disabilities, health status, and time of day. The goal included Resident #116 would be able to wash his face and hands with setup and verbal cues. Interventions included to encourage resident to participate to the fullest extent possible with each interaction and check nail length and trim and clean on bath day and as necessary.

Review of the shower scheduled revealed Resident #116's showers are scheduled on every Monday and Thursday on the 3 PM - 11 PM shift.

An observation on 02/06/23 at 2:15 PM revealed Resident #116's all 10 fingernails were jagged and approximately 1/4 (one-quarter) inches long.

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 02/09/2023

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 677	Continued From page 34	F 677		

An observation on 02/07/23 at 8:37 AM revealed Resident #116's all 10 fingernails were jagged and approximately 1/4 (one-quarter) inches long. During the observation, Resident #116 stated his nails were long and he wanted them cut.

An observation on 02/08/23 at 8:25 AM revealed Resident #116's all 10 fingernails were jagged and approximately 1/4 (one-quarter) inches long.

An observation and interview with the Nurse Unit Manager #2 was conducted on 02/08/23 at 9:39 AM. She stated Resident #116's nails were long, and they needed to be cut. She stated Resident #116 was not diabetic and NAs were able to cut his nails. Residents' nails are to be cut as needed and NAs are able to review each residents' Kardex (software that gives a brief overview of each resident's care needs) to determine what type of care each resident requires. She stated she was not aware if Resident #116 had a history of refusing care.

An observation and interview with Nurse Aide #8 (NA) were conducted on 02/08/23 at 9:41 AM. She stated she was familiar with Resident #116's care needs. She indicated that his nails were long, and they needed to be cut. She stated she had given Resident #116 a bath on 02/06/23, and she was going to cut his nails, but he refused. She indicated she would typically tell the nurse if Resident #116 refused ADL care. She stated she had not attempted to trim his nails since his last refusal on 02/06/23.

A joint interview with the Director of Nursing and the Administrator on 02/09/23 at 1:08 AM revealed it was their expectation that residents'

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 02/09/2023

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 677	Continued From page 35	F 677		

nails should be checked during baths and as needed. Residents' nails should be kept clean to ensure cleanliness and good hygiene.
8. Resident #58 was admitted to the facility on 09/20/19 with diagnoses that included contractures of the left elbow, right lower leg, ankle, hip, and knee, left lower leg, ankle, hip, knee and wrist, and adhesive capsulitis of the right and left shoulders.

Review of Quarterly Minimum Data Set (MDS) assessment, dated 01/25/23, revealed Resident #58 ' s cognition was severely impaired. She required total dependence of one staff member for dressing, personal hygiene, and bathing. She was coded to have impairment on both sides of upper and lower extremities. No rejection of care coded.

Review of Resident #58 ' s care plan last reviewed 01/27/23, included a focus area that read she has an Activities of Daily Living (ADL) Self Care Performance Deficit and requires assistance with ADL's. Interventions included Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Provide Resident with a sponge bath when a full bath or shower cannot be tolerated. Keep fingernail trimmed and clean.

A review of Resident #58's nursing progress notes from 10/1/22 to 1/8/23 revealed no refusals of nail care documented.

An observation occurred of Resident #58 on 02/06/23 at 02:40 PM. She was lying in bed with her eyes open. Fingernails to both hands were medium in length, past the tips of fingers, and 6 out of 10 fingernails were jagged on the tips.

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 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 36	F 677		

An observation occurred of Resident #58 on 02/07/23 at 09:56 AM, 10:28 AM and at 03:58 PM. She was lying in bed with her eyes closed. Fingernails to both hands were medium in length, past the tips of fingers, and 6 out of 10 fingernails were jagged on the tips.

An interview and observation on 02/08/23 at 09:45 AM of Resident #58. She was lying in bed with her eyes open. An interview was conducted with Unit manager #2. She confirmed that Resident #58 ' s fingernails were jagged and needed to be trimmed. She stated nail care was to be completed by Nursing Assistants (NAs) when there was a need.

An interview on 02/08/23 at 09:50 AM was conducted with NA #14 who was not assigned to Resident #58 at the time stated she completes nail care when there was a need and during personal care tasks.

An interview on 02/08/23 at 10:00 AM was conducted with Nursing Assistant (NA) #12. She reported that she was assigned to Resident #58 and that the resident was dependent on staff for personal hygiene care. NA #12 stated that the NAs were responsible for providing fingernail care to residents who needed assistance. Resident #58's fingernails were then observed by NA #12. She confirmed that Resident #58's fingernails needed to be trimmed. She stated she bathed Resident #58 this morning but did not trim or file her nails. She further stated she would need assistance performing nail care on Resident #58 because she would continuously move her hands about when doing so.

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	345421	A. BUILDING _____ B. WING _____	C 02/09/2023

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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F 677	Continued From page 37 An interview was conducted on 02/09/23 at 01:00 PM with the Director of Nursing (DON). She stated she expected for nail care to be performed at least weekly and as needed. An interview was conducted on 02/09/23 at 01:08 PM with the Administrator. He stated his expectation was for nail care to be performed as needed.	F 677		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 3 of 12 residents reviewed for pressure ulcers (Resident #58, #87, and #14). The findings include: Review of the operational manual for the	F 686	F686 Treatment Services to Prevent/Heal Pressure Ulcer The facility will continue to ensure that alternating pressure reducing air mattresses are set according to resident weight. Corrective Action: Residents #58, #14, and #5 had alternating pressure reducing air mattresses readjusted according to	3/3/23

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 02/09/2023

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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F 686	Continued From page 38 alternating air mattress revealed the following: Weight Setting Selection: The pressure of the mattress can be adjusted by choosing the patients ' corresponding weight setting using the weight setting buttons (+) and (-). Use the weight setting buttons to select the desired level. Pressure levels will range from 20 to 60 millimeters of mercury (mmHg). 1. Resident #58 was admitted to the facility on 09-20-2019 with diagnoses that included post traumatic seizures, contractures of the left elbow, right lower leg, ankle, hip, and knee, left lower leg, ankle, hip, knee and wrist, and adhesive capsulitis of the right and left shoulders. Resident #58's active physician orders included an order dated 11/01/21 for nursing to monitor air mattress for proper function every shift. Review of Quarterly Minimum Data Set (MDS) assessment, dated 10/25/22, revealed Resident #58 ' s cognition was severely impaired, no current pressure ulcers, and a pressure reducing device to the bed. Review of Resident #58's care plan dated 11/01/21, last reviewed 01/27/23, included a focus area that read she was at risk for impaired skin integrity/pressure injury R/T: traumatic brain injury, inability to reposition self, altered nutrition status and incontinence. Intervention included: Pressure reduction air mattress to bed. A review of Resident #58's medical record revealed she had a history of pressure ulcers. Resident #58's weight on 02/07/23 was 139.2 pounds (lbs).	F 686	resident weight at the time of discovery on 2.8.23 by the nurse. How the facility will identify those who have the potential to be affected: Current residents with alternating pressure reducing air mattresses have the potential to be affected. Current residents with alternating pressure reducing air mattresses were inspected on 2.23.23 by the Central Supply Coordinator to ensure that alternating pressure reducing air mattresses were adjusted according to resident weight. No negative outcomes were identified relating to these inspections. Systemic changes: All nursing assistants and licensed nurses will be inserviced by the ADON by 2.28.23 on the facility expectation that alternating pressure reducing air mattresses are set according to resident weight. Newly hired staff and agency c n a□s and staff and agency licensed nurses will be educated by the ADON on the facility expectation that alternating pressure reducing air mattresses are set according to resident weight. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the Central Supply Coordinator/designee beginning on 3.1.23. The Central Supply Coordinator/designee will inspect residents with alternating pressure reducing air mattresses 2x/day 5x/week for 2 weeks then daily 5x/week for 2 weeks then 3x/week x 4 weeks then	

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	345421	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 39 The January 2023 Medication Administration Record (MAR) revealed nursing staff had been documenting daily the alternating pressure air mattress was functioning properly. An observation occurred of Resident #58 on 02/06/23 at 02:40 PM. She was lying in bed with her eyes open. The alternating air mattress was set on 700 pounds (lbs) and 10 min cycle intervals. An observation occurred of Resident #58 on 02/07/23 at 09:56 AM, 10:28 AM and at 03:58 PM. She was lying in bed with her eyes closed. The alternating air mattress was set on 700 pounds (lbs) and 10 min cycle intervals. An interview and observation on 02/08/23 at 09:45 AM of Resident #58's. She was lying in bed with her eyes open. The alternating air mattress was set on 700 pounds (lbs) and 10 min cycle intervals. An interview was conducted with Unit manager #2. She confirmed that the air mattress was set on 700 lbs and the nurses are to check setting every shift. She stated staff sometimes hit the buttons when giving care. She corrected the weight to 125lbs. An interview was conducted with Nurse #5 on 02/08/23 at 09:52 AM. She stated she checks air mattresses in the AM. She indicated she had not checked Resident #58's air mattress at that time. She then proceeded to pull the Medication Administration Record (MAR) up on the computer and then stated she had signed the task off as being done. She also stated she only checked to see if the lights were working on the machine, she did not check the actual settings. She confirmed she did not realize the mattress was	F 686	weekly x 4 weeks to ensure that the alternating pressure reducing air mattresses are set according to resident weight. Variances will be corrected at the time of inspection and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.23, who will be responsible for reporting concerns to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified.	

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 02/09/2023

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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F 686	Continued From page 40	F 686		

set at 700lbs.

An interview was conducted on 02/09/23 at 01:00 PM with the Director of Nursing (DON). She stated she expected the alternating air mattress machine to be set according to the resident ' s weight.

An interview was conducted on 02/09/23 at 01:08 PM with the Administrator. He stated his expectation was for the air mattress to be set according to resident ' s weight.

2. Resident #14 was readmitted to the facility on 02/03/22 with diagnoses which included type 2 diabetes, unspecified dementia, chronic kidney disease, and candidiasis of skin and nails.

A physician's order dated 08/30/22 indicated Resident #14 was to have an air mattress on her bed for fragile skin. Setting based on weight every shift for wound care.

A significant change Minimum Data Set (MDS) assessment dated 01/31/23 indicated Resident #14's cognition was moderately impaired and required extensive assistance with one person with bed mobility, dressing, and toilet use. She was coded as having a pressure ulcer/injury and had an unhealed pressure ulcer.

Resident #14's care plan, dated 01/31/23, indicated a focus area of Resident #14 was at risk for impaired skin integrity/pressure injury due to decondition, decline in mobility, incontinence, poor food intake, and fragile skin. The goal included to minimize risk in an effort to reduce likelihood of pressure injury development through next review date. Interventions included for Resident #14 to have an air mattress on her bed

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 02/09/2023

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F 686	Continued From page 41	F 686		

and monitor settings for function and setting based on weight.

Review of Resident #14's vital signs revealed Resident #14 weighed 112.6 pounds on 1/02/23 and 113.4 pounds on 02/07/23.

An observation on 02/06/23 at 1:23 PM revealed Resident #14 was lying in bed. The alternating pressure reducing air mattress showed it was set to 150 lbs.

An observation on 02/07/23 at 11:46 AM revealed Resident #14 was lying in bed. The alternating pressure reducing air mattress showed it was set to 150 lbs.

An observation on 02/08/23 at 08:29 AM revealed Resident #14 was lying in bed. The alternating pressure reducing air mattress showed it was set to 150 lbs.

Nurse #6 was interviewed on 02/08/23 at 2:03 PM. He stated he was familiar with Resident #14 and her care needs. He stated he tries to check the mattress settings every shift because, at times, the settings can be accidentally changed during personal care. He stated he saw the mattress was set to 150 pounds, and moved it to 120 pounds to match Resident #14's weight. He indicated he worked on 02/06/23, and could not recall if he changed the mattress settings during his shift.

The Central Supply Coordinator was interviewed on 02/08/23 at 2:06 PM. She indicated Resident #14 received the alternating pressure reducing mattress in February 2022. Typically, the Durable Medical Equipment company sets up the

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 02/09/2023

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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F 686	Continued From page 42	F 686		

mattress. Nurses can change the weight settings if a resident gains or loses weight.

In a joint interview with the Director of Nursing (DON) and the Administrator on 02/09/23 at 1:11 PM revealed it was their expectation that alternating pressure reducing mattresses were to be set to the resident's weight.

3. Resident #5 was admitted to the facility 8/19/2024 with diagnoses that included contractures and pressure injuries. Interventions included pressure reducing air mattress to the bed.

Resident #5's quarterly Minimum Data Set (MDS) dated 12/29/2022 indicated the resident was severely cognitively impaired, dependent on staff for bed mobility and all activities of daily living. The resident was coded with three stage 3 injuries and two stage 4 injuries during the assessment period.

The resident's medical record contained an order for the following: "air mattress to bed for low Braden and wounds, settings based on weight, check every shift for function and settings. The order was dated 9/25/2022.

Resident #5's medical record included a weight of 160.8 on 1/3/023 and 159 pounds (lbs) documented on 2/7/2023.

On 2/6/2023 at 10:56AM the pressure reducing mattress was observed to be set on 220lbs.

On 2/7/2023 at 2:01PM the pressure reducing mattress was observed to be set on 220lbs during an interview with the wound care nurse. The

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 02/09/2023

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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F 686	Continued From page 43 wound care nurse stated the mattress should not be set that high. She further stated the mattress should be set according to the resident's weight. The floor nurses assigned to the residents are responsible to check in the mattress for function and proper settings. An interview was conducted with Nurse #8 on 2/7/2023 at 2:15PM. She stated she checked the resident's mattress for function, but she did not check the settings. She stated she was not sure who was responsible for ensuring settings are accurate. On 2/9/2023 at 1:30PM an interview was conducted with the Director of Nursing. She stated Resident #5's alternating pressure reducing air mattress should be set according to his weight.	F 686		
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	F 688		3/3/23

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 02/09/2023

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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F 688	Continued From page 44 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to apply the right-hand palm guard (Resident #87) and bilateral elbow extension splints (Residents #58) as ordered for 2 of 3 residents reviewed for range of motion. The findings included: 1. Resident #58 was admitted to the facility on 09-20-2019 with diagnoses that included contractures of the left elbow, right lower leg, ankle, hip, and knee, left lower leg, ankle, hip, knee and wrist, adhesive capsulitis of the right and left shoulders. Resident #58 had a physician ' s order dated 04/07/22 to position bilateral elbow extension (BUE) splints daily following AM care for up to 4 hours or as tolerated. Provide hygiene to BUE hand/creases of elbows with warm soapy water, rinse, and dry thoroughly. Provide slow gentle stretching to BUE at the shoulders, elbows, wrists, and hands as tolerated prior to application. Review of quarterly Minimum Data Set (MDS) assessment, dated 10-25-22, revealed Resident #58 ' s cognition was severely impaired, and range of movement impairment was noted on both sides of upper & lower extremities. Review of Resident #58 ' s care plan and Kardex (a system of communication and organization used to document resident care summaries) last reviewed 01/27/23, included a focus area that	F 688	F688 Increase/Prevent Decrease in ROM/Mobility The facility will continue to ensure that palm guards and splints are applied as ordered for range of motion. Corrective Action: Resident #58 continues to wear splints as ordered. Resident #87 continues to wear the palm guard as ordered. No negative outcome was identified relating to these observations. How the facility will identify those who have the potential to be affected: Current residents with orders for splints and palm guards have the potential to be affected. Current residents with orders for splints and palm guards were reviewed by the Rehab Services Director as of 2.24.23 to ensure that splints and palm guards are being worn as ordered. No negative outcomes were identified relating to these observations. Systemic changes: All licensed nurses and nursing assistants were inserviced by the ADON as of 2.28.23 on the facility expectation that residents must have splints applied as ordered to prevent further contractures. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the RSD/designee beginning on 3.1.23.	

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 02/09/2023

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F 688	Continued From page 45 read; at risk for further contracture development related to: traumatic brain injury (TBI), quadriplegia, and has actual multiple contractures. Interventions including Position bilateral elbow extension splints following AM care for up to 4 hours or as tolerated. Provide hygiene to both upper extremities (BUE) hand/creases of elbows with warm soapy water, rinse, and dry thoroughly. Provide slow gentle stretching to BUE at the shoulders, elbows, wrists, and hands as tolerated prior to application. Record review of Resident #58's active physician orders located on the Medication Administration Record (MAR) were reviewed. The MAR for January and February 2023 revealed nursing staff documented they positioned bilateral elbow extension splints daily on day shift for contractures, time for application read "day shift". No refusals or documentation that splints had not been applied. Nurse #7 initialed the MAR on 2/6/23 and 2/7/23 and Nurse #5 initialed the MAR on 02/08/23 indicating the task had been completed. Record review of Resident #58's nursing notes from 10/01/22 through 02/07/23 revealed no documentation of splint refusal or intolerance of splint application. An observation occurred of Resident #58 on 02/06/23 at 02:40 PM. She was lying in bed with her eyes open. Her bilateral arms were bent at the elbows with hands by her face and there were no elbow splints noted. An observation occurred of Resident #58 on 02/07/23 at 09:56 AM, 10:28 AM and at 03:58 PM. She was lying in bed with her eyes open. Her	F 688	The RSD/designee will observe residents with palm guards and splints 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then every other week x 4 weeks to ensure that palm guards and splints are being worn as ordered. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.23, who will be responsible for reporting concerns to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified.	

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 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 688	Continued From page 46	F 688		

bilateral arms were bent at the elbows with hands by her face and there were no elbow splints noted.

An interview was conducted on 02/07/23 at 3:07 PM with Nurse #7. She confirmed she had signed the MAR for the application of Resident #58 ' s elbow splints on 2/6/23 and 2/7/23 but had not applied them. She indicated Resident #58 could not tolerate the splints and further stated it was difficult to apply them. As far as she knew Physical Therapy (PT) had not been informed.

An interview with Unit Manager #2 and observation of Resident #58 were conducted on 02/08/23 at 09:45 AM. She was lying in bed with her eyes open without her ordered elbow splints applied. Unit Manager #2 stated they were not applied because Resident #58 was not tolerating them. She also stated she, and Nurse #7 had discussed it on 02/07/23 and Nurse #7 was to document that Resident #58 was not tolerating the splints. The interview further revealed staff were to report to therapy if the residents were not tolerating the splints. She was unaware if Physical Therapy (PT) had not been informed.

An interview with Nurse #5 and observation were conducted on 02/08/23 at 09:52 AM. Nurse #5 confirmed she was the nurse caring for Resident #58. An order to apply the elbow splints was on the MAR and were signed off by Nurse #5. Nurse # 5 confirmed Resident #58 did not have elbow splints on and she did not know why she signed it prior to applying the splints. She did not know where the splints were located at time of interview.

An interview with Nursing Assistant (NA) #12 and

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 02/09/2023

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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F 688	Continued From page 47	F 688		

observation were conducted of Resident #58 on 02/08/23 at 10:00 AM. She stated she normally gets report from the off going NA as to what each resident can or cannot do. She also stated she can look at the care plan/kardex, but she did not do so. She further stated she was unaware that Resident #58 was supposed to have splints applied because she had never seen them on her.

An interview was conducted on 02/09/23 T 12:58 PM with the Director of Nursing (DON). She stated she expected splints to be applied per orders. She also stated if the resident cannot tolerate the splints, she expected nursing to document and Physical Therapy (PT) to be notified. She further stated if the resident refused the splint, she expected nursing to document the refusal. She was unaware the splints were not being applied to Resident #58.

An interview was conducted on 02/09/23 at 01:08 PM with the Administrator. He stated his expectation was for splints to be applied per orders.

2. Resident # 87 was admitted to the facility on 3/25/20 with multiple diagnoses including hemiplegia/hemiparesis following cerebro vascular disease affecting right dominant side. The annual Minimum Data Set (MDS) assessment dated 1/24/23 indicated that Resident #87 had impairment in range of motion on both upper and lower extremities.

Resident # 87 had a physician's order dated 11/11/22 to apply right palm guard to right hand after AM care as tolerated and to remove the palm guard from the right hand prior to PM care as tolerated.

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 02/09/2023

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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F 688	Continued From page 48	F 688		

Resident #87's care plan updated on 1/24/23 was reviewed. One of the care plan problems was the resident was at risk for further contracture development related to right sided hemiplegia and contracture of right upper and lower extremities. The goal was for the resident not to develop any further contractures. The approaches included to apply right palm guard to right hand after AM care as tolerated, and to remove palm guard from right hand prior to PM care as tolerated.

Resident #87 was observed on 2/6/23 at 11:24 AM, and on 2/7/23 at 11:05 AM in bed. His right hand was in fist position and there was no palm guard noted.

Nurse #4, assigned to Resident #87, was interviewed on 2/7/23 at 11:06 AM. The Nurse observed the resident's right hand and stated that the resident was supposed to have the right palm guard on, but she could not find it in the room, it might be in the laundry. The Nurse indicated that that she had not known the resident to refuse the palm guard.

Nurse Aide (NA) #10, assigned to Resident #87, was interviewed on 2/7/23 at 12:05 PM. The NA stated that she provided AM care to the resident. She reported that she had not seen the resident wearing a splint or palm guard on his right hand and she didn't know that the resident was supposed to be wearing a device on his right hand.

Resident #87 was again observed on 2/7/23 at 2:05 PM. The resident was still not wearing a palm guard to his right hand.

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 02/09/2023

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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F 688	Continued From page 49 The Nurse Unit Manager #1 was interviewed on 2/9/23 at 11:30 AM. The Unit Manager verified that Resident #87 had a physician's order for the right-hand palm guard and stated that the palm guard should have been applied every day. She reported that she was not aware that the resident's palm guard was not in his room. The Director of Nursing (DON) and the Administrator were interviewed on 2/9/23 at 12:58 PM. The DON stated that she expected the palm guard to be applied as ordered.	F 688		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		3/3/23

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	345421	A. BUILDING _____ B. WING _____	C 02/09/2023

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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F 732	Continued From page 50 (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to display accurate Posted Nurse Staffing Information as compared to the Staff Schedule/Assignment Sheets for 31 out of 31 days reviewed. The findings included: A review of the Staff Schedule/Assignment Sheets and timecard reports compared to the daily Posted Nurse Staffing Information sheets from 01/06/23 through 02/06/23 revealed discrepancies in the areas of actual hours worked and actual nursing staff who worked including the licensed Registered Nurses (RNs) and Licensed Practical Nurses (LPNs), and the unlicensed Medication Aides (MAs), and Nursing Assistants (NAs). Review of the daily Posted Nurse Staffing Information sheets for 01/06/23 through 02/06/23 compared to timecard reports revealed there were no RNs noted on the Posted Nurse Staffing	F 732	F732 Posted Nurse Staffing Information The facility will continue to display accurate Posted Nurse Staffing Information as compared to the Staff Schedule/Assignments Sheets. Corrective Action: The Posted Nurse Staffing Information from 2.9.23, the date of discovery, was reviewed and corrections made as necessary, by the DON. No negative outcome was identified relating to this observation. How the facility will identify those who have the potential to be affected: Subsequent Posted Nurse Staffing Information after 2.9.23 has the potential to be affected. Posted Nurse Staffing Information after 2.9.23 was reviewed on 2.23.23 by the Administrator to ensure that Posted Nurse Staffing Information is accurate as compared to the Staff	

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	345421	A. BUILDING _____ B. WING _____	C 02/09/2023

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 732	Continued From page 51 Information although RNs were working for the following days: 01/20/23, 01/25/23, 01/27/23, and 02/03/23. The number of licensed staff and actual hours worked of licensed staff on 1st shift were incorrect for the following days: 01/06/23, 01/07/23, 01/09/23, 01/10/23, 01/11/23, 01/12/23, 01/13/23, 01/14/23, 01/15/23, 01/16/23, 01/17/23, 01/18/23, 01/19/23, 01/20/23, 01/21/23, 01/22/23, 01/23/23, 01/24/23, 01/25/23, 01/26/23, 01/27/23, 01/30/23, 01/31/23, 02/01/23, 02/02/23, 02/03/23, and 02/06/23. The number of unlicensed staff and actual hours worked of unlicensed staff on 1st shift were incorrect for the following days: 01/07/23, 01/08/23, 01/09/23, 01/10/23, 01/11/23, 01/12/23, 01/13/23, 01/14/23, 01/15/23, 01/17/23, 01/18/23, 01/19/23, 01/20/23, 01/21/23, 01/22/23, 01/23/23, 01/24/23, 01/25/23, 01/26/23, 01/27/23, 01/29/23, 01/30/23, and 01/31/23, 02/01/23, 02/02/23, 02/03/23, and 02/06/23. The number of licensed and unlicensed staff and actual hours worked of licensed and unlicensed staff on 2nd shift were incorrect for the following days: 01/06/23, 01/07/23, 01/08/23, 01/11/23, 01/12/23, 01/13/23, 01/14/23, 01/16/23, 01/17/23, 01/18/23, 01/21/23, 01/22/23, 01/23/23, 01/25/23, 01/26/23, 01/27/23, 01/30/23, 01/31/23, 02/01/23, 02/02/23, 02/04/23, 02/05/23, and 02/06/23. The number of actual hours worked of unlicensed staff on 2nd shift was incorrect for the following days: 01/09/23 and 01/28/23 The number unlicensed staff and actual hours worked of unlicensed staff on 2nd shift were	F 732	Schedule/Assignment Sheets. No negative outcomes was identified relating to these observations. Systemic changes: The Scheduling Coordinator was inserviced by the Administrator on 2.24.23 on the facility policy for ensuring that Posted Nurse Staffing Information is accurate as compared to the Staff Schedule/Assignment Sheets. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON/designee beginning on 3.1.23. The ADON/designee will review Posted Nurse Staffing Information and Staff Schedules/Assignment Sheets 5x/week x 4 weeks then 3x/week x 4 weeks then weekly x 4 weeks to ensure that Posted Nurse Staffing Information is accurate. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.23, who will be responsible for reporting concerns to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled meetings or until resolved and additional	

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 02/09/2023

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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F 732	Continued From page 52 incorrect for the following days: 01/10/23, 01/24/23 and 01/29/23. The number of licensed and unlicensed staff and actual hours worked of licensed and unlicensed staff on 3rd shift were incorrect for the following days: 01/06/23, 01/07/23, 01/08/23, 01/11/23, 01/12/23, 01/13/23, 01/14/23, 01/16/23, 01/17/23, 01/18/23, 01/21/23, 01/22/23, 01/25/23, 01/26/23, 01/27/23, 01/30/23, 01/31/23,02/01/23, 02/02/23, 02/04/23, 02/05/23, and 02/06/23. The number unlicensed staff and actual hours worked of unlicensed staff on 3rd shift were incorrect for the following days: 01/09/23, 01/10/23, 01/15/23, 01/20/23, 01/24/23, and 01/29/23. An interview on 02/09/23 at 09:40 AM was conducted with the Central Supply Coordinator. She stated she was responsible for completing the daily Posted Nurse Staffing Information sheet based on the actual working assignment sheet for the day and posting them in a viewable area. The Central Supply Coordinator confirmed that when any nursing staff called out for the day, she was unaware she had to adjust the posting sheet and she was unaware Medication Aides (MAs) were unlicensed staff. She then stated she was unaware the Registered Nurses (RNs) were to be listed on the Posted Nurse Staffing Information sheet if they were not on a medication cart. An interview on 02/09/23 at 12:03 PM was conducted with the Director of Nursing (DON). She confirmed the daily Posted Nurse Staffing Information sheets were inaccurate and should have included the RNs working as unit managers. The DON further indicated the daily Posted Nurse	F 732	education/training will be provided for any issues identified.	

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	345421	A. BUILDING _____ B. WING _____	C 02/09/2023

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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F 732	Continued From page 53 Staffing Information sheets did not reflect the correct actual working hours or the correct number of staff for the days reviewed.	F 732		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, Medical Director and staff interviews, the facility failed to transcribe vital sign parameters for a blood pressure medication as ordered for 1 of 6 residents whose medications were reviewed (Resident #223). The findings included:	F 757	757 Drug Regimen is Free from Unnecessary Drugs The facility will continue to ensure that vital sign parameters for blood pressure medications are transcribed as ordered. Corrective Action: Resident #223 had vital sign parameters for blood pressure	3/3/23

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 02/09/2023

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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F 757	Continued From page 54	F 757		

Resident #223 was admitted to the facility on 10/13/22 with diagnoses that included atrial fibrillation, anxiety disorder, and muscle weakness.

A nursing progress note dated 9/28/22 read, in part, that therapy had reported that Resident #223 was not doing well because her blood pressure dropped during therapy. The physician was in the building and was updated on Resident #223's condition. An order was provided with new parameters for Metoprolol (a blood pressure medication) 12.5 milligrams (mg). Hold the medication if blood pressure is less than 110/70 or heart rate less than 60.

Review of the September 2022 physician orders revealed an order dated 9/20/22 for Metoprolol 12.5 mg by mouth twice a day for Hypertension. The parameters of when to hold the medication were not listed with the order.

Review of the October 2022 Medication Administration Record (MAR) revealed the Metoprolol was being provided with no parameters of when to hold the medication listed.

The November 2022 physician orders indicated the Metoprolol was changed to 12.5mg one time a day. There were no parameters of when to hold the medication as ordered 9/28/22.

The December 2022 MAR was reviewed and revealed the Metoprolol was being provided with no parameters of when to hold the medication as ordered.

A significant change in status Minimum Data Set (MDS) assessment dated 1/3/23 indicated

medication transcribed as ordered on 2.23.23. No negative outcome was identified relating to this observation.

How the facility will identify those who have the potential to be affected: Current residents with orders for blood pressure medications have the potential to be affected. Current residents with orders for blood pressure medications had order reviews completed on 2.23.23 by the DON to ensure that vital sign parameters were transcribed as ordered. No negative outcomes were identified relating to these reviews.

Systemic changes: All licensed nurses will be inserviced by the ADON by 2.28.23 on the facility policy that vital sign parameters for blood pressure medications will be transcribed as ordered. Newly hired staff and agency licensed nurses will be educated by the ADON on the facility policy that vital sign parameters for blood pressure medications will be transcribed as ordered.

Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 3.1.23. The DON/designee will randomly review 3 residents with orders for blood pressure medications weekly x 4 weeks then bi-weekly x 4 weeks then randomly x 4 weeks to ensure that vital sign parameters for blood pressure medications are transcribed as ordered. Variances will be corrected at the time of review and

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	345421	A. BUILDING _____ B. WING _____	C 02/09/2023

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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F 757	Continued From page 55 Resident #223 had severe cognitive impairment. The January 2023 and February 2023 physician orders and MARs were reviewed and revealed the Metoprolol was being provided without the parameters of when to hold the medication as ordered on 9/28/22. On 2/8/23 at 10:03 AM, Nurse #1 was interviewed. She was the nurse that took the verbal order on 9/28/22 for the Metoprolol medication parameters of when to hold the medication. The 9/28/22 nursing note was reviewed as well as the September 2022 through February 2023 physician orders and MARs. She stated she must have forgotten to transcribe the hold parameters for the Metoprolol after receiving the verbal order. A phone interview occurred with the Medical Director on 2/9/23 at 11:34 AM and stated if a verbal order was provided with hold parameters for the Metoprolol, then he would have expected it to be transcribed and followed. He further stated he felt there was no serious harm caused as he has adjusted the medication and monitored her lab work very closely. The Director of Nursing was interviewed on 2/9/23 at 1:01 PM and stated she expected the nurses to transcribe any verbal orders that were received.	F 757	additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.23, who will be responsible for reporting concerns to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		3/3/23

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 02/09/2023

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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F 761	Continued From page 56 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview with resident and staff, the facility failed to secure medication patches for 1 of 4 (Resident #16) residents observed for medication administration. The findings included: On 2/7/2023 at 9:30AM Nurse #9 was observed administering medication to Resident #16. The resident asked Nurse #9 to apply her patch while she was in the room. Nurse #9 reached down in the draw of the bedside table, next to Resident #9's bed and pulled out two boxes of Asper creme patches (Lidocaine, topical analgesic). Nurse #9 pulled out a patch, placed the boxes	F 761	F761 Label/Store Drugs and Biologicals The facility will continue to secure medication patches in accordance with State and Federal laws. Corrective Action: The patches for Resident #16 were removed from the room and secured in the medication cart. No negative outcome was identified as a result of this observation. How the facility will identify those who have the potential to be affected: Current residents with physician orders for	

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	345421	A. BUILDING _____ B. WING _____	C 02/09/2023

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 761	Continued From page 57 back in the bedside table drawer, and applied patch she removed to Resident #16. After exiting the resident's room, the state surveyor questioned Nurse #9 regarding the storage of medication in Resident #16's bedside table. Nurse #9 stated the resident did not have an order to self-administer the patch and the patches should be secured somehow if kept in the resident's room. She further stated the resident did not like the patches the facility had, therefore she had her family bring the patches into the facility for her. At 9:15AM on 2/7/2023 and interview was conducted with Resident #16. She stated she prefers the asper cream patches over the generic ones the facility had. She also prefered the patches be kept in her room. She further stated the patches had been stored in her bedside table since her admission , "a month and a half", and she did not understand why there was an issue with storage now. On 2/07/2023 at 10:31 AM a second interview was conducted with Nurse #9. She stated Resident #16's was provided education on medication storage and the patches were secured on the medication cart. An interview was conducted with the Director of Nursing on 29/2023 at 1:00PM. She stated residents should not have medication stored unsecure in their rooms.	F 761	medication patches have the potential to be affected. Current residents with physician orders for medication patches were reviewed by the Unit Manager on 2.23.23 to ensure that medication patches were secured in accordance with State and Federal laws. No negative outcome was identified as a result of these observations. Systemic changes: 100% of licensed nurses and medication aides will be inserviced by the ADON as of 2.28.23 on the facility policy for securing medication patches in accordance with State and Federal laws. After this date all newly hired staff nurses, agency nurses, and medication aides will be educated by the ADON on this facility policy upon hire. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the Unit Manager/designee beginning on 3.1.23. The Unit Manager/designee will audit 3 residents with physician orders for medication patches 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then bi-weekly x 4 weeks to ensure that medication patches are secured in accordance with State and Federal laws. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.23, who will be responsible for reporting concerns to the Quality Assurance Committee during monthly meetings.	

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 02/09/2023

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F 761	Continued From page 58	F 761	Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		3/3/23

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F 842	Continued From page 59 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

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F 842	Continued From page 60 Based on record review and staff interviews, the facility failed to maintain accurate medical records for wound care (Resident #123), and respiratory care (Resident #123). This was for 1 of 7 closed records reviewed. The findings included: 1a. Resident #123's physician orders included an order dated 3/23/22 for skin prep to the right foot blister every shift, monitor every shift for changes and report to physician and wound care nurse for treatment change. The April 2022 and May 2022 Treatment Administration Records (TARs) were reviewed and revealed the right foot blister wound care had not been documented as completed or refused by the resident for the following: - Day shift (7:00 AM to 3:00 PM) on 4/3/22, 4/6/22, 4/7/22, 4/9/22, 4/14/22, 4/22/22, 4/27/22, 4/29/22 and 5/1/22. - Evening shift (3:00 PM to 11:00 PM) on 4/8/22, 4/12/22 and 5/6/22. Review of the nursing progress notes from 3/1/22 to 5/9/22 did not reveal any refusals of wound care by Resident #123. On 2/8/23 at 10:17 AM, an interview occurred with the Nurse Unit Manager #1 who was familiar with Resident #123. She was scheduled for the day shift on 4/6/22, 4/9/22, 4/14/22, 4/27/22, and 4/29/22. She recalled completing the wound care to Resident #123's blister on her foot after medication pass had been completed. The Nurse Unit Manager #1 stated she had forgotten to document the wound care as completed on the TAR.	F 842	F842 Resident Records-Identifiable Information The facility will continue to maintain accurate medical records for wound care and respiratory care. Corrective Action: Resident #123 no longer resides at the facility. No negative outcome was identified relating to these observations. How the facility will identify those who have the potential to be affected: Current residents with orders for wound care and respiratory care have the potential to be affected. TAR□s for current residents with orders for wound care and respiratory care were reviewed on 2.23.23 to ensure that medical records for wound care and respiratory care were accurate. No negative outcomes were identified relating to these observations. Systemic changes: All licensed nurses were inserviced by the ADON as of 2.28.23 on the facility policy on ensuring that medical records for wound care and respiratory care are accurate. Newly hired staff and agency nurses that are hired after 2.28.23 will be educated by the ADON on the facility policy on ensuring that medical records for wound care and respiratory care are accurate. Monitoring: A QA monitoring tool will be utilized to ensure ongoing compliance by the Treatment nurse/designee beginning on 3.1.23. The Treatment nurse/designee will randomly audit TAR□s for 3 guests	

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 842	Continued From page 61 A phone interview occurred with Nurse #2 on 2/9/23 at 11:45 AM, who was familiar with Resident #123. She was scheduled for the day shift on 4/7/22 and could not recall Resident #123 refusing wound care to her foot blister. She stated she completed the wound care but had forgotten to sign it was completed. The Director of Nursing was interviewed on 2/9/23 at 1:01 PM and indicated she expected the nursing staff to complete wound care as ordered as well as to document it was completed or refused by the resident. Multiple phone calls were made to Nurse #3 who was assigned to Resident #123 on the evening shift of 4/12/22 with no success. b. Resident #123's physician orders included an order dated 9/27/17 for tracheostomy care every shift, remove inner cannula, clean, and replace. Clean around tracheostomy area, pat dry and replace gauze. The April 2022 and May 2022 Treatment Administration Records (TARs) were reviewed and revealed the tracheostomy care had not been documented as completed or refused by the resident for the following: - Day shift (7:00 AM to 3:00 PM) on 4/3/22, 4/4/22, 4/6/22, 4/7/22, 4/9/22, 4/14/22, 4/22/22, 4/27/22, 4/29/22 and 5/1/22. - Evening shift (3:00 PM to 11:00 PM) on 4/8/22, 4/12/22 and 5/6/22. Review of the nursing progress notes from 3/1/22 to 5/9/22 did not reveal any refusals of	F 842	with orders for wound care and/or respiratory care 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then bi-weekly x 4 weeks to ensure that documentation for wound care and/or respiratory care is accurate. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.8.23, who will be responsible for reporting concerns to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March through May regularly scheduled monthly meetings or until resolved and additional education/training will be provided for any issues identified.	

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F 842	Continued From page 62 tracheostomy care by Resident #123. On 2/8/23 at 10:17 AM, an interview occurred with the Nurse Unit Manager #1 who was familiar with Resident #123. She was scheduled for the day shift on 4/6/22, 4/9/22, 4/14/22, 4/27/22, and 4/29/22. She recalled completing tracheostomy to Resident #123 after medication pass had been completed. The Nurse Unit Manager #1 stated she had forgotten to document the tracheostomy care as completed on the TAR. A phone interview occurred with Nurse #2 on 2/9/23 at 11:45 AM, who was familiar with Resident #123. She was scheduled for the day shift on 4/7/22 and could not recall Resident #123 refusing tracheostomy care. She stated she completed the tracheostomy care but had forgotten to sign it was completed. The Director of Nursing was interviewed on 2/9/23 at 1:01 PM and indicated she expected the nursing staff to complete tracheostomy care as ordered as well as to document it was completed or refused by the resident. Multiple phone calls were made to Nurse #3 who was assigned to Resident #123 on the evening shift of 4/12/22 with no success.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and	F 867		3/3/23

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F 867	Continued From page 63	F 867		

procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success,

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 867	Continued From page 64	F 867		

and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope

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F 867	Continued From page 65 and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification and complaint survey completed on 1/24/20. This was for 3 deficiencies that were cited in the areas of Accuracy of Assessments, Services Provided Meet Professional Standards, and Increase/Prevent Decrease in Range of Motion/Mobility. In addition, one further deficiency	F 867	F867 QAPI/QAA Improvement Activities The facility will continue to ensure that the quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 867	Continued From page 66 was cited during the annual recertification and complaint survey on 3/17/22 in the areas of Resident Records. The duplicate citations during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This citation is cross referenced to: 1. F641- Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of cognition (Residents #89. #87 & #19), pressure ulcer (Resident #114) and diagnoses (Resident #28) for 5 of 31 residents whose MDS were reviewed. During the facility's recertification survey of 1/24/20, the facility failed to code the MDS assessment accurately in the areas of Activities of Daily Living (ADLs), active diagnosis, discharge, restraints, behaviors, medications and bowel and bladder for 9 of 31 sampled residents reviewed. In an interview with the Administrator on 2/9/23 at 1:30 PM, he felt the repeat citation in MDS accuracy was felt to be related to human error. 2. F658- Based on record review, observation and staff interview, the facility failed to transcribe the correct medication administration route for 1 (Resident #87) of 4 residents reviewed for gastric feeding tube and with orders for nothing by mouth (NPO). During the facility's recertification survey of	F 867	Corrective Action: The facility will continue to code assessments to accurately reflect the resident□s status. The facility will continue to ensure that the correct medication administration route is transcribed for residents receiving gastric tube feeding with orders for nothing by mouth. The facility will continue to ensure that palm guards and splints are applied as ordered for range of motion. The facility will continue to maintain accurate medical records for wound care and respiratory care. Residents #87, #114, #28, #89, and #19 had MDS corrections completed by 2.9.23. No negative outcome was identified relating to these observations. Resident #87 had physician order corrections completed on 2.8.23. No negative outcome was identified relating to this observation. Resident #58 continues to wear splints as ordered. Resident #87 continues to wear the palm guard as ordered. No negative outcome was identified relating to these observations. Resident #123 no longer resides at the facility. No negative outcome was identified relating to these observations. How the facility will identify those who have the potential to be affected: Current residents with MDS assessments that are coded as BIMS not completed due to rarely/never understood and no staff interview completed, current residents with pressure ulcers, and current residents with diagnoses of	

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 867	Continued From page 67 1/24/20, the facility failed to accurately transcribe physician orders for diabetic ulcers and a surgical wound for 1 of 6 residents reviewed with pressure ulcers. In an interview with the Administrator on 2/9/23 at 1:30 PM, he indicated the facility had experienced some staff turn-over and felt the information may not always be readily available to the MDS Nurse for proper coding of the MDS assessment. 3. F688- Based on record review, observations, and staff interviews, the facility failed to apply the right-hand palm guard (Resident #87) and bilateral elbow extension splints (Residents #58) as ordered for 2 of 3 residents reviewed for range of motion. During the facility's recertification survey of 3/17/22, the facility failed to apply splints as ordered for 1 of 2 residents reviewed for contractures and limited range of motion. An interview with the Administrator was conducted 2/9/23 at 1:30 PM, and he indicated there had been some staff turn-over to include management. The facility was utilizing agency staff and felt there was a lack in oversight and education to ensure the splints were applied as ordered. 4. F842- Based on record review and staff interviews, the facility failed to maintain accurate medical records for wound care (Resident #123), and respiratory care (Resident #123). This was for 1 of 7 closed records reviewed.	F 867	Hypothyroidism and Atrial Fibrillation, have the potential to be affected. All current residents that meet these criteria were reviewed by 2.24.23 to ensure that assessments had been completed that accurately reflect each resident□s status. No negative observations were identified. Current residents that receive gastric tube feeding and have orders for nothing by mouth have the potential to be affected. Current residents meeting this criteria were audited on 2.21.23 to ensure that the correct medication administration route is transcribed for all ordered medications. No negative outcome was identified relating to these observations. Current residents with orders for splints and palm guards have the potential to be affected. Current residents with orders for splints and palm guards were reviewed by the Rehab Services Director as of 2.24.23 to ensure that splints and palm guards are being worn as ordered. No negative outcomes were identified relating to these observations. Current residents with orders for wound care and respiratory care have the potential to be affected. TAR□s for current residents with orders for wound care and respiratory care were reviewed on 2.23.23 to ensure that medical records for wound care and respiratory care were accurate. No negative outcomes were identified relating to these observations. Systemic changes: The MDS Coordinator	

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F 867	Continued From page 68 During the facility's recertification survey of 1/24/20, the facility failed to have complete medical records in the areas of treatments, showers, accuchecks, sliding scale insulin and nursing assessment for 4 of 27 residents reviewed for complete and accurate medical records. An interview with the Administrator was conducted 2/9/23 at 1:30 PM and indicated the facility had experienced some challenges due to nursing staff, to include management turnover. The facility was utilizing agency staff and felt the repeat citation could be a result of the need for education and oversight.	F 867	and Social Worker were inserviced by the Clinical Resource Specialist on 2.28.23 on completing assessments that accurately reflect the resident□s status. All licensed nurses will be inserviced by the ADON by 2.24.23 on the facility policy for ensuring that the correct medication administration route is transcribed for all ordered medications. Newly hired staff and agency nurses that are hired after 2.28.23 will be educated by the ADON on the facility policy for ensuring that the correct medication administration route is transcribed for all ordered medications. All licensed nurses and nursing assistants were inserviced by the ADON as of 2.28.23 on the facility expectation that residents must have splints applied as ordered to prevent further contractures. All licensed nurses were inserviced by the ADON as of 2.28.23 on the facility policy on ensuring that medical records for wound care and respiratory care are accurate. Newly hired staff and agency nurses that are hired after 2.28.23 will be educated by the ADON on the facility policy on ensuring that medical records for wound care and respiratory care are accurate. The facility□s quality assurance committee will be inserviced by the Regional Clinical Coordinator on the procedures for developing and implementing appropriate plans of action to correct identified quality concerns on 2.28.23. Education will include determining the root cause of the identified concerns, and identifying,	

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 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 69	F 867	implementing, and monitoring the corrective action plan and recognizing when an action plan may need to be revised. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 3.1.23. The DON/designee will randomly audit 5 resident MDS□s weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 4 weeks to ensure that MDS assessments are being completed that accurately reflect the resident□s status. Variances will be corrected at the time of audit and additional education provided when indicated. A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON beginning on 3.1.23. Residents that receive gastric tube feeding and have orders for nothing by mouth will have order audits completed 3x/week x 4 weeks then weekly x 4 weeks then bi-weekly x 4 weeks. Variances will be corrected at the time of the observation and additional education provided when indicated. A QA monitoring tool will be utilized to ensure ongoing compliance by the RSD/designee beginning on 3.1.23. The RSD/designee will observe residents with palm guards and splints 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then every other week x 4 weeks to ensure that palm guards and splints are being worn as ordered.	

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F 867	Continued From page 70	F 867	Variances will be corrected at the time of audit and additional education provided when indicated. A QA monitoring tool will be utilized to ensure ongoing compliance by the Treatment nurse/designee beginning on 3.1.23. The Treatment nurse/designee will randomly audit TAR□s for 3 guests with orders for wound care and/or respiratory care 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then bi-weekly x 4 weeks to ensure that documentation for wound care and/or respiratory care is accurate. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator monthly for the next 3 months beginning on 3.8.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Coordinator. The Regional Clinical Coordinator will attend the facility quality assurance committee meeting monthly x 3 months to ensure committee is developing and implementing appropriate plans of action to correct quality concerns. Variances will be corrected and/or additional education provided when indicated. Continued compliance will be monitored through the facility□s Quality Assurance	

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F 867	Continued From page 71	F 867	Program. Compliance will be monitored by the QA Committee and the Regional Clinical Coordinator for 3 months or until resolved and additional education/training will be provided for any issues identified.	