STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	**700 JOHNSON RIDGE ROAD** **ELKIN, NC 28621**

(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 157 SS=G	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		11/4/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 10/23/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interview the facility failed to notify the physician of a new and worsening pressure ulcer for 2 of 7 residents (Resident #133 and Resident #40) reviewed for pressure ulcers which resulted in delayed assessment and treatment. The findings included: 1. Resident #133 was admitted to the facility on 2/2/2017 with diagnoses which included Benign Prostatic Hypertrophy, Non-Alzheimer's Dementia, Anxiety Disorder, Depression, and Chronic Obstructive Pulmonary Disease (COPD). During record review of the admission Minimum Data Set (MDS) Assessment for resident #133 dated for 2/13/17 documented the resident to be severely cognitively impaired. For assessment of ADL's in Section G the resident required two person extensive assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and one person extensive assistance for eating meals. This MDS from coded that the resident was at risk for pressure ulcers but did not have any skin conditions on admission. Review of the signed physician telephone orders	F 157	1. The plan of correcting the specific deficiency. Addressing processes that lead to the deficiency cited. a. The facility identified a concern with regards to wound management on 8/30/17 during a routine audit. The physician and resident representative were notified on 9/1/17 for resident #133 and resident #40, both prior to survey on 9/24/17. Documentation in the resident□s health record was updated to reflect assessment, notification and any new orders. b. A plan of action was developed and initiated with the facility DON (at that time) to provide oversight of the plan. A 100% skin sweep was completed by 9/7/17, and this was compared to wound reports, wound documentation, and treatment orders for accuracy in a meeting. Identified items and the plan of action were brought to the facility QAPI meeting on 9/14/17 and the said plan was discussed. It was found the DON (at that time) had failed to address the said plan as directed. The DON (at that time) was terminated on 9/15/17. Two corporate directed treatment nurses were brought in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 157	Continued From page 2 dated 7/13/17 indicated treatment for right & left hip abrasions to be cleaned with normal saline, apply an Aquacel foam dressing (wound dressing) and change daily. MD #1 requested a wound consult by Wound MD on 7/25/17. Physician note from 7/25/17 from Wound MD was his initial consult and assessment of resident #133's wounds. The wounds assessed included: large abscess to right hip with cellulitis, ulcer to right foot, and pressure ulcer of left heel stage 2. The Wound MD recommended intramuscular (IM) Invanz 1 gram (antibiotic) for 7 days for cellulitis and to reevaluate in a few days. No measurements or descriptions of the wounds were documented. Review of a wound assessment note by Nurse 1 from 7/25/17 revealed documentation for right hip unstageable pressure ulcer measuring 9 centimeters (cm) in length by 7 cm in width, covered with 100% eschar (dry, dark scab or falling away of dead skin) tissue. No other assessment of the stage 2 pressure ulcer identified on resident #133's feet was provided. Review of a Wound Assessment note by Nurse 1 from 7/28/17 at 7:34 PM revealed documentation for a right medial heel unstageable pressure ulcer measuring 6 cm in length by 3 cm in width covered with 100% eschar tissue. The treatment for this wound was to be cleaned with normal saline and apply Sure Prep (skin protective wipes) on Monday, Wednesday, and Friday. A left medial ankle unstageable measuring 3 cm in length by 3 cm in width by 0.2 cm in depth covered in 90% eschar tissue and 10%	F 157	on 9/19/17 to perform another total skin sweep, update all documentation, notifications, and orders. The Wound MD rounded on 9/19/17 and 9/21/17 with these nurses to assess conditions of wounds identified. Another wound meeting was held on 9/21/17 with notifications verified. Weekly meetings have continued since and notifications have been in compliance. c. It was determined by the facility administrative staff and the QAPI committee that a disruption in practice and protocol was the cause of the error for both Resident 133 and Resident 40. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a. An in-house facility plan of action (POA) was initiated on 8/30/17 by the facility Executive Director and DON relating to wound care treatment and documentation, which included notification of physician and Resident Representative. The POA was revised and re-instated on 9/15/17 due to the termination status of the treatment nurse and facility DON. This POA was in place and actively pursued at the time of the survey on 9/24/17. b. Licensed staff were re-inserviced on 10/4/17 by the Corporate Director of Clinical Operations with regards to following facility policy for notification of physician and Resident Representative of changes in a resident□s condition. A follow-up inservice conducted on 10/13/17 and 10/17/17 for those not in attendance on 10/4/17. New licensed staff will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 157	Continued From page 3 granulation tissue (new connective tissue and microscopic blood vessels that is formed on the surfaces of a wound during the healing process). The treatment for this wound was to be cleaned with normal saline, apply an Aquacel foam dressing (wound dressing) and change daily. A Deep Tissue Injury (DTI - Purple or maroon discolored localized area of intact skin or blood-filled blister due to damage of underlying soft tissue from pressure) to resident #133's sacrum measuring 6 cm in length by 8 cm in width described as 100% purple/blue in color. There were no treatment orders for this wound. A left hip DTI measuring 4 cm in length by 4 cm in width described as 100% purple/blue in color. This wound was to be cleaned with normal saline, apply an island dressing, and change daily. The note stated that the resident's responsible party (RP) was notified and that MD #1 was updated by fax. During an interview on 9/28/2017 at 8:48 AM with the Wound MD when asked when he was consulted to treat the resident's wound he stated he was consulted by MD #1 and first assessed the resident's wound on 7/25/17. Stated after his initial assessment the resident was started on antibiotics, couldn't remember details about the wounds. Stated that the resident was on comfort measures at the time of the assessment. When asked if he had seen or assessed the wounds after the follow-up assessment on 7/27/17 until 9/1/17, he stated that he had not, and that he relied on Nurse 1 to assess and notify him of any changes that were seen, none were reported until 9/1/17. When asked if he had staged the wounds to be end of life by assessing them, he stated he made the determination based on the assessment and the information about the	F 157	trained during orientation. c. A Corporate directed treatment nurse has served in the building weekly to provide continued assessment/ treatment, with proper notifications to the physician and Resident Representative. The facility DON, Quality Surgical Management, and Corporate Directors are providing oversight of said program and notifications. d. A new treatment nurse will begin on 10/30/17 and training will be provided by a corporate directed nurse. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements a. Since 9/21/17, notification of the physician/ Resident Representative with regards to skin issues/wounds is being audited by the DON/ appropriate designee during the facility weekly wound meeting. This audit will be ongoing as the wound meetings will continue weekly indefinitely. Any non-compliance will be promptly addressed. b. Notation on the Nurse 24 Hour reports indicating changes in resident condition will be audited 5X per week for 4 weeks, and as needed going forward, through review of nursing documentation by DON/ administrative nursing staff for notification of physician/ Resident Representative. Any non-compliance will be promptly addressed. c. Compliance of audits regarding physician/ Resident Representative notification of wound(s) and/or changes in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 157

Continued From page 4

wounds given to him by Nurse 1. When asked if he had assessed the resident's sacrum on 7/25/17 or 7/27/17, he stated he hadn't assessed it because he wasn't told about the wound by Nurse 1 on those dates.

During an interview on 9/28/2017 at 12:55 PM with the previous DON she stated that she wasn't aware of the wounds or problems with the treatments until the last week of August. Stated that Nurse 1 was supposed to let her know of wound changes, she relied on her to tell her of changes in the wounds, and that Nurse 1 was over the whole wound process. She also stated she wasn't aware of the exact time that the resident's wounds appeared or worsened.

Attempted to call Nurse 1, the nurse was no longer working at the facility, and no interview was obtained.

During an interview with MD #1 on 9/29/17 at 11:28 AM, when asked if he was resident #133's primary physician he stated that he and his nurse practitioner (NP 2) were his primary and secondary providers. When asked when and why he had consulted the Wound MD he stated that he assumed it was for a decubitus ulcer but consulted the Wound MD as soon as he was notified of the wounds. He did not remember who notified him and stated that it is usually sent as a fax to his office, but could not find the documentation to answer the question. When asked if he had assessed the wounds, he stated he had not seen them until 9/1/17 because he relied on the Wound MD for assessing and treating the wounds. When asked if he had received any information from the facility or from the Wound MD about worsening of the wounds

F 157

resident condition will be brought to the morning administrative meeting by the DON/ Appropriate designee weekly X 4 weeks for review by administrative staff.
d. Compliance with of random audits regarding physician/ Resident Representative notification of wound(s) and/or changes in resident condition will be brought to the facility monthly QAPI meeting x 3 months, and as needed going forward, for review of compliance with said plan by the QAPI committee members.
e. Outcomes, discussions, and revisions if needed, will be part of the meeting minutes
f. Applicable staff will be re-inserviced as needed for any revisions to said plan.
g. Revisions to said plan will require monitoring to begin again at step 3(a).
4. The title of the person responsible for implementing the acceptable plan of correction.
a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program.
b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 157	Continued From page 5 he stated he had received no faxed information about the wounds. On 9/1/17 when he was notified in person (couldn't remember by who) and assessed the wounds on 9/1/17 after being told of their status. He also stated he wanted the Wound MD to continue with treatment of this resident's wounds. When asked if he thought the wounds were unavoidable he stated that due to information given to him by staff about resident #133's poor nutrition, his late stage dementia, and his low albumin levels, he had assumed that they were unavoidable. On 9/29/17 the facility was asked to provide information to show that MD #1 had been notified of the change in the pressure ulcers on 7/28/17 via fax and the facility did not provide any information. The facility attempted to call NP 2 on 9/29/17 at approximately 10:30 AM and 12:00 PM, but was unable to obtain her for an interview. 2. Resident # 40 was admitted 6/26/17 with cumulative diagnoses of Alzheimer ' s Disease, diabetes, contractures, multiple pressures ulcers to include an unstageable pressure ulcer to his left ischium. A wound Assessment Report dated 6/26/17 read Resident #40 ' s left ischium measured 3 centimeters (cm) by 3 cm by 0.3 cm with 90% eschar and 10% granulation with a small amount of serous drainage. Orders were to treat the area with Dakin ' s Solution (solution use to kill germs) and Santyl (ointment use to clear way unhealthy tissue) daily. The wound was to be covered with Aquacel (a silver-based dressing use to absorb wound drainage). His admission Minimum Data Assessment (MDS) dated 7/3/17 indicated Resident #40 had severe	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 157	Continued From page 6 cognitive impairments, no behaviors and extensive assistance with his activities of daily living (ADLs). He was coded as incontinent of bowel and bladder and coded for pressure ulcers present on admission. The Care Area Assessment dated 7/3/17 indicated he was at risk for the development and worsening of pressure ulcers due to his impaired mobility, contractures and poor nutritional status. Resident #40 was care planned on 7/3/17 for his left Ischial unstageable pressure ulcer with interventions to include the following: -Record appearance, amount and odor of drainage and report decline to his wound status A Wound Assessment Report dated 7/7/17 read the left ischium unstageable pressure ulcer remained the same as far as measurement but was described as having 100% eschar. The wound was documented as having no odor or drainage. The treatment was to clean with wound with Normal Saline, apply Aquacel daily. The wound assessment note read the Nurse Practitioner was updated via a form in his folder by Nurse #1. A Wound Assessment Reports dated 7/14/17, 7/20/17, 7/28/17 and 8/4/17 read the left ischium unstageable pressure ulcer remained the same as far as measurement but was described as having 100% eschar. The wound was documented as having no odor or drainage. The wound assessment note read the physician was updated via a form in his folder for 7/14/17, 7/20/17, 7/28/17 and 8/4/17 by Nurse #1. A Wound Assessment Reports dated 8/11/17 and 8/15/17 read the left ischium unstageable	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 157	Continued From page 7	F 157		

pressure ulcer remained the same as far as measurement but described as having 10% slough and 90% eschar with a scant amount of drainage with no odor. The wound was documented as having no odor or drainage. The wound assessment note read the physician was updated via a form in his folder for 8/11/17 and 8/15/17by Nurse #1.

A Wound Assessment Report dated 8/24/17 read the left ischium unstageable pressure ulcer remained the same as far as measurement but described as having 10% slough and 90% eschar with a scant amount of drainage with no odor. The wound was documented as having no odor or drainage. The wound assessment note read the physician was updated via a form in his folder by Nurse #1.

A nursing note dated 8/31/17 at 2:25 AM read there was new order to culture Resident #40 ' s left ischium and start Rocephin (antibiotic) Intramuscularly daily for 7 days.

A Wound Assessment Report dated 9/1/17 read the left ischium stage 4 pressure ulcer measured 6 cm by 5 cm by 4.5 cm with undermining at 12 PM of 6 cm with 90% wet eschar and 10% granulation tissue with a moderate amount of serous drainage with noted odor. Cipro was started twice daily for 2 weeks and continue the Rocephin.

A review of the Wound Culture read Resident #40 cultured Proteus mirabilis (gram-negative rod bacteria) on 9/2/17.

A review of the physician orders and TAR read

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 157 Continued From page 8

starting on 9/2/17, Resident #40 ' s left ischium was to be cleaned with Dakin ' s Solution and packed with Dakin ' s Solution and covered daily.

A review of the physician orders read on 9/4/17 the Cipro and Rocephin were stopped and Amikacin (antibiotic) Intramuscularly twice daily for 10 days was ordered. The bacteria were sensitive to the Amikacin.

A review of the physician orders read on 9/5/17, a Peripherally Inserted Central Catheter (PICC) line was inserted and the Amikacin was changed to Intravenous twice daily for 10 days.

A nursing note dated 9/11/17 at 4:18 PM read Resident #40 was more lethargic. The physician was notified and ordered Stat Lab work. At 6:26 PM, Resident #40 ' s vital signs were: temperature 97.3 degrees Fahrenheit, blood pressure of 79/41 and pulse 106. At 6:26 PM, the physician ordered Resident #40 be sent to the hospital for a change in his level of consciousness.

A review of the hospital discharge summary dated 9/14/17 read Resident #40 was discharged to the hospice house with cumulative diagnoses of pneumonia and sepsis from his multiple pressure ulcers.

In a telephone interview on 9/27/17 at 11:49 AM, Nurse #1 stated she was the treatment nurse for the facility and her last days was 9/1/17. She stated Resident #40 was admitted with multiple pressure ulcers and she updated the physician weekly in writing. Nurse #1 stated the physician nor the DON ever observed Resident #40 ' s wounds until 8/31/17 but the DON would give her

F 157

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 157	Continued From page 9	F 157		

advice if she asked. She confirmed the Nurse Practitioner was at the facility weekly but he did not ask him to assess Resident #40 ' s left ischium. She stated Resident #40 ' s physician also had his own wound clinic and told her what treatments to use.

In a telephone interview on 9/27/17 at 2:57 PM, the Nurse Practitioner stated he was at the facility Mondays, Wednesdays and Fridays and Nurse #1 never asked him to assess Resident #40 ' s left ischial pressure ulcer and no one asked him to assess Resident #40 ' s left ischial pressure ulcer until the DON asked on 8/31/17. The Nurse Practitioner stated Resident #40 ' s left ischial pressure ulcer looked infected and had a noted odor.

In an interview on 9/28/17 at 8:50 AM, the physician stated he only visually assessed wounds as needed. He stated Nurse #1 would communicate the status of Resident #40 ' s pressure ulcers by leaving him a note in his folder. The physician stated he was not notified of the worsening of Resident #40 ' s left ischial pressure ulcer until sometime after 9/1/17. He stated he ordered a PICC line and changed his antibiotics on 9/5/17. The physician stated it was his expectation that someone for the facility team would have notified him of worsening the Resident #40 ' s left ischial pressure ulcer.

In a telephone interview on 9/28/17 at 12:30 PM, the previous DON stated staff reported that Resident #40 ' s left ischial pressure ulcer had developed an odor so a culture was obtained. She stated the called the physician and spoke with the Nurse Practitioner and asked if they were aware of the change in Resident #40 ' s left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 157	Continued From page 10 ischial pressure ulcer. She stated they told her they were not aware. The previous DON stated it was her expectation that Nurse #1 would have notified the physician or the Nurse Practitioner or non-healing or worsening of Resident #40 ' s left ischial pressure ulcer. In an interview on 9/29/17 at 11:30 AM, the Administrator stated it was her expectation that the nursing department notified the attending physician for any changes or worsening in Resident #40 ' s pressure ulcer.	F 157		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat 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. This REQUIREMENT is not met as evidenced by: The facility failed to serve the food to all residents seated at the same table during two meal observations. Resident # 106 waited 40 minutes for her food while a table mate ate supper, Resident #114 waited 35 minutes and Resident # 16 waited 30 minutes to be fed while her table mate was fed lunch. Failing to provide a dignified dining experience occurred in 2 of 3 separate dining areas, the main dining room and the silver spoon dining room. The findings included: 1. Continuous observations of the supper meal service to the residents in the main dining room	F 241	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited. a. Residents #106, #114, #16 with regards to the cited deficiency received their meals and were assisted as needed. b. It has been determined by the facility QAPI committee that the disparity of residents receiving meals by table and timely was related to (1) miscommunication between seating for residents and tray assembly in dietary. (2) inadequate oversight in the resident dining areas.	11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 11 on 9/24/17 from 4:30 PM to 5:05 PM, revealed there were 11 separate dining tables in the room. Resident #106 was seated at table #3 on the left side of the room. Residents # 21 and 114 were at the same table. Resident #21 received her supper meal at 4:40 PM and she began to eat her food. Residents were served randomly at other tables during the observation. Observation at 4:45 PM revealed Resident #16 was heard saying "Hello, hello, where's my food?" Observation at 5:00 PM revealed Resident #21 left the dining room and Resident #106 used her hand to eat some of the food left by Resident #21. Resident # 114 was observed to grab some of the food left by Resident #21. Aide # 11 came by the table at 5:03 PM and pushed the food away from both residents. Observations at 5:05 PM revealed Aide #11 removed Resident #21's plate with the remaining food from the table. Observation at 5:07 PM revealed Resident #114 received her food and at 5:12 PM Resident #106 received her food. Interview with aide #10 on 9/28/17 at 4:30 PM revealed he was not aware Resident #106 was asking for her food. He explained the trays were not in the same order as the resident tables. Aide #10 further explained they try to get the trays out as fast as possible. Interview with the Administrator on 9/29/17 at 12:58 revealed the trays were not in any order in the tray cart for the main dining room due to residents sitting wherever they wanted. There was not a seating assignment. The Administrator explained ideally there would be 3 aides in the silver spoon dining room, and one aide and a patient care assistant (PCA) in the main dining room. The residents in the main	F 241	2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited a. Dining times were changed on 10/16/17 to where the main dining room/ Silverspoons Dining is served first before the units are served to eliminate the staff from being called to both the units and the dining rooms. b. An updated list of the location for dining for each resident was completed by facility administrative staff on 10/18/17. Resident KARDEX updated by facility administrative staff with the current information c. The presence of a tray cart was eliminated in the main dining room on 10/3/17. Residents are now served restaurant style. Once the table of residents is seated, dietary prepares the resident□s plates and they are served at one time. d. A staff member has been assigned to the main dining room for each meal to oversee the dining process. e. A minimum of 2 CNAs have been assigned to the Silverspoons Dining room for each meal to provide assistance in resident dining. f. The Certified Dietary Manager (CDM) and the Registered Dietician (RD) have updated their orientation to include the revised dining service in order for staff to be aware of dining process expectations. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 12 dining room required cueing for meals. She would expect the nurse to supervise the aides and alert management if there was not enough staff. The Administrator expected residents to receive trays at the same table within a reasonable timeframe. 2. Continuous observations on 9/26/17 in the silver spoon dining room from 11:43 AM to 12:35 PM revealed there were six residents with 2 staff members in the room. Resident #16 was seated at a table with another resident and one staff member (Aide #9). Aide #9 fed the other resident and Resident #16 did not receive her tray. A visitor was observed to enter and feed the table mate while Resident #16 remained at the table without her food. Aide # 9 left the table, left the silver spoon dining room and began assisting in the main dining room (adjacent to the silver spoon dining room). Observations revealed at 11:52 a third Aide # 3 came to the silver spoon dining room with another resident, and provided the resident a tray and assisted that resident. Observations at 11:54 AM revealed Aide #5 entered the dining room and provided another resident with feeding assistance. Observations at 12:15 revealed Resident #16 received her tray and feeding assistance. An interview was conducted on 9/29/17 at 12:31 PM with aides # 8 and 9, who had worked in the silver spoon dining room on 9/26/17. Interview revealed they were supposed to have 3 aides assigned to the silver spoon dining room. They both explained there would be 2 aides on each hall. One aide from each of the halls (100, 200 and 300 halls) were to come to the silver spoon dining room. If there were only 4 total aides on for all three halls, there would be 2 aides in silver	F 241	a. Dining Room audits are and will continue to be completed by the Administrative Staff 5 times per week X 4 weeks. b. Followed by 3 meals observed on a weekly basis X 4 weeks, and as needed. c. Followed by 3 meals observed on a monthly basis X 4 months, and as needed. d. Compliance outcomes will be brought to the morning administrative meeting by the Executive Director/appropriate designee weekly for 3 months. Any non-compliance will be promptly addressed. e. The plan and outcomes will be reviewed by the facility QAPI committee members monthly X 3 and going forward, as needed. f. All discussion of said plan, outcomes, revisions, etc. will be included in the meeting minutes. g. The CDM/RD/appropriate designee will re-inservice applicable staff should revisions be made to the said plan. h. Any revision of plan will require monitoring of said plan to begin again at step 3(a). 4. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility CDM/RD, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 13 spoon dining room. The residents in that dining room required feeding assistance. The staffing for 9/29/17 was reviewed and revealed there were 3 aides for 100, 200 and 300 halls (one aide per hall). Interview with the Administrator on 9/29/17 at 12:58 revealed the trays were not in any order in the tray cart for the main dining room due to residents sitting wherever they wanted. There was not a seating assignment. The Administrator explained ideally there would be 3 aides in the silver spoon dining room, and one aide and a patient care assistant (PCA) in the main dining room. The residents in the main dining room required cueing for meals. She would expect the nurse to supervise the aides and alert management if there was not enough staff. The Administrator expected residents to receive trays at the same table within a reasonable timeframe. Interview with the charge nurse for the 100, 200 and 300 halls was conducted on 9/29/17 at 1:05 PM. Nurse # 11 explained she was from a "sister" facility and was not familiar with what a silver spoon dining room meant. She explained she thought it was restorative dining. Nurse #11 was not aware the silver spoon dining room did not have enough staff to provide assistance at mealtime.	F 241	Executive Director's absence.	
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial	F 250		11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 250	Continued From page 14 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family, staff and physician interviews, the facility failed to provide a psychiatric service recommended by the physician to evaluate one of one resident (Resident #53) reviewed for social services needs. Findings included: 1. Resident #53 was admitted to the facility on 5/29/17 with diagnoses that included, in part, major depressive disorder, single episode, unspecified. A review of the quarterly Minimum Data Set (MDS) assessment dated 8/2/17 revealed Resident #53 was cognitively intact. He did not have any problems with mood, nor did he have any psychosis or negative behaviors. A review of a social services note dated 8/2/17 revealed cognition and mood interviews were conducted by the social worker on 8/1/17. "Resident was alert and oriented. He reported no mood concerns and has had no behaviors. However, Social Services Director (SSD) had a meeting earlier this week where resident stated that he felt he had outlived his usefulness and that he felt hopeless. He did not state this during this interview. He stated that 'Everyone thinks of suicide, it used to frighten me but it no longer does.' He contracted for safety today, this was also reported to the nurse practitioner (NP) that was in the building today." A review of the physician note (MD) dated 8/3/17 revealed, "The social worker in the nursing facility	F 250	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. Resident #53 was seen by the psychiatrist on 10/11/17 with no further verbal expressions of depression. b. Facility administrative team (QAPI committee members) reviewed the cited deficiency and determined human error and miscommunication to be the definitive causes. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a. The facility Social Service Director was re-inserviced by the Executive Director on 10/2/17 regarding (1) asking the physician to complete an order for any recommendations as it is outside the scope of a social worker to write orders. (2) to act promptly on any returned consents for ancillary treatment/ procedures prior to filing. b. Standing order has been added for mental health consults and other ancillary services to prevent a delay in treatment. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; a. All orders are and will continue to be reviewed during the morning clinical meeting 5x per week, by the administrative nurses/ medical records,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 250	Continued From page 15	F 250		

reported that the resident felt more depressed lately. He is on multiple medications. He has not seen psychiatrist recently. After medication review will try to simplify some of his medications although he is on multiple antidepressants. Will recommend a psychiatric evaluation."

A review of the care plan updated 8/6/17 revealed Resident #53 was at risk for side effects from antianxiety and antidepressant medication use. Care plan interventions included, "observe for adverse side effects, document and report to physician."

A review of the care plan updated 9/25/17 revealed a problem of combative behavior, hallucinations and delusions. Care plan interventions included, "approach resident warmly and positively, allow resident opportunity to make choices, do not argue with resident and praise resident for demonstrating desired behavior."

A review of Resident #53's medical record revealed no order or paperwork for a psychiatric evaluation and no evidence that the resident was seen by any psychiatric service.

An interview was completed with the nurse practitioner (NP) on 9/28/17 at 8:18 AM. He stated he didn't recall being notified of Resident #53's mood. He said if he knew about the resident's statements about suicide he would have made a note in the chart.

An interview was completed with the MD on 9/28/17 at 9:01 AM. He recalled that the SSD notified him of a change in the resident's mood and that they talked about an evaluation the next time the psychiatric service came into the

with any non-compliance promptly addressed.
b. Results of compliance with said program will be brought to the morning administrative meeting by the Director of Social Services/ appropriate designee weekly X 4 weeks, and as needed, for discussion by administrative team and any non-compliance promptly addressed.
c. Results of compliance with said program will be brought to the facility monthly QAPI meeting by the Director of Social Services/ appropriate designee monthly X 3 months, and as needed, for discussion by the QAPI committee members for root cause of any non-compliance, and the need to revise the said plan if needed.
d. All discussion and revisions to said plan, if any, will be noted in the QAPI meeting minutes and additional in-servicing by the Executive Director as appropriate.
e. Any revision to said plan will require monitoring to begin again at 3(a)
4. The title of the person responsible for implementing the acceptable plan of correction.
a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program.
b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 250	Continued From page 16 building. The MD said he spoke with the resident and family member and made some medication changes. He further stated he did not have to write a specific order for a psychiatric evaluation. An interview was completed with the SSD on 9/28/17 at 9:09 AM. She said Resident #53 hadn't had any psychiatric issues since he was admitted to the facility. She recalled his statement that everyone thought of suicide was made during a resident group meeting and said "He has said things like that from time to time." She said she notified the NP or MD after Resident #53 made that statement. She stated that an outside provider came in every other week and provided psychiatric services. She said the process for obtaining psychiatric services was that the primary MD wrote an order for a psychiatric evaluation and a copy of the order was given to the SSD. Once she received the copy of the order an authorization form had to be completed and signed by the primary MD before the psychiatric service evaluated a resident. She stated the company that provided the psychiatric service required the primary MD's signature on the authorization form prior to seeing a resident. The SSD said she didn't have any record that Resident #53 had received psychiatric services in the facility, or that any authorization paperwork was completed. An interview was completed with Resident #53 on 9/28/17 at 10:05 AM. He stated he did not recall being offered psychiatric services after he voiced comments back in August during a resident group meeting. He could not remember if the MD spoke with him about a psychiatric evaluation. He said the SSD talked with him earlier on 9/28/17 about psychiatric services and he said he	F 250		

(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 250	Continued From page 17	F 250		

would talk to his family about it.

An interview was completed with Resident #53's family member (Family Member #1) on 9/28/17 at 12:00 PM. Family Member #1 stated the SSD gave her some forms to fill out about six weeks ago to authorize psychiatric services. She stated she completed the paperwork and returned it to the SSD about 3-4 weeks ago. Family Member #1 said she thought it was a good idea for Resident #53 to be followed by psychiatry because of his history of depression.

A second interview was completed with the SSD on 9/28/17 at 2:30 PM. She stated she thought the forms Family Member #1 turned in were for dental services, not psychiatric services but wasn't sure and would look for the forms
.
A follow up interview was completed with Family Member #1 on 9/28/17 at 2:36 PM. She stated the SSD had just found the authorization forms for psychiatric services in a file.

An interview was completed with the Administrator and Director of Operations on 9/28/17 at 4:34 PM. The Administrator stated she would have expected that if the MD recommended a psychiatric consult that the facility would have arranged for those services.

An interview was completed with the SSD on 9/28/17 at 5:15 PM. She provided a copy of the consent agreement signed on 8/11/17 by Family Member #1. She stated she did not remember if Family Member #1 had turned in the forms to her and that Family Member #1 told her she returned the signed forms on 9/13/17. The SSD said the psychiatric provider was at the facility on 9/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 250	Continued From page 18 but did not see Resident #53 because only urgent cases were seen that day. She stated the provider would return again to the facility in two weeks.	F 250		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278		11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 278	Continued From page 19 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code on the comprehensive admission Minimum Data Set (MDS) assessment a level II PASRR (Preadmission Screening and Resident Review) for 1 of 1 resident (Resident #53) reviewed for PASRR. Findings included: 1. Resident #53 was admitted to the facility on 5/29/17 with diagnoses that included major depressive disorder, single episode, unspecified. A review of the PASRR Level II Determination Notification dated 12/11/14 revealed that Resident #53 was determined to be a PASRR level II (The purpose of the Level II screening is to assure that individuals with serious mental illness entering or residing in Medicaid-certified nursing facilities receive appropriate placement and services). A review of the admission MDS assessment dated 6/5/17 indicated Resident #53 was not coded as a level II PASRR. An interview was completed with MDS Nurse #1 on 9/28/17 at 11:09 AM. She stated the nurse who completed Resident #53's assessment no longer worked at the facility and probably incorrectly coded the MDS. MDS Nurse #1 said the PASRR information was located under the admissions tab in the medical record and typically she was notified of any new residents with level II PASRRs in morning meetings. MDS Nurse #1 stated she would correct the MDS to reflect the	F 278	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. Resident #53 MDS was corrected to reflect the Level II PASRR and re-submitted on 9/28/17. All MDS for residents displaying a Level II PASRR were audited on 9/28/17 for accuracy with coding. No other MDS were found to be inaccurately coded. b. It was determined by the facility administrative staff (QAPI committee members) the communication process between admissions and MDS staff needed revision to include prompt and accurate relaying of information for assessment purposes. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; a. The process for distributing PASRR II information to the appropriate staff was reviewed during morning administrative meeting on 10/2/17 by the facility Executive Director. b. The Corporate Director of Clinical Reimbursement will reinforce the communication process for relaying information between Admissions, Business Office, and MDS necessary for accurate assessments. This meeting will occur on/before 10/20/17 to ensure understanding by all parties. Any new MDS staff will be in-serviced during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 278	Continued From page 20 resident's level II status. An interview was completed with the Admission Nurse Liaison on 9/28/17 at 3:22 PM. She said the level II PASRR information was placed in the medical record and she assumed the MDS Nurse got the information from there. An interview was completed with Human Resources/Payroll Employee on 9/28/17 at 3:55 PM. She stated if a resident was admitted to the facility with a level II PASRR she notified the Administrator. She said she was new to the PASRR process and was not aware the MDS Coordinator was to be notified of any residents with level II PASRRs. An interview with the Administrator on 9/28/17 at 4:34 PM revealed her expectation that the level II PASRR infor mation be correctly coded on the MDS assessment.	F 278	orientation. c. PASRR level was added to the admission alert on 10/18/17 which is given to the MDS staff prior to any new admission. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; a. Checking PASRRs for every newly admitted/ readmitted resident was added to the facility 5 day chart check to insure accurate coding of assessments b. The Corporate Director of Clinical Reimbursement / appropriate design will audit MDS completed for any newly admitted or re-admitted with a Level II PASRR X 3 months. Any non-compliance will be promptly addressed. c. Compliance results with said plan will be brought by the DON/appropriate designee to the facility monthly QAPI meeting for review of outcomes, corrective actions, and compliance by the QAPI committee members. d. All discussion, outcomes and revisions will be contained in the meeting minutes. e. The Corporate Director of Clinical Reimbursement / appropriate designee will re-inservice appropriate staff should revision to the said plan be revised. f. Any revision to said plan will result in the monitoring process to begin again at Step 3(a). 4. The title of the person responsible for implementing the acceptable plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	**700 JOHNSON RIDGE ROAD ELKIN, NC 28621**

(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 278	Continued From page 21	F 278	a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and	F 280		11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 280	Continued From page 22 shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident’s strengths and needs. (iii) Incorporate the resident’s personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident’s medical record if the participation of the resident and their resident representative is determined	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 280	Continued From page 23 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to update the care plan for the use of a comfy splint for one (Resident #129) of two sampled residents with splints. The findings included: Resident #129 was admitted to the facility on 8/18/16 with diagnoses including Alzheimer's disease, previous fracture of the lower leg and short Achilles tendon of the right ankle. The annual Minimum Data Set, dated 7/3/17 indicated Resident # 129 had severe impairment with long and short term memory. The MDS indicated she required extensive assistance of two staff persons for transfer, dressing and hygiene. Review of the area of limitation of functional movement revealed she had no limitation in the lower extremities. Review of the care plan that was not dated revealed the use of the comfy splint for the foot drop was not addressed. Review of the Kardex (aides' care plan in the computer) did not instruct the aides to apply the comfy splint. Observations on 09/25/17 at 10:54 AM revealed	F 280	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. Therapy re-assessed Resident #129 on 9/28/17 for the continued need for the splint and a clarification order was written and processed for continued use of the splint. b. Resident #129 plan of care and KARDEX were revised on 9/28/17 to include the application of the comfy splint. c. After review of the situation, the facility administrative team (QAPI committee members) determined a revision to the process of communication between ancillary services (therapy in this case) and nursing with regards to splint usage was needed. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; a. Therapy Manager/ appropriate designee completed an audit of all residents with splints was completed on 10/16/17 to insure continued splint usage	

F 280

Continued From page 24

Resident #129 was seated in a wheelchair and the right foot was noted to have foot drop. No devices were applied to support the left foot. A soft splint was observed in the room.

Interview on 09/28/2017 at 11:41 AM with the MDS nurse revealed she did not have a communication form from therapy for the brace. These communication forms were initiated in the last two months. The MDS nurse explained there were no Care Area Assessments that included the problem of foot drop due to no contractures were present. During the interview, she explained the care plans were updated quarterly and as needed.

Interview with Physical Therapist #2 on 09/28/2017 at 12:03 PM revealed the last therapy discharge note was dated 1/31/17 for a comfy splint to be applied.

Interview with the MDS nurse on 09/28/2017 at 12:41 PM revealed the comfy splint was not care planned and it must have been missed by the former MDS nurse.

F 280

and usage was reflected on the Plan of Care/ KARDEX as appropriate.

b. Licensed/unlicensed staff were re-in serviced on 10/4/17 by the Corporate Director of Clinical Operations with regards to reviewing a resident□s plan of care/ KARDEX when delivering care. New staff will be trained during orientation.

c. MDS and assessment team were re-in serviced on 10-20-17 by Corporate Director of Clinical Reimbursement regarding direct observation and interviews prior to completing MDS

d. All new orders will be reviewed during routine morning clinical meeting 5 x per week and on-going.

e. When orders for splints are reviewed during morning clinical meeting, the MDS personnel/ appropriate designee will review the Plan of Care/ KARDEX for accuracy with regards to splints.

f. Information regarding any splint placement will be communicated to the applicable direct care staff by an in-house Interdisciplinary Communication form and KARDEX.

3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

a. Splint usage will be audited weekly X 4 weeks, and as needed by the Therapy Manager/ appropriate designee with any non-compliance promptly addressed and re-inservicing of applicable staff as needed.

b. Splint usage will be audited monthly X 2 months, and as needed, by Therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 280	Continued From page 25	F 280	Manager/ appropriate designee with any non-compliance promptly addressed and re-inservicing of applicable staff as needed. c. Results of the weekly audit will be brought to the morning administrative meeting weekly X 4 weeks for discussion of compliance and any needed revision. d. Results of the monthly audits will be brought to the facility monthly QAPI meeting by the Therapy Manager/ appropriate designee for review of compliance by the QAPI committee members and any revision deemed needed by committee members. e. All discussion/ revisions will be included in the monthly QAPI meeting minutes. f. Therapy Manager/ appropriate designee will re-inservice involved staff regarding any revisions to said plan. g. Any revision will require monitoring to begin again at 3(a). 4. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 281	Continued From page 26 (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 observations, staff and physician interviews and medical record review, the facility failed to clarify an admission order for a tabs monitor or bed alarm for 1 of 4 residents (Resident #150) reviewed for accidents. Findings included: 1. Resident #150 was admitted to the facility on 7/12/17 and discharged to the hospital on 9/13/17 after sustaining a fall. She re-admitted to the facility on 9/16/17 with diagnoses that included, in part, right hip fracture status post fall and mild dementia. A review of the Admission Minimum Data Set (MDS) assessment dated 7/19/17 revealed Resident #150 had moderately impaired cognition. She required extensive assistance with transfers. She had fallen once since her original admission date with no injury. She was on physical therapy (PT) caseload. A review of the care plan updated 9/12/17 revealed Resident #150 was at risk for falls related to impaired mobility, increased weakness and decreased endurance. Care plan interventions included, "Provide assistance for all safety compromising activities, encourage her to summon assistance for any activity that might	F 281	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. The order for the Resident 150□s tab / bed monitor was written by the hospital physician who was unaware that the facility does not use alarms. The order was not transcribed to the facility orders because the nursing staff was aware of no alarm policy. The order was discontinued on 9/26/17 by the facility physician. b. Resident 150 has not experienced any falls since readmission on 9/16/17 due to not having the alarm. c. Review of the cited deficiency was reviewed by the facility administrative team (QAPI committee members) and determined to be caused human error in not following protocol for order clarifications. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a. Corporate Director of Clinical Reimbursement provided training to MDS/medical record on clarifying orders from the hospital on 10/20/17. b. Any newly admitted/ re-admitted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 281	Continued From page 27 compromise her safety, check for needs often as she has periods of confusion, monitor for changes in condition that may warrant increased supervision/assistance and notify physician (MD) and therapy per orders." A review of admission orders dated 9/16/17 and signed by the hospital Medical Doctor (MD) revealed, "Please order tabs monitor or bed alarm for patient safety." A review of a nurse's note dated 9/16/17 revealed, "MD order in chart as follows: 'Please order tabs monitor or bed alarm for patient safety.'" An observation of Resident #150's room on 9/26/17 at 9:38 AM revealed no alarm on the bed. An observation was made of Resident #150 on 9/26/17 at 9:39 AM. She was in her wheelchair, self-propelling around the nurse's station. There was no tabs alarm on the wheelchair. An interview completed with the Administrator, Director of Rehabilitation and MDS Nurse #1 on 9/26/17 at 2:38 PM revealed the facility didn't use tab monitors or bed alarms because it caused more agitation in residents with dementia. An interview was completed with the Administrator on 9/26/17 at 3:45 PM. She stated the MD from the hospital had ordered the tabs monitor/bed alarm, not the facility MD. An interview was completed with the Interim Director of Nursing (DON) on 9/26/17 at 4:11 PM. She said when a resident was admitted to the facility from the hospital the nursing staff used the	F 281	resident is reviewed by the administrative nurses/ medical records for 5 Day Chart Review post admission for clarification/ completion of actions needed. This practice will continue with the facility Executive Director providing oversight for compliance. c. Any clarifications will be noted in the resident□s medical record for review by the administrative nurses during clinical morning meeting. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; a. Results of the 5 Day Chart Review will be brought to the morning administrative meeting weekly X 4 weeks by the Medical Records Director and as needed. b. Random observations by the Executive Director monthly X 2 months, and as needed. Results of compliance will be brought to the monthly QAPI meeting X 2 months, and as needed. c. Discussion by the QAPI committee members regarding outcomes, and/or any revision to the said plan will be documented in the QAPI meeting minutes. d. The Executive Director/ appropriate designee will provide re-inservicing as needed to any revision of plan. e. Any revision of said plan will require monitoring to begin again at step 3(a). 4. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	**700 JOHNSON RIDGE ROAD ELKIN, NC 28621**

(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 281	Continued From page 28 hospital discharge orders until the facility MD reviewed the information. She stated the MD would be called once the resident was admitted and notified of new orders that needed to be reviewed. She further stated if any immediate clarifications were needed the nurse called the facility MD. An interview was completed with Resident #150's MD on 9/27/17 at 12:10 PM. He stated tab monitors were not used in the facility and couldn't remember if the facility used bed alarms. He said he was not notified by the nurse about clarifying the order for tabs monitor/bed alarm. The MD stated he expected the nursing staff to contact him to clarify orders if it was something the facility didn't use or provide. An interview was completed with Nurse #7 on 9/27/17 at 2:49 PM. She was the nurse on duty when Resident #150 was re-admitted to the facility. She remembered the order for the tabs monitor/bed alarm and said, "I was hoping it would be followed through, I wasn't sure." She stated the facility didn't use tab monitors or bed alarms, and then clarified she thought the facility could use tab monitors, but they did not actually use them. She added that she did not know if an alarm was placed on the resident and that she should have followed up on it. An interview was completed with the Administrator and Director of Operations on 9/28/17 at 4:31 PM. The Administrator stated that staff knew the facility didn't use alarms. She said she expected the nurse would have contacted the MD to clarify the order or have the order discontinued since the facility didn't use chair or bed alarms.	F 281	conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide cueing and assistance while eating for one (Resident #106) of three sampled residents that required limited assistance for eating. The findings included: Resident #106 was admitted to the facility on 6/15/17 with diagnosis of Alzheimer's dementia. Review of the dietician's note dated 6/19/17 indicated Resident #106 had "some confusion but is alert and able to feed herself." Review of a "Restorative Care Referral" form dated 8/30/17 indicated she was to attend restorative dining six days a week. The interventions included for restorative to have the resident stay at the table, lock her brakes, stay close to the resident for verbal cues and please feed the resident if needed to initiate intake. Resident #106 required "supervision - max (maximum) A (assistance) if pt (patient) not self feeding." The type of cues needed included "up to max vc's (visual cues) to attend to task." The quarterly Minimum Data Set (MDS) dated 9/1/17 indicated Resident #129 had severe impairment with short and long term memory and required extensive assistance of one staff member for eating. The care plan that was not dated included a	F 311	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. Resident 106 received dining assistance for meals on 9/25/17 and continues to receive assistance with dining as needed (e.g. cutting food, preparing setting, and cueing) by facility staff. Resident was added to the Silverspoon Dining on 10/5/17 and KARDEX was updated to reflect need for assistance. b. The facility administrative team (QAPI committee members) reviewed the cited deficiency and found human error to be the cause. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; a. Licensed/ unlicensed staff were re-inserviced on 10/4/17 by the Corporate Director of Clinical Operations and on 10/13/17 and 10/17/17 by the facility Executive Director with regards to assisting any resident with Activities of Daily Living (ADLs) as needed and as care planned. Inservice included checking the resident KARDEX for updated information regarding the	11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 311 Continued From page 30

problem for potential weight loss related to diagnosis of dementia. The approaches included the aides were to allow the resident ample time to consume food, provide assistance as needed (cueing, feeding assist) and provide verbal cues for all meals and assist to eat if needed.

Review of the Kardex (care plan for aides) indicated Resident #106 ate in the dining room or in her room, received a regular diet and no straws. The Kardex did not provide instructions to assist or cue the resident.

Continuous observations in the main dining room on 9/24/17 from 4:45 PM to 5:30 PM revealed Resident #106 rolled away from the table at 4:48 PM and a visitor pushed her up to her table. She received her supper tray at 5:12 PM. Aide #10 delivered her tray and offered no assistance with the meal. Nurse Aide (NA) #10 continued passing supper trays in the dining room. Resident #106's meal included a piece of turkey that covered a slice of light bread with gravy, fruit cup and a frozen nutritional supplement. Observations revealed she was unable to cut up the meat and she did not receive assistance with eating. Resident #106 made 3 attempts to cut the meat. A small corner piece remained attached to the whole piece. Resident #106 was observed putting her fork in the small attached piece of turkey. The entire piece of turkey slid off the plate and onto the tray edge. Resident #106 was observed to put her fork down and not attempt to eat the turkey, slice bread or fruit cup. NA#10 came by her table and instructed her to eat her supper. No other cues or assistance was provided. Resident #106 ate the magic cup.

Interview with NA #10 on 9/28/17 at 4:40 PM

F 311

resident. New staff will be trained during orientation.

b. All resident□s KARDEX will be reviewed on/before 10/26/17 by the MDS team/ appropriate designee for accuracy of care needs, with any discrepancies promptly corrected.

c. MDS team re-inserviced on 10/20/17 by the Corporate Director of Clinical Reimbursement on the need to keep the KARDEX current with information related to the care/ needs of the resident(s).

3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

a. Dining Room audits are and will continue to be completed by the Administrative Staff 5 times per week X 4 weeks.

b. Followed by 3 meals observed on a weekly basis X 4 weeks, and as needed.

c. Followed by 3 meals observed on a monthly basis X 4 months, and as needed.

d. Compliance outcomes will be brought to the morning administrative meeting by the Executive Director/appropriate designee weekly for 3 months. Any non-compliance will be promptly addressed.

e. The plan and outcomes will be reviewed by the facility QAPI committee members monthly X 3 and going forward, as needed.

f. All discussion of said plan, outcomes, revisions, etc. will be included in the meeting minutes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 311	Continued From page 31 revealed he had started work at the facility in August. He had worked with Resident #106 and knew she needed cueing. During the interview, he was asked how he would know who needed assistance and cueing in the dining room. NA #10 explained he would ask the other staff if he had a question about a resident and if they needed assistance. Further interview revealed he did not remember if she needed assistance cutting her meat during the supper meal on 9/24/17 . Observations of the main dining room on 09/28/17 at 4:59 PM revealed Resident #106 received her tray and NA #14 provided set up assistance. NA #14 cut the meat into bite size portions. Resident #106 was observed to eat independently after she received set up assistance. Interview with the Interim Director of Nursing on 9/29/17 at 4:00 PM revealed residents should receive assistance with their meals, set up assistance and feeding assistance. The Kardex system informs the NA's of the care that was to be provided. Further interview revealed she would expect the MDS nurse to update the Kardex.	F 311	g. Applicable staff will be re-inserviced by the facility Executive Director/ appropriate designee regarding any revisions to said plan. h. Any revisions to said plan will require monitoring to begin again at 3(a) 4. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.	
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (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 observations, staff, family and resident	F 312	1. The plan of correcting the specific	11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 312	Continued From page 32	F 312		

interviews and record review, the facility failed to provide showers and bed baths as scheduled during a month period of time for 3 (Resident #84, Resident # 100 and Resident #53) of 9 residents reviewed for activities of daily living (ADLs).

Findings included:

1. Resident #84 was admitted 4/12/13 with cumulative diagnoses Rheumatoid Arthritis, contractures, aphasia and dysphasia.

The Quarterly Minimum Data Set (MDS) dated 8/15/17 indicated Resident #84 had severe cognitive impairments with no behaviors and required total assistance with her ADLs to include bathing.

Resident #84's care plan, last revised on 8/30/17, read she required full staff assistance for all her ADLs.

A review of Resident #84 ' s nursing notes from 8/1/17 to 9/28/17 included no refusals of her showers.

A review of the shower schedule indicated Resident #84 was to receive a shower Tuesday and Fridays on first shift.
A review of the facility documented showers provided to Resident #84 read as follows:
Shower-Friday 8/4/17 (no evidence of a bed bath or shower until 8/8/17)
Showers-Tuesday 8/8/17 (no evidence of a bed bath or shower until 8/15/17)
Shower-Tuesday 8/15/17
Shower-Tuesday 8/22/17 (no evidence of a bed bath or shower until 8/25/17 and not another

deficiency. The plan should address the processes that lead to the deficiency cited;
a. Residents/Resident representative of #84, #100 and #53 have been interviewed regarding their bathing preferences. A bath calendar has been established with their preferences and every attempt is being made to provide baths/showers as requested. #53 has received a shower daily since survey.
b. The facility will initiate a shower team on/before 11/4/17 .
c. Following review by the administrative team (QAPI committee members) of the cited deficiency it was determined the lack of availability of possible new hires in nursing staff was the reason.
2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
a. Since end of survey on 9/29/17, the facility has hired 9 CNAs, 2 nurses, 2Medication Aides to improve staffing ratios
b. Wage increase will be given to all current CNA staff on/before 11/3/17 to encourage longevity
c. The facility has offered many incentive bonuses to current staff and new hiring packages in order to attract staff.
d. Licensed and unlicensed staff were re-inserviced on 9/25/17 and 10/4/17 by the Corporate Director of Clinical Operations, and on 10/13/17; 10/17/17 by the facility Executive Director on the importance of providing ADL assistance to dependent residents, to include bed baths daily and/or showers as scheduled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 312	Continued From page 33 shower until 8/29/17) Shower-Tuesday 8/29/17 Shower- Thursday 8/31/17 (no evidence of a bed bath or shower until 9/12/17) Shower- Tuesday 9/12/17 (no evidence of a bed bath or shower until 9/19/17 when he received a bed bath, no evidence of a bed bath on 9/22/17 and not another shower until 9/26/17) Shower-Tuesday 9/26/17 In an interview on 9/26/17 at 3:10 PM, Nursing Assistant (NA) #1 stated due to inadequate staffing, she was often unable to complete her showers and bed baths as scheduled. She stated Resident #84 did receive her scheduled shower today. NA #1 stated for alert and oriented residents, she often asks those residents if it was acceptable to them to postpone their showers to the next day. She stated if she was unable to complete her assigned showers, she reported it to the charge nurse. NA #1 stated Resident #84 was non-verbal and never refused her ADLs. In an observation on 9/26/17 at 3:15 PM, Resident #84 was observed with a dressing to her left elbow and her arm resting on a pillow in bed. She was clean and absent of odors. In an interview on 9/27/17 at 10:22 AM, NA #2 stated she was often unable to complete her assignment when working on one half of 200 hall and all of 300 hall. She stated she was scheduled to give 6 showers and had to assist some residents with eating breakfast and dinner. She stated she often asked her alert and oriented resident if they minded having their showers postponed if she was unable to complete all her showers and some days she did not do a bed bath but reported it to the oncoming shift. NA #2	F 312	e. Residents/resident representatives will be interviewed to determine bathing preferences. Their preferences will be added to their bath/shower calendar. f. Newly admitted residents will be asked about their bathing preference within 5 days of admission. Preferences will be added to their calendar. g. Direct care staff will be in-serviced regarding the bath/shower calendar by 10/27/17. Staff has been instructed to notify the nurse if a resident refuses a bath/shower. New staff will be trained during orientation. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements a. During the 5 Day Chart Review, the bathing calendar will be established based on their preference. b. The bath/shower calendar books will be brought to the morning meetings by the Social Services Director. The previous day baths/showers will be monitored for compliance. Any baths/showers not given will be given that day. c. The Compliance outcomes of step 3(b) will be brought to the morning administrative meeting (where QAPI committee members are present) by the DON/ appropriate designee weekly X 4, and as needed for discussion. d. Compliance outcomes will be brought to the facility monthly QAPI meeting X 2 months for discussion by committee members, determination of root cause for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 312

Continued From page 34

stated she always informed her charge nurse if she did not give her showers. She stated Resident #84 did not refuse showers but she often made noises when she was moved due to her contractures.

In an interview on 9/27/17 at 10:33 AM, the Administrator stated it was her expectation that resident receives their showers and bed baths as scheduled.

In an interview on 9/27/17 at 10:55 AM, Nurse #4 stated the aides often reported to her that they were unable to complete their assigned showers due to time constraints and staffing. She was not aware that the aides were not giving bed baths. She stated management was aware and had been working on staffing for at least six months or more.

In another observation on 9/28/17 at 10:38 AM, there was a left elbow protector in place. Her family member was present and at the bedside. She stated she did not feel Resident #84 was receiving her showers as scheduled. She stated she felt it was due to inadequate staffing.

2. Resident #100 was admitted 5/20/14 with cumulative diagnoses of Cerebral Vascular Accident (CVA) with left sided hemiplegia (weakness)

Resident #100 ' s quarterly MDS dated 8/9/17 indicated moderate cognitive impairment with a Brief Interview of Mental Status was 7. He was coded for no behaviors and as requiring total assistance with bathing.

Resident #100 was care planned, and last

F 312

any non-compliance and revision as needed.
e. All discussion will be included in the QAPI committee meeting minutes.
f. The DON/ appropriate designee will re-inservice applicable staff should any revisions to said plan be determined and implemented.
g. Should a revision to said plan occur, monitoring will begin again at 3(a).
4. The title of the person responsible for implementing the acceptable plan of correction.
a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program.
b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 312	Continued From page 35 revised on 8/1/17, for assistance with many of his ADLs. He was not care planned for refusals of showers. A review of Resident #100 ' s nursing notes from 8/1/17 to 9/28/17 did not include any refusals of his showers. A review of the facility documented showers provided to Resident #100 read as follows: No evidence of a bed bath or shower from 8/2/17 shower until a shower on 8/8/17) Shower-Tuesday 8/8/17 Shower-Friday 8/11/17 (no evidence of a bed bath or shower from 8/16/17 until a shower on 8/22/17) Shower-Tuesday 8/22/17 Shower- Friday 8/25/17 (no evidence of a bed bath or a shower until a shower on 8/29/17) Shower- Tuesday 8/29/17 Shower- Friday 9/1/17 (no evidence of a bed bath or shower until a shower on 9/5/17) Shower-Tuesday 9/5/17 (no evidence of a bed bath or shower from 9/12/17 until a bed bath on 9/25/17 and a shower on 9/26/17) Shower-Tuesday 9/26/17 In an interview on 9/27/17 at 9:25 AM, Resident #100 stated he did not receive his showers as scheduled. He stated the aides would ask him if it was acceptable to postpone showers on some days due to what the aides report and a lack of staff. He stated he did not receive a bed bath on some days. In an interview on 9/27/17 at 10:33 AM, the Administrator stated it was her expectation that resident receives their showers and bed baths as scheduled.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 312	Continued From page 36	F 312		

In an interview on 9/27/17 at 10:55 AM, Nurse #4 stated the aides often reported to her that they were unable to complete their assigned showers due to time constraints and staffing. She was not aware that the aides were not giving bed baths. She stated management was aware and had been working on staff for at least six months or more.

In an interview on 9/28/17 at 10:20 AM, NA #4 stated on days when she was unable to complete her assignment by not giving all her showers, she would give bed baths instead and report it to the charge nurse. She stated the days she was unable to complete her showers was due to staffing.

3. Resident #53 was admitted to the facility on 5/29/17 with diagnoses that included, in part, Major Depressive Disorder, Parkinson's Disease, Chronic Pain and Generalized Muscle Weakness.

A review of the quarterly MDS (Minimum Data Set) assessment dated 8/2/17 revealed Resident #53 was cognitively intact. Further review revealed the resident was totally dependent and needed 2-person assistance for bathing activities of daily living.

A review of the care plan updated 8/6/17 revealed Resident #53 was at risk for further decline and required assistance with activities of daily living due to the diagnosis of Parkinson's Disease. Care plan interventions included, extensive assistance with personal hygiene.

A review of the Bathing and Shower Log for Resident #53 from 5/29/2017 to 9/29/2017, had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 312	Continued From page 37	F 312		

documentation that Resident #53 only received a bath or shower for 62 days out of 123 days.

An observation was conducted of Resident #53 on 9/27/2017 at 6:30 PM. Resident #53's forehand appeared oily with a white flaky substance on his scalp.

An interview was conducted with an involved family member of Resident #53 on 9/27/2017 at 6:50PM. During this interview, the family member stated that Resident #53 gets showers on Mondays and Thursdays, but no baths in between shower days. The family member further stated they had spoken to the Social Worker about their concern with bathing and stated the Social Worker stated "she is trying to get a shower team hired". The family member further stated, "there are never enough staff to bath". She also stated that Resident #53 is dependent upon staff for bathing and showering.

An interview was conducted with Resident #53 on 9/27/2017 at 6:55PM. During this interview, Resident #53 stated he gets a shower on Mondays and Thursdays. The resident further stated he gets "oily skin and sweats a lot due to Parkinson's and needs to be bathed every day". Stated he has talked to the Social Worker and stated she told him they were hiring new staff, but Resident #53 stated that he is not getting bed baths in between his shower days. Resident #53 stated he was "very dissatisfied".

An interview was conducted with a NA #7 (Nurse Aide) on 9/28/2017 at 8:50 AM. NA #7 reported working with Resident #53 around 5 to 6 days a week. During this interview, NA #7 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 312	Continued From page 38	F 312		

there are not enough staff to give Resident #53 a bed bath in between shower days. She further stated that she will sometimes be the only aide working on Resident #53's hall. The NA stated that Resident #53 is dependent for bathing and requires 2-person assistance. She further stated that she knew Resident #53 wanted a bath every day, but stated "there are not enough staff".

An interview was conducted with the Social Worker on 9/29/2017 at 8:30 AM. During this interview the Social Worker stated she was under the impression the staff are giving Resident #53 bed baths in between his shower days. She further stated Resident #53 gets a shower on Monday and Thursday.

A second observation was conducted of Resident #53 on 09/29/2017 at 8:50 AM . The resident was dressed, seated in his wheelchair in the dining room eating breakfast. The residents face was noted to be oily with a white crusty substance on his forehead.

An additional interview was conducted with Resident #53 on 09/29/2017 9:10 AM. During this interview, Resident #53 stated that he got a shower yesterday (Thursday) but stated he has not gotten a bed bath today. Resident #53 further stated "I won't get one". The resident stated "if it is not a shower day, I do not get a bath". Resident #53 stated he "wants a shower every day and if not a shower he wants a bed bath at the very least". Resident #53 further stated he needed his "face washed today and needs help and no one has helped".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 312	Continued From page 39 An interview was conducted with NA #2, who reported working with Resident #53 about 4 days a week on 09/29/2017 at 9:57 AM. During this interview, NA #2 stated Resident #53 is supposed to get showers on Mondays and Thursday with bed baths in between. She stated he is dependent upon staff for baths and further stated Resident #53 "does not get a bed bath everyday like he is supposed to". She stated " there are not enough staff". NA #2 further stated she is aware Resident #53's care plan says to assist him with bathing and knows he wants a bath daily, but says there are not enough staff to bath him every day. An interview was conducted with the Administrator on 9/29/2017 at 12:55PM. During this interview, the Administrator stated her expectation was for residents to get a bed bath on the days in between shower days and further stated residents should get bathed in accordance with their preferences. .	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the	F 314		11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 40 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 observations, physician and staff interviews and record review, the facility failed to assess for worsening of pressure ulcer, failed to assess for worsening of a facility acquired pressure ulcer and failed to prevent the development of a new pressure ulcer for 3 of 7 (Resident #40, Resident #133 and Resident # 84) residents reviewed for pressure ulcers. Findings included: 1. Resident # 40 was admitted 6/26/17 with cumulative diagnoses of Alzheimer ' s Disease, diabetes, contractures, multiple pressures ulcers to include an unstageable pressure ulcer to his left ischium. A wound Assessment Report dated 6/26/17 read Resident #40 ' s left ischium measured 3 centimeters (cm) by 3 cm by 0.3 cm with 90% eschar and 10% granulation with a small amount of serous drainage. Orders were to treat the area with Dakin ' s Solution (solution use to kill germs) and Santyl (ointment use to clear way unhealthy	F 314	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. (1) As of 9/28/17 Resident 133 no longer resides at the facility. (2) As of 9/11/17 Resident 40 no longer resides at the facility (3) Resident 84 received updated treatment beginning 9/19/17 by Corporate directed treatment nurses. In addition, the facility□s newly contracted wound care service began to see Resident 84 on 10/3/17 and has continued on a weekly basis. In addition, therapy will evaluate Resident 84 on/before 9/27/17 for additional off-loading measures to facilitate additional healing. Resident #84 has a pressure re-distribution mattress, a wheelchair cushion, floating heels in bed and floating elbow. Resident remains non-compliant due to dementia, but receives continued oversight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314

Continued From page 41

tissue) daily. The wound was to be covered with Aquacel (a silver-based dressing use to absorb wound drainage).

Resident #40 was ordered sugar Free Prostat (supplement) three times daily on 6/27/17 to promote wound healing.

His admission Minimum Data Assessment (MDS) dated 7/3/17 indicated Resident #40 had severe cognitive impairments, no behaviors and extensive assistance with his activities of daily living (ADLs). He was coded as incontinent of bowel and bladder and coded for pressure ulcers present on admission. The Care Area Assessment dated 7/3/17 indicated he was at risk for the development and worsening of pressure ulcers due to his impaired mobility, contractures and poor nutritional status.

Resident #40 was care planned on 7/3/17 for his left Ischial unstageable pressure ulcer with interventions to include the following:
-Measure his wound facility protocol
-Record appearance, amount and odor of drainage and report decline to his wound status
-For wound drainage, obtain culture and let the physician know the results
-Treatments as ordered
-Pressure relieving mattress to bed and wheelchair

A Wound Assessment Report dated 7/7/17 read the left ischium unstageable pressure ulcer remained the same as far as measurement but was described as having 100% eschar. The wound was documented as having no odor or drainage. The treatment was to clean with wound with Normal Saline, apply Aquacel daily.

F 314

b. Following review of the cited deficiency by the facility administrative team (with QAPI committee members) it was determined that due to the termination status of the prior DON and treatment nurse a deviation in protocol occurred.
2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
a. The facility identified a concern with regards to wound management on 8/30/17 during a routine audit. A plan of action was developed and initiated with the facility DON (at that time) was to provide oversight of the plan. A 100% skin sweep was completed, and this was compared to wound reports, wound documentation, and treatment orders for accuracy. The facility treatment nurse had resigned without notice on 9/1/17.
b. Identified items were brought to the facility QAPI meeting on 9/14/17 and the said plan was discussed. It was found the DON (at that time) had failed to address the said plan as directed. The DON (at that time) was terminated on 9/15/17.
c. Two Corporate directed treatment nurses were brought in on 9/19/17 to perform another total skin sweep, update all documentation, notifications, and orders.
d. The Wound MD rounded on 9/19/17 and 9/21/17 with these nurses to assess conditions of wounds identified.
e. The facility contracted with an outside wound management company, Quality Surgical Management (QSM) to provide wound certified physicians and physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ____ B. WING ____	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314

Continued From page 42

A Wound Assessment Reports dated 7/14/17, 7/20/17, 7/28/17 and 8/4/17 read the left ischium unstageable pressure ulcer remained the same as far as measurement but was described as having 100% eschar. The wound was documented as having no odor or drainage. The Wound Assessment Report dated 7/14/17 read the treatment order was to apply Silvadene (ointment use to prevent infection) twice daily.

A review of the July 2017 physician orders for treatments to Resident #40 ' s left ischium did not include any orders changing the treatment to Silvadene. There was also no evidence documented on the July Treatment Administration Record (TAR) that the left ischial unstageable pressure ulcer was treated with Silvadene but rather Aquacel.

A Wound Assessment Reports dated 8/11/17 and 8/15/17 read the left ischium unstageable pressure ulcer remained the same as far as measurement but described as having 10% slough and 90% eschar with a scant amount of drainage with no odor. The wound was documented as having no odor or drainage.

A Wound Assessment Report dated 8/24/17 read the left ischium unstageable pressure ulcer remained the same as far as measurement but described as having 10% slough and 90% eschar with a scant amount of drainage with no odor. The wound was documented as having no odor or drainage. The treatment was to use Aquacel daily.

A nursing note dated 8/31/17 at 2:25 AM read there was new order to culture Resident #40 ' s

F 314

extenders on a weekly basis to oversee the wound management/ prevention program in the facility.

f. QSM began services on 10/3/17 and have been in the facility on a weekly basis since (10/3/17; 10/11/17; 10/17/17) providing assessment, treatment orders, and documentation of wounds and skin conditions. Documentation is reviewed by the current facility DON on a weekly basis prior to filing documentation in the resident medical record, with any non-compliance with said program promptly addressed.

g. A treatment nurse has been retained and will begin on 10/30/17. Until that time, Corporate directed treatment nurses will continue in the facility on a weekly basis, and the current DON to provide oversight of the said program by rounding with the treatment nurses on a weekly basis X 6 weeks beginning on 9/21/17, with any non-compliance promptly addressed.

h. Corporate Nurses will also review compliance with said program and wound documentation on a weekly basis beginning 9/21/17 and continuing X 6 weeks, with any non-compliance promptly addressed.

i. All licensed and unlicensed staff were re-inserviced on 9/20/17 by the current DON regarding observing the skin for changes and completing weekly skin observations.

j. All licensed and unlicensed staff were re-inserviced by the Corporate Director of Clinical Operations on 9/25/17 and 10/4/17 with regards to monitoring skin for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314

Continued From page 43

left ischium and start Rocephin (antibiotic) Intramuscularly daily for 7 days.

A Wound Assessment Report dated 9/1/17 read the left ischium stage 4 pressure ulcer measured 6 cm by 5 cm by 4.5 cm with undermining at 12 PM of 6 cm with 90% wet eschar and 10% granulation tissue with a moderate amount of serous drainage with noted odor. Cipro was started twice daily for 2 weeks and continue the Rocephin.

A review of the Wound Culture read Resident #40 cultured Proteus mirabilis (gram-negative rod bacteria) on 9/2/17 which was resistant to the Cipro and Rocephin.

A review of the physician orders and TAR read starting on 9/2/17, Resident #40 ' s left ischium was to be cleaned with Dakin ' s Solution and packed with Dakin ' s Solution and covered daily.

A review of the physician orders read on 9/4/17 the Cipro and Rocephin were stopped and Amikacin (antibiotic) Intramuscularly twice daily for 10 days was ordered. The bacteria were sensitive to the Amikacin.

A review of the physician orders read on 9/5/17, a Peripherally Inserted Central Catheter (PICC) line was inserted and the Amikacin was changed to Intravenous twice daily for 10 days.

A review of a Registered Dietician note dated 9/5/17 read she recommended Resident #40 start magic cup twice daily for weight stabilization and wound healing.

A nursing note dated 9/11/17 at 4:18 PM read

F 314

changes, weekly skin checks, providing showers and bed bath along with routine incontinent care and turning and repositioning to assist in maintaining skin integrity. This inservice was repeated by the Executive Director on 10/13/17 and 10/17/17.

k. Recommendations for therapy involvement have been made by QSM and/or the treatment nurses with regards to additional techniques for off-loading high risk areas.

l. All applicable care plans and KARDEX have been updated to reflect actions taken.

m. Following 2(e) random monthly audits will be completed by the DON/ appropriate designee X 2 months, and as needed.

3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

a. Compliance on consistency of wound management, required documentation, and compliance with showers/ bed baths, prompt incontinence care, and frequent turning/ repositioning (Observation of Care audits) will be brought by the DON/ appropriate designee, to the administrative morning meeting (with QAPI committee members) weekly X 4 weeks, and as needed.

b. Compliance on consistency of wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314

Continued From page 44

Resident #40 was more lethargic. The physician was notified and ordered Stat Lab work. At 6:26 PM, Resident #40 ' s vital signs were: temperature 97.3 degrees Fahrenheit, blood pressure of 79/41 and pulse 106. At 6:26 PM, the physician ordered Resident #40 be sent to the hospital for a change in his level of consciousness.

A review of the hospital discharge summary dated 9/14/17 read Resident #40 was discharged to the hospice house with cumulative diagnoses of pneumonia and sepsis from his multiple pressure ulcers.

In an interview on 9/27/17 at 11:05 AM, Nurse #3 stated she recalled Resident #40 was admitted with multiple pressure ulcers. She stated she often found Resident #40 ' s left ischium dressing missing and noted an odor from the wound one could smell in the hall. Nurse #3 stated she reported her concerns to the previous Director of Nursing (DON) but by the time the DON assessed Resident #40 ' s left ischial wound, he had gotten sicker and was ultimately discharged to the hospital. Nurse #3 stated Nurse #1 and nursing assistant (NA) #3 were responsible for doing Resident #40 ' s treatments as ordered.

In a telephone interview on 9/27/17 at 11:49 AM, Nurse #1 stated she was the treatment nurse for the facility and her last day was 9/1/17. She stated Resident #40 was admitted with multiple pressure ulcers and she updated the physician weekly in writing. Nurse #1 stated the physician nor the DON ever observed Resident #40 ' s wounds until 8/31/17 but the DON would give her advice if she asked. She confirmed the Nurse Practitioner was at the facility weekly but he did

F 314

management, required documentation, and compliance with showers/ bed baths will be brought by the DON/ appropriate designee, to the monthly QAPI meeting X 5 months, and as needed.

c. Compliance, outcomes, any revisions will be discussed by the committee members and all discussion will be contained in the meeting minutes.

d. The DON/ appropriate designee will re-inservice applicable staff, as needed, with any revisions to said plan.

a. Any revisions to said plan will require monitoring to begin again at 3(a).

4. The title of the person responsible for implementing the acceptable plan of correction.

a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program.

b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 45	F 314		

not assess Resident #40 ' s left ischium. Nurse #1 stated Resident #40 ' s left ischial ulcer deteriorated quickly and Resident #40 ' s physician also had his own wound clinic and told her what treatments to use.

In a telephone interview on 9/27/17 at 12:03 PM, NA #3 stated she started assisting with treatments the end of June 2017. She stated she decided to stop doing treatments a month or so ago and returned to the floor because she did not feel treatments or wound assessments were being done as ordered. She recalled Resident #40 and stated his left ischial wound started getting worse sometime in late August. She stated she reported the change in the appearance Nurse #1 but did not recall what day.

In an interview on 9/27/17 at 2:33 PM, Nurse #7 stated she was doing the treatments on weekends and once Nurse #1 resigned, she began doing Resident #40 ' s treatments daily. She recalled going to the previous DON about concerns over Resident #40 ' s left ischial pressure ulcer. She stated the wound was getting worse and she felt his wound was not being accurately assessed or treated. Nurse #7 stated the previous DON stated she would assess Resident #40 ' s left ischium but she did not recall her ever going and assessing it.

In a telephone interview on 9/27/17 at 2:57 PM, the Nurse Practitioner stated he was at the facility Mondays, Wednesdays and Fridays and Nurse #1 never asked him to assess Resident #40 ' s left ischial pressure ulcer. He stated the previous DON asked him to assess the wound on 8/31/17. He stated he gave new orders at that time but the physician was a wound specialist and would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 46 assess Resident #40 as needed. The Nurse Practitioner stated Resident #40 ' s left ischial pressure ulcer looked infected and had a noted odor. In a telephone interview on 9/27/17 at 3:06 PM, Nurse #8 stated she worked 8/31/17 and the aides called her in to see Resident #40 ' s ischial wound because there was no dressing. She stated she was concerned about the appearance of the wound and obtained a wound culture and left a note for the DON and physician about her concerns of the worsening of the left ischium pressure ulcer. In another interview on 9/28/17 at 8:20 AM, the Nurse Practitioner stated on 8/31/17, the previous DON asked him to assess Resident #40 ' s left ischial pressure ulcer and he started antibiotic and changed the treatment orders to Dakin ' s Solution and told the DON the physician would need to assess Resident #40 ' s left ischium since he was a wound specialist. In an interview on 9/28/17 at 8:50 AM, the physician stated he only visually assessed wounds as needed. He stated Nurse #1 would communicate the status of Resident #40 ' s pressure ulcers by leaving him a note in his folder. The physician stated he was not notified of the worsening of Resident #40 ' s left ischial pressure ulcer until sometime after 9/1/17. He stated he ordered a PICC line and changed his antibiotics on 9/5/17. In a telephone interview on 9/28/17 at 12:30 PM, the previous DON stated staff reported that Resident #40 ' s left ischial pressure ulcer had developed an odor so a culture was obtained.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 47	F 314		

She stated she called the physician and spoke with the Nurse Practitioner and asked if they were aware of the change in Resident #40 ' s left ischial pressure ulcer. She stated they told her they were not aware. The previous DON stated she reviewed the weekly wound reports and met with Nurse #1 weekly to discuss the progress or worsening of all the residents with pressure ulcer but Nurse #1 reported all his pressure ulcers were the same. It was not until 8/31/17 when she and the Nurse Practitioner assessed the left ischium that concerns were evident about the assessment of the left ischium.

A review of the September Treatment Administration Record (TAR) read omissions for treatments 9/5/17 through 9/8/17. During the telephone interview with the previous DON on 9/28/17 at 12:30 PM, she stated she provided the treatments after Nurse #1 resigned on 9/1/17. The previous DON stated her last day was 9/15/17.

In an interview on 9/29/17 at 11:20 AM, the Interim DON stated she was the nurse who sent Resident #40 to the hospital on 9/11/17. She stated she and the previous DON completed his treatment earlier in the day but he was exhibiting a change in his level of consciousness so, the previous DON got orders to send him to the hospital for an evaluation. The Interim DON stated Resident #40 was receiving IV antibiotics and the wound had an odor at the time of his discharge.

In an interview on 9/29/17 at 11:30 AM, the Administrator stated it was her expectation that Resident #40 ' s pressure ulcers were assessed and treated accurately to ensure no worsening in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 48	F 314		

status.

2.

3. Resident #84 was admitted 4/12/13 with cumulative diagnoses Rheumatoid Arthritis, contractures, aphasia and dysphasia.

Her most recent lab work dated 6/7/17 indicated her Albumin was low at 2.9 with normal ranges from 3.2 to 5.5 the and total protein was 7.30 with normal ranges from 6.0 to 7.80. These lab results are indicators of nutritional status.

The Quarterly MDS dated 8/15/17 indicated Resident #84 had severe cognitive impairments with no behaviors and required total assistance with her ADLs. She was coded as having no skin impairment. Resident #84 was coded for a feeding tube supplying all her nutritional needs.

A review of the nursing notes for August and September 2017 read a skin assessment were completed on 8/2/17, 8/16/17, 8/23/17 and on 9/6/17 and 9/13/17 with no identified skin impairments.

A review if Resident #84 ' s September 2017 orders read she received Jevity 1.5 at 45 milliliters (ml)/hour for 16 hours and 150 ml of water four times daily.

A review of the TAR for September 2017 indicated Resident #84 received the treatments as ordered.

A nursing note dated 9/18/17 at 2:59 AM, read at 2:30 AM, a 1 cm by 1 cm open area was noted to Resident #84 ' s left elbow. There was yellowish

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	**700 JOHNSON RIDGE ROAD ELKIN, NC 28621**

(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 314	Continued From page 49	F 314		

drainage present. The area was cleaned with normal saline and an island dressing was applied. The nursing note read the physician was notified. There were no documented skin assessments from 9/18/17 through 9/26/17.

Resident #84 was care planned on 9/18/17 for the actual development of a left elbow unstageable pressure ulcer to her left elbow.
Interventions were as follows:
-skin assessment with routine care
-Notify the Treatment Nurse and physician for new skin issues
-Provide tube feeding as ordered
-treatment as ordered
-Dietician to evaluate as needed
-Pressure relieving mattress to bed and wheelchair

A review of the Wound Assessment Report dated 9/19/17 read the unstageable pressure ulcer to Resident #84 ' s left elbow measured 2.1 cm by 1.7 cm with 90% slough and 10% necrotic tissue. There was a small amount of purulent drainage and the peri-wound was macerated. New orders were to clean the area with Normal Saline and apply Aquacel daily. Offload the elbow with an elbow protector every shift.

A review of a wound assessment note dated 9/22/17 read there was a moderate amount of sero-purulent drainage oozing from wound. A note was written and left for the physician.

A review of a wound assessment note dated 9/25/17 read the left elbow had deteriorated. The Nurse Practitioner assessed the area and new orders were given for Prisma Collagen to the left elbow and Cipro daily for 10 days via the feeding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 50	F 314		

tube.

In an interview on 9/26/17 at 3:10 PM, NA #1 stated Resident #84 required staff assistance for all her ADLs to include turning and repositioning. She stated Resident #84 ' s left elbow was to be elevated on a pillow for pressure relief. She stated Resident #84 was not able to move her arm enough to remove the pillow. NA #1 stated she was not aware that Resident #84 had an elbow pressure relieving device and had not seen one in her room as of 9/26/17.

In an observation on 9/26/17 at 3:15 PM, Resident #84 was observed with a dressing to her left elbow and her arm resting on a pillow in bed.

A review of a nursing note dated 9/26/17 read occupation therapy was to elevate the left elbow for positioning since Resident #84 did not keep her arm on a pillow provided. The note read the physician was at the facility but did not assess Resident #84 ' s left elbow.

In an observation on 9/27/17 at 9:20 AM, Resident #84 was sitting up in bed. There was no observed pressure relieving device observed to her left elbow. She was on a pressure relieving mattress. Her tube feeding was not in progress.

In an interview on 9/27/17 at 2:33 PM, Nurse #7 stated she was doing the treatments on weekends and but when Nurse #1 resigned, she began doing treatments daily. She stated the first of the month, two wound care nurses from other facilities came and took over the treatments. She stated she had not seen Resident #84 ' s left elbow until this past weekend but it looked

(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 314	Continued From page 51	F 314		

infected by the appearance of the drainage. Nurse #7 stated she left a note for the Nurse #5 to ask the physician or the Nurse Practitioner to assess on 9/25/17.

In a telephone interview on 9/27/17 at 2:57 PM, the Nurse Practitioner stated he was at the facility Mondays, Wednesdays and Fridays. He stated he gave orders to start an antibiotic 9/25/17 and he was asked today to assess Resident #84 ' s left elbow and gave new orders for a wound culture.

In an interview on 9/27/17 at 4:20 PM, the RD stated she was only made aware of the new pressure ulcer on 9/26/17 and she saw Resident #84 today. She recommended Prostat twice daily and a multivitamin via the feeding tube. Resident #84 ' s tube feeding was also increased to promote wound healing.

In an interview on 9/28/17 at 8:50 AM, the physician stated he only visually assessed wounds as needed. He stated Resident #84 developed a pressure ulcer to her left elbow and the staff requested an order to culture the area but he discontinuing the wound culture until he saw the wound. The physician stated he had not yet assessed the wound. He stated Resident #84 ' s area to her left elbow was from pressure of the elbow on her mattress and avoidable. He stated he wrote orders to therapy to evaluate for positioning needs.

In another observation on 9/28/17 at 10:38 AM, there was a left elbow protector in place.

In a wound care observation on 9/28/17 at 10:40 AM, the unstageable pressure ulcer to Resident #84 ' s left elbow measured 2.5 cm by 2.7 cm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314		F 314		

Continued From page 52
There was no odor but there was moderate purulent drainage. There were no observed concerns with the wound care observation. Nurse #5 stated she was a certified wound nurse from the coast and was asked to come to the facility to assist with wound care early September 2017 when Nurse #1 resigned.

In an interview on 9/29/17 at 11:20 AM, the Interim DON stated she was aware Resident #84 developed a pressure ulcer to her left elbow but the facility was quick to treat and put interventions in place.

In an interview on 9/29/17 at 11:30 AM, the Administrator stated it was her expectation that Resident #84 would not have developed a pressure ulcer.

3. Resident #133 was admitted to the facility on 2/2/2017 with diagnoses which included Benign Prostatic Hypertrophy, Non-Alzheimer's Dementia, Anxiety Disorder, Depression, and Chronic Obstructive Pulmonary Disease (COPD).

The admission Minimum Data Set (MDS) Assessment for resident #133 dated 2/13/17 documented the resident to be severely cognitively impaired. For assessment of ADL's in Section G the resident required two person extensive assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and one person extensive assistance for eating meals. This MDS from coded that the resident was at risk for pressure ulcers but did not have any skin conditions on admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 53	F 314		

Review of the signed physician telephone orders dated 7/13/17 indicated treatment for right & left hip abrasions to be cleaned with normal saline, apply an Aquacel foam dressing (wound dressing) and change daily.

During an interview on 9/28/2017 at 10:25 AM with the Director of Rehab when asked about resident #133, she stated that resident was evaluated on 7/17/17 for his wheelchair being too small related to his hip wounds. She stated that the chair was found to be too small so a new one was ordered. It was determined by facility staff that the actual cause of the wounds was because he was a side sleeper and it was not from the wheelchair that was too small for the resident. The Therapy Director stated that at that point a recommendation for a bed wedge and air mattress to be put in place was made to the treatment nurse, Nurse 1.

MD #1 requested a wound consult by Wound MD on 7/25/17.

The following wounds occurred from 7/13/17 to 9/1/17. The wounds were per the documentation in the medical record by the wound nurse (Nurse 1) and the Wound MD. The wounds have been assigned numbers for easy identification.
Wound #1 -
Began as a right hip abrasion on 7/13/ 17. It progressed to a large abscess on 7/25/17 based on the Wound MD's assessment and was documented as an unstageable pressure ulcer on 7/25/17 by Nurse 1's wound assessment.
Wound #2 -
Began as an ulcer to right foot on 7/25/17. Progressed to a right medial heel unstageable pressure ulcer on 7/28/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 54	F 314		

Wound #3 -
Began as a stage 2 pressure ulcer to left heel during the Wound MD's assessment on 7/25/17 and not mentioned in any documentation after that assessment.
Wound #4 -
Began as an ulcer to left medial ankle on 7/27/17 during Wound MD assessment. Progressed to an unstageable pressure ulcer on 7/28/17.
Wound #5 -
Began as a left hip abrasion on 7/13/17. Progressed to a left hip deep tissue injury (DTI - Purple or maroon discolored localized area of intact skin or blood-filled blister due to damage of underlying soft tissue from pressure) on 7/28/17. Progressed to a left hip unstageable pressure ulcer on 8/15/17.
Wound #6 -
Began as a Sacral Coccyx DTI on 7/28/17. Was described as a stage 4 pressure ulcer by the Wound MD on his 9/1/17 assessment. Progressed to an unstageable pressure ulcer on 9/21/17.

Physician note from 7/25/17 from Wound MD was his initial consult and assessment of resident #133's wounds. The wounds assessed included: large abscess to right hip (Wound #1) with cellulitis, ulcer to right foot (Wound #2), and pressure ulcer of left heel stage 2 (Wound #3). The Wound MD recommended intramuscular (IM) Invanz 1 gram (antibiotic) for 7 days for cellulitis and to reevaluate in a few days. No measurements or descriptions of the wounds were documented. The left hip abrasion was not assessed.

Review of a wound assessment note by Nurse 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ___ B. WING ___	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 55	F 314		

from 7/25/17 revealed documentation for Wound #1 as an unstageable pressure ulcer measuring 9 centimeters (cm) in length by 7 cm in width, covered with 100% eschar (dry, dark scab or falling away of dead skin) tissue. Wounds #2 and #3 were not assessed by Nurse 1.

Physician note from 7/27/17 from Wound MD was a follow-up assessment of resident #133's wounds. The document stated that staff did not report any fevers or decompensation since recent evaluation (7/25/17). It also stated that resident #133 had progressive dementia with poor by mouth intake and protein calorie malnutrition per staff reports. The wounds assessed on 7/27/17 included: Wound #1 was described as an abscess to right hip, Wound #2 was described as pressure ulcer to right heel, and a ulcer of Left Medial Ankle (Wound #4). The Wound MD documented there was slight improvement with the IM antibiotics and that the plan was to continue supportive care with palliative approach per family, continue off-loading resident's feet with pressure reducing boots, and would continue to monitor. No measurements of the wounds were documented. Wound #3 was not assessed.

Review of a Wound Assessment note by Nurse 1 from 7/28/17 at 7:16 PM revealed that Nurse 1 had spoken with resident #133's RP concerning his condition and decline in health. The note stated that the Responsible Party (RP) wished for the resident to remain in the facility, to be treated with comfort care measures and not sent to the Emergency Room (ER). Resident had several new end of life pressure wounds that included a right medial heel (Wound #2) unstageable end of life pressure injury, a left hip deep tissue injury (DTI - Purple or maroon discolored localized area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 56 of intact skin or blood-filled blister due to damage of underlying soft tissue from pressure) end of life pressure injury (Wound #5), a left medial ankle unstageable end of life pressure injury (Wound #4), and a sacral/coccyx DTI end of life pressure injury (Wound #6). Nurse 1 stated that "All of these wounds have developed within the last 24 hours". Nurse 1 documented the resident continued to have a right hip unstageable end of life pressure injury (Wound #1), and that after speaking to the resident's RP she understood his health was very poor and that he would continue to decline with the outcome of possible death. The note stated that Nurse 1 notified MD #1 of his condition and new orders were received from NP #2. Wound #3 was not described. Review of a Wound Assessment note by Nurse 1 from 7/28/17 at 7:34 PM revealed documentation for Wound #2 as an unstageable pressure ulcer measuring 6 cm in length by 3 cm in width covered with 100% eschar tissue. The treatment for this wound was to be cleaned with normal saline and apply Sure Prep (skin protective wipes) on Monday, Wednesday, and Friday. Wound #4 was described as an unstageable measuring 3 cm in length by 3 cm in width by 0.2 cm in depth covered in 90% eschar tissue and 10% granulation tissue. The treatment for this wound was to be cleaned with normal saline, apply an Aquacel foam dressing (wound dressing) and change daily. Wound #6 measured 6 cm in length by 8 cm in width described as 100% purple/blue in color. There were no treatment orders for this wound. Wound #5 measured 4 cm in length by 4 cm in width described as 100% purple/blue in color. This wound was to be cleaned with normal saline, apply an island dressing, and change daily. The	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 57	F 314		

note stated that the resident's RP was notified and that MD #1 was updated by fax. Wound #1 and #3 were not assessed or measured.

Skin Conditions in Section M for a significant change MDS assessment dated 7/28/17 coded 3 unstageable pressure ulcers, 2 of those with slough or eschar.

Review of resident's active care plan dated 7/28/17 revealed a care plan was in place for: Resident has multiple unstageable wounds with treatments in place (unstageable to sacrum, unstageable to right & left hip, and blisters to left thigh, left thumb, and left elbow); He has suffered a global decline physically and cognitively. He is now palliative care and he is at risk for multiple medical diagnoses/problems that may affect his health status due to delayed wound healing, further skin impairment, decreased ability to perform ADLs, Falls, due to immobility, incontinence, fluctuating appetite, advanced age, and declining status. Interventions put into place for his wounds included an air mattress, increased repositioning and turns by staff, supplements (Prostat 30 milliliters three times a day for skin integrity - ordered 7/12/17) and dietician consult for wound healing, treatments as ordered by the physician, pressure reducing boots, and notification of provider for worsening wounds.

Review of a Wound Assessment note by Nurse 1 from 8/4/17 revealed documentation for Wound #1 that measured 9 cm in length by 7 cm in width covered in 100% eschar tissue. Treatment was to clean with normal saline and apply aquacel ag (wound dressing), island dressing, and change daily. Wound #2 measured 6 cm in length by 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 58	F 314		

cm in width covered with 100% Eschar tissue. Wound #4 measured 3 cm in length by 3 cm in width by 0.2 cm in depth covered in 90% eschar tissue and 10% granulation tissue. Wound #6 measured 6 cm in length by 8 cm in width described as 100% purple/blue in color. There were no treatment orders for this wound. Wound #5 measured 4 cm in length by 4 cm in width described as 100% purple/blue in color. This wound was to be cleaned with normal saline and apply an island dressing, change daily. The note stated that the resident's RP was notified and that MD #1 was updated by fax. Treatments ordered did not change and Wound #3 was not assessed or measured.

The wound assessment by Nurse 1 on 8/11/17 for Wounds #1, #2, #4, #5, and #6 revealed no change in size, description, or treatment orders. Wound #3 was not assessed or measured. The note stated that the resident's RP was notified and that MD #1 was updated by fax.

The wound assessment by Nurse 1 on 8/15/17 for Wounds #1, #2, #4 revealed no change in size, description, or treatment orders. Assessment of Wounds #5 (measured 7 cm in length by 6 cm in width) and #6 (8 cm in length by 12 cm in width) revealed they were larger. Both Wound # 5 and #6 changed from 100% blue/purple in color to 100% eschar, no new treatment orders were placed for any of the wounds. Wound #3 was not assessed or measured. The note stated that the resident's RP was notified and that MD #1 was updated by fax.

The wound assessment by Nurse 1 on 8/24/17 for Wounds #2 and #5 revealed no change in size, description, or treatment orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 59	F 314		

Assessment of Wounds #1 (measured 10 cm in length by 7 cm in width) and #6 (12 cm in length by 12 cm in width) revealed they were larger. Treatment orders did not change. Wound #3 was not assessed or measured. The note stated that the resident's RP was notified and that MD #1 was updated by fax.

The wound assessment by Nurse 1 on 9/1/17 for Wounds #1, #2, and #4 revealed no change in size, description, or treatment orders. Assessment of Wound #5 (measured 7 cm in length by 7 cm in width) revealed it was larger. Wound #6 measured 12 cm in length by 12 cm in width described as 80% wet eschar and 20% slough (a white or yellow covering on the base of the wound can prevent a wound from healing properly; infection) with moderate amount of serosanguinous exudate with foul odor. Treatment orders were placed to clean with Dakin's solution and cover with Aquacel AG (wound dressing) and island dressing. Treatment orders did not change for Wound #1, #2, #4, and #5. Wound #3 was not assessed or measured. The note stated that the resident's RP was notified, that MD #1 was updated, and that he had stated he wanted to have Wound MD continue to treat of the resident's wounds.

Record review revealed a wound assessment was completed on 9/1/17 by the Wound MD and revealed that staff had asked him to check sacral area wound due to worsening. The wounds assessed included a pressure ulcer of hip (did not specify which hip), Wound #6 was described as a stage 4, a stage 2 pressure ulcer of ankle (did not specify which ankle), a stage 1 pressure ulcer of heel (did not specify which heel), and cellulitis to sacral area. The recommendation for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 60	F 314		

cellulitis and wound infection was to start Rocephin (antibiotic) 500 mg IM every day for 7 days and Cipro (antibiotic) 500 mg by mouth twice daily for a couple of weeks with Flora-Q (probiotic).

No assessments, measurements, or descriptions of wounds were completed after 9/1/17 until 9/21/17.

Review of a Wound Assessment note by Nurse 10 from 9/21/17 revealed Wound #5 was larger in size measuring 7.5 cm in length by 7 cm in width covered in 95% eschar tissue and 5% granulation tissue, with small amount of purulent exudate. Wound #1 measured 8.5 cm in length by 9 cm in width unstageable due to 95% eschar tissue and 5% granulation tissue, with small amount of purulent exudate. Wound #6 was larger in size measuring 14 cm in length by 12 cm in width by 3.5 cm in depth and was described as unstageable due to 75% slough and 25% granulation tissue, with a large amount of purulent malodorous drainage. Wound MD was notified and a new order was received to cleanse wound with normal saline, pat dry, and pack with Dakin's 0.25% solution, cover with a dry dressing, and change daily or as needed if soiled. Wounds #2, #3, and #4 were not assessed or measured.

The Medication Administration Record (MAR) and Treatment Administration Record (TAR) from July to September 2017 was reviewed and all treatments were documented to be completed as ordered.

During an interview with Nurse 10 on 9/26/2017 11:42 AM when asked when she had started treating resident #133's wounds she stated had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 61	F 314		

started on 9/21/17. She stated she had spoken with the Wound MD about changing the wound treatment for debridement for Wound #6 but the MD refused to change the order due to the resident's RP not wanting to debride the wound. When she started doing the treatments the resident was only receiving dry dressings to Wound #1 and #5 and Aquacel AG on Wound #6. Stated that since she started doing treatments on 9/21/17, and new orders were placed, the wounds had gotten better. When asked about the status of the wounds she stated that the wounds did not seem to be taken care of and were in poor condition when she first assessed them. She also stated that the wounds did not seem to be end of life pressure wounds but wounds that have happened over a longer period of time.

During a resident observation and interview on 9/27/2017 at 9:47:39 AM resident #133 was in his room propped with several pillows and wedge to right side, air mattress in place, pressure reducing boots on, and RP at bedside. The RP stated that the resident was not doing well today and that he stopped eating 2 days ago. He started coughing up green stuff yesterday evening and had been lethargic more than usual. Stated staff had ordered a chest x-ray and had drawn labs. The family member stated she did not want the resident to go to the hospital at this point, she wanted him to be comfortable.

During an interview with Nurse 5 on 9/27/2017 at 9:55 AM the nurse stated she was not able to do wound treatments until after 11 AM, due to having a staff member call out and being on the cart passing medications. She also stated that the resident may not be getting his dressings changed today due to a sudden decline in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	**700 JOHNSON RIDGE ROAD ELKIN, NC 28621**

(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 314	Continued From page 62	F 314		

health, the MD would advise following the lab results and chest x-ray results.

During an observation and interview on 9/27/2017 2:42 PM Nurse 5 set up the supplies for the dressing changes and performed clean dressing changes per protocol and followed orders correctly. Wounds #1 and #5 were completely covered in eschar, and Wound #6 had large amounts of malodorous exudate on the dressing. The wound base was unable to be seen due to excess slough. When asked about the resident's wounds, she stated that when she first assessed the wounds with Nurse 10 on 9/21/17 that they were in bad condition, especially Wound #6.

During an interview on 9/28/2017 at 8:48 AM with the Wound MD when asked when he was consulted to treat the resident's wounds he stated he was consulted by MD #1 and first assessed the resident's wounds on 7/25/17. Stated after his initial assessment the resident was started on antibiotics, couldn't remember details about the wounds. Stated that the resident was on comfort measures at the time of the assessment. When asked if he had seen or assessed the wounds after the follow-up assessment on 7/27/17 until 9/1/17, he stated that he had not, and that he relied on Nurse 1 to assess and notify him of any changes that were seen, none were reported until 9/1/17. When asked if he had staged the wounds to be end of life by assessing them, he stated he made the determination based on the assessment and the information about the wounds given to him by Nurse 1. When asked if he had assessed the resident's sacrum on 7/25/17 or 7/27/17, he stated he hadn't assessed it because he wasn't told about the wound by Nurse 1 on those dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 63 Attempted to call Nurse 1 on 9/28/17, the nurse was no longer working at the facility, and no interview was obtained. During an interview on 9/28/2017 at 12:55 PM with the previous DON she stated that she wasn't aware of the wounds or problems with the treatments until the last week of August. Stated that the Nurse 1 was supposed to let her know of wound changes and she relied on her to tell her of changes in the wounds, and that she was over the whole wound process. She also stated she wasn't aware of the exact time that the resident's wounds appeared or worsened. During an interview with MA 3 on 9/28/17 at 3:10 PM, when asked when she had noticed skin changes in the resident, she said she had reported two red places on his sacrum shortly after he had moved to his new unit on 6/5/17 to Nurse 1. Stated that Nurse 1 told her she would keep an eye on it and told staff to apply barrier cream to the wound during every brief change. Stated that approximately 2 months after he had moved to the unit, the wound had opened and described it as the first layer of skin was gone and was told by Nurse 1 to continue using the cream. (Note: The barrier cream used by the facility stated "Do not use on deep or puncture wounds"). When asked to describe the wound she stated that the odor was terrible, and oozed blood constantly. Stated she did not see the treatment nurse observe or measure the wound on any occasion. At that time he was sitting up in his chair all day and she stated she would come into work at 2:30 PM and he would be saturated in urine. Stated there was not enough staff at times to perform incontinence care because he	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	**700 JOHNSON RIDGE ROAD ELKIN, NC 28621**

(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 314	Continued From page 64 required two person assistance and a mechanical lift to get in and out of his wheelchair and bed. During an interview on 9/28/17 5:21 PM with the Administrator and Corporate Nurse (CN), the CN came to the facility to audit the facility. On 8/30/17 the previous DON voiced concerns with wound care. When the CN did the audit she found problems. A 100% skin sweep was completed, and this was compared to wound reports, wound documentation, and treatment orders for accuracy. Identified items on 9/8/17. A QA (Quality Assurance) meeting was held on 9/14/17 and issue was discussed. Previous DON was determined to be the one to address the discrepancies found. DON did not follow the plan of correction and was terminated on 9/15/17 and two treatment nurses from sister facilities were called in to perform another skin sweep, and new orders were obtained. The Wound MD rounded on 9/19/17 to 9/21/17 with both certified wound nurses. All RP's updated and TARs updated. All treatments were reviewed in weekly risk meeting on 9/21/17. Skin check continued to be completed weekly. Corporate will oversee wound care program. A new wound nurse was hired and a contract was signed with Quality Surgical Management to take over wound program for the facility. The interim DON is supposed to round weekly with treatment nurse for 6 weeks to monitor, every other week for 6 weeks, and then monthly. During an interview with MDS Nurse #1 on 9/29/17 at 9:00 AM, when asked how she received her information needed to fill out the skin condition section in the MDS, she stated that she relied on Nurse 1 to fill out that portion, and stated she signed the document but did not	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 314	Continued From page 65	F 314		

visualize the wounds.

During an interview with MD #1 on 9/29/17 at 11:28 AM, when asked if he was resident #133's primary physician he stated that he and his nurse practitioner (NP 2) were his primary and secondary providers. When asked when and why he had consulted the Wound MD he stated that he assumed it was for a decubitus ulcer but consulted the Wound MD as soon as he was notified of the wounds. He did not remember who notified him and stated that it is usually sent as a fax to his office, but could not find the documentation to answer the question. When asked if he had assessed the wounds, he stated he had not seen them until 9/1/17 because he relied on the Wound MD for assessing and treating the wounds. When asked if he had received any information from the facility or from the Wound MD about worsening of the wounds he stated he had received no faxed information about the wounds. On 9/1/17 when he was notified in person (couldn't remember by who) and assessed the wounds on 9/1/17 after being told of their status. He also stated he wanted the Wound MD to continue with treatment of this resident's wounds. When asked if he thought the wounds were unavoidable he stated that due to information given to him by staff about resident #133's poor nutrition, his late stage dementia, and his low albumin levels, he had assumed that they were unavoidable.

The facility attempted to call NP 2 on 9/29/17 at approximately 10:30 AM and 12:00 PM, but was unable to obtain her for an interview.

On 9/29/17 the facility was asked to provide information to show that MD #1 had been notified

(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 314	Continued From page 66 of the change in the pressure ulcers on 7/28/17 via fax and the facility did not provide any information. During an interview with the Administrator on 9/29/17 at 2:30 PM when asked what her expectations were for wound care in the facility, she stated that she expected staff to perform care per protocol and follow doctor's order to maintain the highest well-being for any resident with wounds.	F 314		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (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. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family and staff interviews the facility failed to provide the therapy recommended splint to the right ankle for treatment of foot drop for one of two sampled residents with splints (Resident #129). The findings included: Resident #129 was admitted to the facility on 08/18/16 with diagnoses including Alzheimer's disease, previous fracture of the lower leg with	F 318	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. Resident #129□s plan of care and KARDEX was promptly revised to include the use of the comfy splint as ordered. b. Resident #129 comfy splint is in place as ordered. c. Upon review of the cited deficiency by	11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 318

Continued From page 67

surgical repair and short Achilles tendon.

The annual Minimum Data Set, dated 07/3/17 indicated Resident #129 had severe impairment with long and short term memory. The MDS indicated she required extensive assistance of two staff persons for transfer, dressing and hygiene. Review of the area of limitation of functional movement revealed she had no limitation in the lower extremities.

Review of the care plan that was not dated, revealed the use of the comfy splint for the foot drop was not addressed. The Restorative care plan, which was not dated, included use of the splint to the right ankle.

Review of the Kardex (aides' care plan in the computer), not dated, revealed there were no instructions for the aides on the floor to apply the comfy splint. The restorative Kardex included the comfy splint to be worn when transferring and standing in the standing frame.

Observations on 09/24/17 at 5:55 PM revealed Resident #129 did not have a splint on her right foot and a soft splint was observed in the room. A sign was posted on the outside of the closet door to apply a splinting device to the right ankle due to foot drop. The sign indicated the device was to be worn 24/7 except for bathing.

Observations on 9/25/17 at 10:54 AM revealed Resident #129 was seated in a wheelchair and the right foot was noted to have foot drop. Her heel and bottom of her foot did not rest on the foot pedal. No devices were applied to support the right foot. A soft splint was observed in the

F 318

the administrative team (includes QAPI committee members) it was determined human error was the cause for the omission of the splint.

2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited;

a. A complete audit of all residents was conducted by the Therapy Manager on 10/16/17 to ascertain the placement of splints. Any non-compliance was promptly addressed.

b. Based on the audit, the Therapy Manager provided pictures for any resident with a splint to show proper application and length of time. These were posted inside the applicable resident□s closet door for staff usage and placed in the residents□ medical record.

c. Going forward the Therapy Manager/ appropriate designee will take pictures of any newly applied splint and notify the administrative team of any changes on a weekly basis.

d. Care plans/ KARDEX of applicable residents were audited by the MDS team for inclusion of use of splints, with any non-compliance promptly addressed.

e. The Corporate Director of Clinical Reimbursement re-inserviced the facility assessment team on 10/20/17 regarding the requirement to conduct visual observations and staff interviews prior to completing a resident assessment.

f. Physician orders will continue to be reviewed 5 times/week by the administrative nurses with any splint orders placed on the resident□s plan of care/ KARDEX and an Interdisciplinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 318

Continued From page 68
room.

Observations on 09/25/17 at 2:00 PM revealed Resident #129 did not have the splint on her right foot. Her heel and bottom of her foot did not rest on the foot pedal. There were no devices applied to support the right foot.

Observations on 09/26/17 at 9:00 AM revealed Resident #129 did not have the splint on her right foot. The resident was in the bed at this observation.

Observations on 09/26/17 at 10:08 AM revealed aide # 12 and aide # 13 provided morning care for Resident #129. Both aides assisted in dressing the resident and transferring her from the bed to the wheelchair. After the care was provided, aides # 12 and 13 were interviewed about the signage on the closet door indicating Resident #129 was to wear a brace 24/7 except for bathing. Neither aide was aware of a brace or a splint for the right lower leg/ankle.

Interview on 09/26/17 at 10:15 AM with the restorative aide revealed the comfy splint was used during restorative treatment when Resident #129 stood in the standing frame. The restorative aide explained she was not responsible for applying the comfy splint each day, the aides on the floor would put it on the resident's ankle. Interview with the restorative aide revealed she had no further knowledge about the splint.

Interview with the therapy manager on 09/27/17 at 10:20 AM revealed the resident had surgical repair of a fracture in October 2016. The resident

F 318

Communication form completed and given to the direct care staff for the applicable resident.

3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

a. Splint usage will be audited weekly X 4 weeks, and as needed by the Therapy Manager/ appropriate designee with any non-compliance promptly addressed and re-inservicing of applicable staff as needed.

b. Splint usage will be audited monthly X 2 months, and as needed, by Therapy Manager/ appropriate designee with any non-compliance promptly addressed and re-inservicing of applicable staff as needed.

c. Compliance outcomes will be brought to the morning administrative meeting by the Therapy Manager/ appropriate designee weekly X 4 weeks for discussion by the administrative team.

d. Compliance outcomes will be brought to the facility monthly QAPI meeting X 2 months by the Therapy Manager/ appropriate designee for discussion by committee members, determination of root cause for any non-compliance and revision as needed.

e. All discussion will be included in the QAPI committee meeting minutes

h. The Therapy Manager/ appropriate designee will re-inservice applicable staff should any revisions to said plan be determined and implemented.

i. Should a revision to said plan occur,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 318	Continued From page 69 had foot drop and a splint had been ordered. A brace had been used in the beginning after the resident was able to bear weight. Due to family request, the brace was discontinued and the splint was ordered. Resident #129 was discharged from therapy and transferred to the restorative program. Restorative worked with the resident in a standing frame and the resident wore the splint during those times. In reviewing the multiple times of being on therapy case load, the last discharge dealing with the right ankle was dated 1/31/17. On the discharge summary, the therapist indicated the resident was to wear a comfy splint on the right ankle at all times, except for bathing. The therapy manager explained the process for communication to the nursing department included using a form that was given to the Director of Nursing and the MDS nurse. Therapy would train the nursing staff on the hall. With staff turnover, the new staff should be informed by the current staff, and to look at the Kardex for the plan of care. The MDS nurse updated the Kardex.. Interview with aide #12 on 09/27/17 at 12:11 PM revealed she saw the sign about the leg brace but was not sure what it was or where it was kept. Aide #12 explained she had asked someone about the device, but could not remember who she asked. Aide #12 further explained she had not received instructions a splint or brace was to be applied. She explained she knew what care was to be provided by checking the Kardex in the kiosk (aide's computer chart). She further explained she did not remember seeing anything about the splint on the Kardex. The splint was in her (Resident #129)'s wheelchair this morning. After seeing the signage on the closet door, Aide #12 explained she could not find the splint on the	F 318	monitoring will begin again at 3(a). 4. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 318	Continued From page 70 other days (9/25 and 9/26) this week. Interview with the Interim Director of Nursing on 09/27/2017 at 3:10 PM revealed physician orders were reviewed in the morning team meeting. The therapy communication form had been implemented in the past two months. Further interview revealed she had no explanation why the comfy splint had been missed. The physical therapist #1 had worked with the resident most recently and was interviewed on 9/28/17 at 12:15 PM. She and the MDS nurse accompanied the surveyor to the resident's room. The device on the resident's leg was a comfy splint. She explained it was to prevent further damage to the Achilles tendon which caused foot drop after she had sustained a fracture of the lower leg. The therapist explained, if the splint was not used, she could have further damage to the foot which would cause her pain due to the flexion of the foot. She was supposed to wear the comfy splint 24 hours a day except for bathing. Physical therapist #1 explained she had written a telephone order for use of the splint. The telephone order for the use of the comfy splint was not provided.	F 318		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 332		11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 332	Continued From page 71 Based on observation, record review, and staff and pharmacist interviews, the facility failed to be free of a medication error rate less than 5% as evidenced by 2 errors out of 25 opportunities, resulting in a medication error rate of 8% for 1 of 6 residents observed during medication administration (Resident #86). The findings included: Review of the medical record revealed Resident #86 was admitted to the facility on 9/17/2014 with diagnoses including Dementia, Diabetes Mellitus, Hypertensive Heart Disease, and Atrial Fibrillation. Review of Physician's orders for September 2017 revealed Resident #86's prescribed medications included Omeprazole DR 20 milligrams (mg); give one capsule by mouth (Do Not Crush) and Myrbetriq ER 25mg tablet; give 3 tablets to equal 75mg. Review of the pharmacy label attached to the medication card for Myrbetriq 25mg revealed a sticker that read in part: "Do Not Crush". During an observation of medication administration on 9/26/17 from 9:00 am until 9:15 am, Nurse #9 was observed preparing Resident #86's medications which included Myrbetriq 75mg and Omeprazole 20mg. She was observed to crush the medications. Nurse #9 entered Resident #86's room and administered the medications. During an interview with Nurse #9 on 9/26/17 at 11:00 am, the nurse stated she made an error and crushed medications (Omeprazole and	F 332	1. The plan of correcting the specific deficiency. Addressing processes that lead to the deficiency cited. a. The nurse was counseled by the DON in regards to following medication instructions regarding medications not to be crushed. b. Pharmacist was contacted by the DON on 9/26/17 to determine if crushing the medicine could produce a negative outcome. The pharmacist informed the DON that it would not produce a negative outcome. c. A Medication Error Report was completed by the DON on 9/26/17 and was taken to the QAPI monthly meeting on 10/19/17 for review by the Committee Members. d. It was determined by the nursing administrative team and other QAPI members that human error was the cause of the mistake. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a. Licensed staff and medication aids/techs were in-serviced by the Corporate Director of Clinical Operations on 10/4/17 with regards to medication administration with particular emphasis on following instructions: (1) regarding crushing of meds (2) infection control practices when administering medications, (3) administer meds to one resident at a time with appropriate follow-up documentation b. Med pass audits conducted by Pharmacist/appropriate designee will be conducted on/before 10/26/17 on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 332	Continued From page 72 Myrbetriq) that should not have been crushed. In an interview with the Pharmacist on 9/28/17 at 9:40 am, the pharmacist noted the "Do Not Crush" instructions on the medications, Omeprazole and Myrbetriq and verified that the medications should not have been crushed before administration to Resident #86 and that they should have been given whole. During an interview with the DON on 9/28/17 at 9:45 am, she stated she expected the nurses to administer the medications as ordered and as indicated on the medication card. She confirmed Myrbetriq was an extended release medication and the Omeprazole was a delayed release medication and they should not have been crushed to be administered. An interview was conducted with the Administrator on 9/29/17 at 12:55 pm. She stated her expectation is for residents medication to be given in the form it is ordered and in accordance with manufacturer specifications.	F 332	Licensed Nursing Staff and Med Aides. Any non-compliance will be promptly addressed. c. Pharmacist/appropriate designee will re-inservice Licensed Nursing Staff and Med Aides on/before 10/26/17 regarding items stated in 2(a) of this said plan. New staff will be orientated to proper medication administration. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. a. Random med pass audits will be conducted weekly X 4 weeks, and as needed, by the DON/ administrative nursing staff/appropriate designee beginning 10/23/17. Any non-compliance will be promptly addressed. b. The DON/appropriate designee will bring the outcomes of random audits to the morning administrative meeting weekly X 4 weeks. c. Random med pass audits will be conducted monthly X 3 months, and as needed, by the pharmacist/appropriate designee. Any non-compliance will be promptly addressed. d. The DON will bring outcomes of the monthly random audits to the facility monthly QAPI meeting x 3 months. e. The plan and outcomes will be reviewed by the facility QAPI committee members monthly X 3 and going forward, as needed. f. All discussion of said plan, outcomes, revisions, etc. will be included in the meeting minutes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 332	Continued From page 73	F 332	g. The DON/appropriate designee will re-inservice applicable staff should revisions be made to the said plan. h. Any revision of plan will require monitoring of said plan to begin again at step 3(a). 4. The title of the person responsible for implementing the acceptable plan of correction. a. The facility DON, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility Executive Director, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.	
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]	F 353		11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 353	Continued From page 74 (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, family interviews and record review, the facility failed to provide sufficient staff to provide showers and bed baths as scheduled for residents who required staff assistance with bathing for 3 (Resident #84, Resident #100 and Resident #53) of 7 residents reviewed for activities of daily living (ADLs). The facility failed to provide a dignified dining experience for	F 353	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. Residents/Resident representative of #84, #100 and #53 have been interviewed regarding their bathing preferences. A bath calendar has been established with their preferences and every attempt is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 353 Continued From page 75

residents in 2 of 3 separate dining areas, the main dining room and the silver spoon dining room.

Findings included:

This citation is cross referenced to:

1. F312-Based on observations, staff, family and resident interviews and record review, the facility failed to provide showers and bed baths as scheduled during a month period for 3 (Resident #84, Resident # 100 and Resident #53) of 9 residents reviewed for activities of daily living (ADLs).

In an interview on 9/25/17 at 10:14 AM, Nurse #3 stated residents do not get their showers because there was not enough staff. She stated she often had a difficult time convincing the aides to come in or stay over due to short staffing.

In an interview on 9/26/17 at 3:10 PM, Nursing Assistant (NA) #1 stated due to inadequate staffing, she was often unable to complete her showers and bed baths as scheduled. She stated Resident #84 did receive her scheduled shower today. NA #1 stated for alert and oriented residents, she often asks those residents if it was acceptable to them to postpone their showers to the next day. She stated if she was unable to complete her assigned showers, she reported it to the charge nurse. NA #1 stated Resident #84 was non-verbal and never refused her ADLs.

In an observation on 9/26/17 at 3:15 PM, Resident #84 was observed with a dressing to her left elbow and her arm resting on a pillow in bed. She was clean and absent of odors.

F 353

being made to provide baths/showers as requested. #53 has received a shower daily since survey.

b. Residents #106, #114, #16 with regards to the cited deficiency received their meals and were assisted as needed.

c. Following review by the administrative team (QAPI committee members) of the cited deficiency it was determined (1) lack of availability of possible new employees (2) miscommunication between seating for residents and tray assembly in dietary. (3) adequate oversight in the resident dining areas.

2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited;

a. Since end of survey on 9/29/17, the facility has hired 9 CNAs, 2nurses, 2 Medication Aides to improve staffing ratios

b. Wage increase will be given to all current CNA staff on/before 11/3/17 to encourage longevity

c. The facility has offered many incentive bonuses to current staff and new hiring packages in order to attract staff

d. Daily staffing levels will continue to audited/ reviewed by the Executive Director/ appropriate designee with actions taken for open areas and call-offs.

e. Facility Retention Committee has been initiated by the Executive Director and will meet at a minimum of monthly and as needed to determine additional steps/programs for retaining staff.

f. Licensed and unlicensed staff were re-inserviced on 9/25/17 and 10/4/17 by the Corporate Director of Clinical Operations, and on 10/13/17; 10/17/17 by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 353

Continued From page 76

In an interview on 9/27/17 at 9:25 AM, Resident #100 stated he did not receive his showers as scheduled. He stated the aides would ask him if it was acceptable to postpone showers on some days due to what the aides report and a lack of staff. He stated he did not receive a bed bath on some days.

In an interview on 9/27/17 at 10:22 AM, NA #2 stated she was often unable to complete her assignment when working on one half of 200 hall and all of 300 hall. She stated she was scheduled to give 6 showers and had to assist some residents with eating breakfast and dinner. She stated she often asked her alert and oriented resident if they minded having their showers postponed if she was unable to complete all her showers and some days she did not do a bed bath but reported it to the oncoming shift.

In an interview on 9/27/17 at 10:33 AM, the Administrator stated prior to 9/15/17, the precious Director of Nursing (DON) was responsible for staffing. The Administrator she assumed the reasonability of staffing as of 9/15/17. She stated it was her expectation that resident receives their showers and bed baths as scheduled. The Administrator stated the facility has been advertising for additional help and was offering a sign-on bonus for newly hired staff. She stated the facility was hosting a job fair and stated the facility does not use any agency staff.

In an interview on 9/27/17 at 10:55 AM, Nurse #4 stated the aides often reported to her that they were unable to complete their assigned showers due to time constraints and staffing. She was not

F 353

the facility Executive Director on the importance of providing ADL assistance to dependent residents, to include bed baths daily and/or showers as scheduled.

g. During this meeting on 10/4/17, staff was queried on possible reasons for staffing/ new hire obstacles. Staff suggestions were given to the facility Executive Director and Corporate Director of Operations (DOO) on 10/4/17 with several suggestions to be implemented on/before 10/20/17 and others under consideration.

h. Direct supervisors will meet with employees, who decide to resign, in order to determine reasons for resignation and possible alternate actions available for retention.

i. As needed the Executive Director and administrative staff will be called upon to assist, in addition to PCAs and Medication Aides in determining resident needs for any shift by answering call lights and obtaining the appropriate staff to assist the resident as needed but will not operate out of their scope of practice

3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;

a. The Executive Director/ appropriate designee will notify the DOO of staffing numbers and any staffing issues with adjustments weekly to evaluate the effectiveness of advertising and hiring practices and the covering of shifts as needed.

b. Observation of Care audits will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 353

Continued From page 77

aware that the aides were not giving bed baths. She stated management was aware and had been working on staff for at least six months or more.

In an interview on 9/28/17 at 10:20 AM, NA #4 stated she was not able to give all her showers and offered her alert and oriented resident a bed bath instead.

In another observation on 9/28/17 at 10:38 AM, Resident #84 was in bed. She appeared clean and groomed. Her family member was present and at the bedside. She stated she did not feel Resident #84 was receiving her showers as scheduled. She stated she felt it was due to inadequate staffing.

2. F241 The facility failed to serve the food to all residents seated at the same table during two meal observations. Resident # 106 waited 40 minutes for her food while a table mate ate supper, Resident #114 waited 35 minutes and Resident # 16 waited 30 minutes to be fed while her table mate was fed lunch. Failing to provide a dignified dining experience occurred in 2 of 3 separate dining areas, the main dining room and the silver spoon dining room.

a. Continuous observations of the supper meal service to the residents in the main dining room on 9/24/17 from 4:30 PM to 5:05 PM, revealed there were 11 separate dining tables in the room. Resident #106 was seated at table #3 on the left side of the room. Residents # 21 and 114 were at the same table. Resident #21 received her supper meal at 4:40 PM and she began to eat her food. Residents were served randomly at other

F 353

conducted weekly by administrative and charge nurses to ensure care is being given as needed and according to policy. Any non-compliance will be addressed immediately.

c. Compliance with expected staffing levels will be brought to the morning administrative meeting (with QAPI committee members) 5x per week for 4 weeks. Followed by weekly on-going. Non-compliance will be promptly addressed.

d. Compliance outcomes of Dining and Shower/bed bath audits will be brought to the morning administrative meeting (where QAPI committee members are present) by the DON/ appropriate designee weekly X 4, and as needed for discussion.

e. Compliance with staffing levels, dining assistance, shower/bed bath schedules will be brought to the monthly facility QAPI meeting x 2 months, and as needed for discussion by committee members of outcomes and revisions to said plan if needed.

f. All discussion of outcomes and any revisions will be contained the QAPI meeting minutes.

g. The DON/appropriate designee will re-inservice applicable staff to any revision in said plan as needed.

h. Any revision will require monitoring to begin again a step 3(a).

4. The title of the person responsible for implementing the acceptable plan of correction.

a. The facility Executive Director, in conjunction with the facility QAPI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 353	Continued From page 78 tables during the observation. Observation at 4:45 PM revealed Resident #16 was heard saying "Hello, hello, where's my food?" Observation at 5:00 PM revealed Resident #21 left the dining room and Resident #106 used her hand to eat some of the food left by Resident #21. Resident # 114 was observed to grab some of the food left by Resident #21. Aide # 11 came by the table at 5:03 PM and pushed the food away from both residents. Observations at 5:05 PM revealed Aide #11 removed Resident #21's plate with the remaining food from the table. Observation at 5:07 PM revealed Resident #114 received her food and at 5:12 PM Resident #106 received her food. Interview with aide #10 on 9/28/17 at 4:30 PM revealed he was not aware Resident #106 was asking for her food. He explained the trays were not in the same order as the resident tables. Aide #10 further explained they try to get the trays out as fast as possible. b. Continuous observations on 9/26/17 in the silver spoon dining room from 11:43 AM to 12:35 PM revealed there were six residents with 2 staff members in the room. Resident #16 was seated at a table with another resident and one staff member (Aide #9). Aide #9 fed the other resident and Resident #16 did not receive her tray. A visitor was observed to enter and feed the table mate while Resident #16 remained at the table without her food. Aide # 9 left the table, left the silver spoon dining room and began assisting in the main dining room (adjacent to the silver spoon dining room). Observations revealed at 11:52 a third Aide # 3 came to the silver spoon dining room with another resident, and provided the resident a tray and assisted that resident.	F 353	committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 353	Continued From page 79 Observations at 11:54 AM revealed Aide #5 entered the dining room and provided another resident with feeding assistance. Observations at 12:15 revealed Resident #16 received her tray and feeding assistance. An interview was conducted on 9/29/17 at 12:31 PM with aides # 8 and 9, who had worked in the silver spoon dining room on 9/26/17. Interview revealed they were supposed to have 3 aides assigned to the silver spoon dining room. They both explained there would be 2 aides on each hall. One aide from each of the halls (100, 200 and 300 halls) were to come to the silver spoon dining room. If there were only 4 total aides on for all three halls, there would be 2 aides in silver spoon dining room. The residents in that dining room required feeding assistance. The staffing for 9/29/17 was reviewed and revealed there were 3 aides for 100, 200 and 300 halls (one aide per hall). Interview with the Administrator on 9/29/17 at 12:58 revealed the trays were not in any order in the tray cart for the main dining room due to residents sitting wherever they wanted. There was not a seating assignment. The Administrator explained ideally there would be 3 aides in the silver spoon dining room, and one aide and a patient care assistant (PCA) in the main dining room. The residents in the main dining room required cueing for meals. She would expect the nurse to supervise the aides and alert management if there was not enough staff. The Administrator expected residents to receive trays at the same table within a reasonable timeframe.	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 353	Continued From page 80 Interview with the charge nurse for the 100, 200 and 300 halls was conducted on 9/29/17 at 1:05 PM. Nurse # 11 explained she was from a "sister" facility and was not familiar with what a silver spoon dining room meant. She explained she thought it was restorative dining. Nurse #11 was not aware the silver spoon dining room did not have enough staff to provide assistance at mealtime.	F 353		
F 354 SS=E	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to staff Registered Nurse (RN) coverage 8 consecutive hours for 3 of 28 days reviewed for RN staffing. Findings included: A review of the facility staffing hours and staffing schedules from 8/19/17 through 9/27/17 revealed no 8 hours consecutive RN coverage on 8/31/17, 9/19/17 and 9/20/17. In an interview on 9/27/17 at 10:33 AM, the	F 354	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. Eight continuous hours of daily RN coverage has been maintained since 9/21/17 b. After review of the RN coverage situation by the facility administrative team (with QAPI committee members) on 9/25/17 it was determined although 8	11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	**700 JOHNSON RIDGE ROAD ELKIN, NC 28621**

(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 354	Continued From page 81 Administrator stated the previous Director of Nursing (DON) was over the facility staffing and she assumed the role as of 9/15/17 when the DON was terminated. She stated she was aware of the lack of RN coverage on the days identified and it was her expectation that there be an RN for 8 consecutive hours daily.	F 354	hours of daily RN hours were available for the majority of days, when the change in ADON to DON occurred there were a few scattered days without additional RN hours scheduled. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited a. Daily staffing levels will continue to audited/ reviewed by the Executive Director/ appropriate designee with special attention to the presence of 8 continuous hours of RN coverage daily. Actions will be taken for open areas and call-offs. b. Actions taken will be, as needed, administrative nursing staff and other nursing staff will be re-scheduled as needed to assure 8 hours of RN coverage. c. Corporate nurses will be used as needed to provide coverage. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; a. The Executive Director/ appropriate designee will notify the DOO of staffing numbers and any staffing issues with adjustments weekly, and as needed, to evaluate the effectiveness of said plan. b. Compliance with expected 8 hours of continuous RN coverage will be brought to the morning administrative meeting (with QAPI committee members) 5x per week for 4 weeks, and as needed. Followed by weekly on-going. Non-compliance will be promptly addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	**700 JOHNSON RIDGE ROAD ELKIN, NC 28621**

(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 354	Continued From page 82	F 354	c. Compliance with 8 hours of continuous RN hours daily will be brought to the monthly facility QAPI meeting x 2 months, and as needed for discussion by committee members of outcomes and revisions to said plan if needed. d. All discussion of outcomes and any revisions will be contained the QAPI meeting minutes. e. Any revision will require monitoring to begin again a step 3(a). 4. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 431		11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 431	Continued From page 83	F 431		

biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(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.

(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 431	Continued From page 84 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure and label unidentified loose pills in 3 of 3 medication carts. (Medication Cart 100, 300 and 600) The findings included: 1. An observation on 9/27/17 at 2:48 pm of the 100 hall medication cart revealed there were four unidentified loose pills found in the top drawer and two unidentified loose pills found in the bottom drawer. During an interview with Nurse #4 on 9/27/17 at 2:48 pm, she verified the unidentified loose pills in the cart and stated she did not know what the medications were. 2. An observation on 9/27/17 at 3:40 pm of the 600 hall medication cart revealed there were two plastic medicine cups of pre-poured pills (6 pills in the cup on the right and 5 pills in the cup on the left side of the first drawer), seven and one half loose pills in the top drawer, two and one half loose pills in the middle drawer, and two loose pills in the bottom drawer. An interview with Nurse #3 on 9/27/17 at 3:45 pm revealed that she did not know what the loose pills in the 600 hall medication cart were. When asked about the pre-poured medications the nurse stated the 6 pills in one cup and the 5 pills in the other cup for 2 separate residents and that the medications had been sitting in the drawer for an hour to an hour and a half. She further stated that she had placed the medications in the cup, but had not administered them to the residents	F 431	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. Pre-poured medication was discarded as were all loose pills found in the medication carts. b. After review of the cited deficiency by the administrative staff (with QAPI committee members) it was determined that the cause for the pre-pour was human error and the loose pills in the cart was caused by overstock medication cards in with the regular medication cards which made the space very tight for pulling out the needed medication cards. When pulling them out, due to the tightness, some pills were pushed out of the medication card and fell to the bottom of the drawer. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; a. Regarding pre-pouring of medications: Nurse in question was counseled by the DON for improper medication delivery. b. All licensed staff were re-inserviced by the Corporate Director of Clinical Operations on 9/20/17, 9/28/17, 10/4/17, on the 8 rights of medication administration including, but not limited to, preparing medication for one resident at a time. c. The Corporate Director of Clinical Operations contacted pharmacy representative with regards to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 431	Continued From page 85 yet. When asked how she would know who the pills were for the nurse stated she just knows what the residents get and she usually puts the room number on the cup. Nurse #3 further stated, "I know this is a no-no." 3. An observation on 9/27/17 at 3:58 pm of the 300 hall medication cart revealed one loose pill in the second drawer and one loose pill in the third drawer. During this observation, Medication Aide (MA) #3 identified one loose pill as Colace (stool softener) but was unable to identify the other loose medication. During an interview with pharmacist on 9/28/17 at 9:40 am he indicated that all medications stored in the medication cart should be labeled. During an interview with the Director of Nursing (DON) on 9/28/17 at 9:40 am she stated that third shift nurses check the medication carts every other day and remove loose pills. She further stated it was her expectation that medications were not pre-poured and that any pre-poured medication should be discarded and prepared again just prior to administration. During an interview with the administrator on 9/29/17 at 12:55 pm she stated her expectation was that all loose pills be disposed of. She further stated that pre-pouring of medications was never allowed. She stated it was her expectation that medication be poured or placed in a cup and immediately given to the resident.	F 431	overcrowding of medication cards in the medication carts and then to establish an overflow area for the extra cards not in use. Pharmacy representative will review the carts and the overstock on/before 10/26/17. d. Licensed nurses were re-inserviced by the Corporate Consultant on 10/4/17 with regards to checking the medication carts daily and remove any loose pills that may fallen to the bottom of the drawers in the medication carts. e. Medication pass audits will be conducted by the Pharmacist/ appropriate designee during each shift by 10/26/17. Any non-compliance will be promptly addressed. f. Random medication audits will be done weekly X 4 weeks, and as needed, by the DON/ appropriate designee. Any non-compliance will be promptly addressed. g. Random medication cart audits will be done weekly X 4 weeks, and as needed, by the midnight charge nurse. Any non-compliance will be promptly addressed. h. The DON/appropriate designee will bring the outcomes of random audits to the morning administrative meeting weekly X 4 weeks. i. Random med pass audits will be conducted monthly X 3 months, and as needed, by the pharmacist/appropriate designee. Any non-compliance will be promptly addressed. j. The DON will bring outcomes of the monthly random audits to the facility monthly QAPI meeting x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	**700 JOHNSON RIDGE ROAD ELKIN, NC 28621**

(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 431	Continued From page 86	F 431	k. The plan and outcomes will be reviewed by the facility QAPI committee members monthly X 3 and going forward, as needed. l. All discussion of said plan, outcomes, revisions, etc. will be included in the meeting minutes. m. The DON/appropriate designee will re-inservice applicable staff should revisions be made to the said plan. n. Any revision of plan will require monitoring of said plan to begin again at step 3(a). 3The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements a. Compliance with the medication audits on 10/26/17 will be brought by the DON/ appropriate designee to the morning administrative meetings (with QAPI committee members) on/before 10/30/17 for review by administrative staff. b. Compliance with random medication audits will be brought by the DON/ appropriate designee to the morning administrative meetings weekly X 4 weeks, and as needed, for review by administrative team. c. Compliance with Medication Pass audits and Medication Cart audits will be brought to the facility monthly QAPI meeting X 2 months by the DON/ appropriate designee, for review of said program by the committee members. d. Any discussion of compliance, outcomes, and revisions, if needed will be included in the QAPI meeting minutes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 431	Continued From page 87	F 431	e. The DON/ appropriate designee will re-inservice applicable staff should any revision to said plan occur. f. Any revision to said plan will require monitoring to begin again at 3(a). 4. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE (i) Medical records. (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 (5) The medical record must contain- (i) Sufficient information to identify the resident;	F 514		11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 514	Continued From page 88 (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: Based on staff, physician and director of clinical operations interviews the facility failed to maintain accurate medical records for one of seven (Resident #133) sampled residents with pressure ulcers. The facility failed to document accurate weekly and complete assessments with measurements, wound descriptions, and stages for Resident #133 wounds. The findings included: Resident #133 was admitted to the facility on 2/2/2017 with diagnoses which included Benign Prostatic Hypertrophy, Non-Alzheimer's Dementia, Anxiety Disorder, Depression, and Chronic Obstructive Pulmonary Disease (COPD). Review of the signed physician telephone orders dated 7/13/17 indicated treatment for right & left hip abrasions to be cleaned with normal saline, apply an Aquacel foam dressing (wound dressing) and change daily. The following wounds occurred from 7/13/17 to 9/1/17. The wounds were per documentation found in the wound assessments, progress notes,	F 514	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. The facility identified a concern with regards to wound management on 8/30/17 during a routine audit. The physician and resident representative were notified on9/1/17 for resident #133, prior to survey on 9/24/17. Documentation in the resident□s health record was updated to reflect assessment, notification and any new orders. Resident discharged from the facility on 9/28/17. b. An in-house facility plan of action (POA) was initiated on 8/30/17 by the facility Executive Director and DON relating to wound care treatment and documentation, which included notification of physician and Resident Representative. A 100% skin sweep was completed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	**700 JOHNSON RIDGE ROAD ELKIN, NC 28621**

(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 514	Continued From page 89 physician orders, and physician notes by the wound nurse (Nurse 1) and the Wound MD. The wounds have been assigned numbers for easy identification. Wound #1, identified as a right hip abrasion on 7/13/ 17. It progressed to a large abscess on 7/25/17 based on the Wound MD's assessment and was documented as an unstageable pressure ulcer on 7/25/17 by Nurse 1's wound assessment. Wound #2, identified as an ulcer to right foot on 7/25/17. Progressed to a right medial heel unstageable pressure ulcer on 7/28/17. Wound #3, identified as a stage 2 pressure ulcer to left heel during the Wound MD's assessment on 7/25/17 and not mentioned in any documentation after that assessment. Wound #4, identified as an ulcer to left medial ankle on 7/27/17 during Wound MD assessment. Progressed to an unstageable pressure ulcer on 7/28/17. Wound #5, identified as a left hip abrasion on 7/13/17. Progressed to a left hip deep tissue injury (DTI - Purple or maroon discolored localized area of intact skin or blood-filled blister due to damage of underlying soft tissue from pressure) on 7/28/17. Progressed to a left hip unstageable pressure ulcer on 8/15/17. Wound #6, identified as a Sacral Coccyx DTI on 7/28/17. Was described as a stage 4 pressure ulcer by the Wound MD on his 9/1/17 assessment. Progressed to an unstageable pressure ulcer on 9/21/17. Review of the signed physician telephone orders dated 7/13/17 indicated treatment for right & left hip abrasions to be cleaned with normal saline, apply an Aquacel foam dressing (wound dressing) and change daily. A physician's note from 7/25/17 from Wound MD	F 514	9/7/17, and this was compared to wound reports, wound documentation, and treatment orders for accuracy in a meeting. Identified items and the plan of action were brought to the facility QAPI meeting on 9/14/17 and the said plan was discussed. It was found the DON (at that time) had failed to address the said plan as directed. The DON (at that time) was terminated on 9/15/17. Two corporate directed treatment nurses were brought in on 9/19/17 to perform another total skin sweep, update all documentation, notifications, and orders. The Wound MD rounded on 9/19/17 and 9/21/17 with these nurses to assess conditions of wounds identified. Another wound meeting was held on 9/21/17 with notifications verified. Weekly meetings have continued since and notifications have been in compliance. c. This POA was in place and actively pursued at the time of the survey on 9/24/17. d. It was determined by the facility administrative staff and the QAPI committee that a disruption in practice and protocol was the cause of the error for both Resident 133. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; a. Corporate directed treatment nurses have been on-site weekly to provide oversight, routine measurements, treatments, notification of physician/Resident Representative, and complete/ accurate documentation in the resident□s medical record of status of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 514	Continued From page 90 was his initial consult and assessment of resident #133's wounds. The wounds assessed included: large abscess to right hip (Wound #1) with cellulitis, ulcer to right foot (Wound #2), and pressure ulcer of left heel stage 2 (Wound #3). Review of a wound assessment note by Nurse 1 from 7/25/17 revealed documentation for Wound #1 as an unstageable pressure ulcer measuring 9 centimeters (cm) in length by 7 cm in width, covered with 100% eschar (dry, dark scab or falling away of dead skin) tissue. Wounds #2 and #3 were not assessed by Nurse 1. Physician note from 7/27/17 from Wound MD was a follow-up assessment of resident #133's wounds. The wounds assessed on 7/27/17 included: Wound #1 was described as an abscess to right hip, Wound #2 was described as pressure ulcer to right heel, and an ulcer of Left Medial Ankle (Wound #4). No measurements of the wounds were documented. Wound #3 was not assessed. From 7/27/17 through 9/1/17 there is no documentation in the medical record that wound #3 was measured or assessed. Record review revealed a wound assessment was completed on 9/1/17 by the Wound MD and revealed that staff had asked him to check sacral area wound due to worsening. The wounds assessed included a pressure ulcer of hip (did not specify which hip), Wound #6 was described as a stage 4, a stage 2 pressure ulcer of ankle (did not specify which ankle), a stage 1 pressure ulcer of heel (did not specify which heel), and cellulitis to sacral area. No assessments, measurements, descriptions, or staging the of the resident's wounds were completed after 9/1/17 until 9/21/17. Review of a Wound Assessment note by Nurse 10 from 9/21/17 revealed Wound #5, # 1 and #6	F 514	wounds and current treatments. b. The facility has hired an experienced treatment nurse and will begin on 10/30/17. Until that time, Corporate directed wound nurses will continue to provide consistent care, notifications, and documentation for any resident with wounds or other skin issues. c. The facility contracted with a skin/ wound company, Quality Surgical Management, who began services on 10/4/17. Providers are either physicians, or physician extenders with special training in wound management. They are in the facility on a weekly basis on-going and provide additional documentation with regards to wounds and other skin issues. This documentation is maintained in the resident record. d. Since 9/21/17, notification of the physician/ Resident Representative with regards to skin issues/wounds is being audited by the DON/ appropriate designee during the facility weekly wound meeting. This audit will be ongoing as the wound meetings will continue weekly indefinitely. Any non-compliance will be promptly addressed. e. Corporate Nurses review the wound documentation on a weekly basis, beginning on 10/4/17, and weekly X 6 weeks, and as needed. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements a. Compliance on consistency of wound management and required documentation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 514	Continued From page 91 were assessed and measured. Wounds #2, #3, and #4 were not assessed or measured. Attempted to call Nurse 1 on 9/28/17, the nurse was no longer working at the facility, and no interview was obtained. During an interview on 9/28/2017 at 8:48 AM with the Wound MD when asked when he was consulted to treat the resident's wounds he stated he was consulted by MD #1 and first assessed the resident's wounds on 7/25/17. He stated he could not remember details about the wounds. When asked if he had seen or assessed the wounds after the follow-up assessment on 7/27/17 until 9/1/17, he stated that he had not, and that he relied on Nurse 1 to assess and notify him of any changes that were seen, none were reported until 9/1/17. During an interview on 9/28/17 5:21 PM with the Administrator and Corporate Nurse (CN) they stated Administration identified discrepancies in the wound assessments and skin documentation. The expectation was that Nurse 1 would document weekly assessments of wounds to include measurements, descriptions, and stages of pressure ulcers. During an interview with MD #1 on 9/29/17 at 11:28 AM, when asked if he had assessed the wounds, he stated he had not seen them until 9/1/17 because he relied on the Wound MD for assessing and treating the wounds.	F 514	will be brought by the DON/ appropriate designee, to the administrative morning meeting (with QAPI committee members) weekly X 4 weeks, and as needed. b. Compliance on consistency of wound management and required documentation will be brought by the DON/ appropriate designee, to the monthly QAPI meeting X 2 months, and as needed. c. Compliance, outcomes, any revisions will be discussed by the committee members and all discussion will be contained in the meeting minutes. d. The DON/ appropriate designee will re-inservice applicable staff, as needed, with any revisions to said plan. e. Any revisions to said plan will require monitoring to begin again at 3(a). 4. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a	F 520		11/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 520	Continued From page 92 minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to	F 520	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	**700 JOHNSON RIDGE ROAD ELKIN, NC 28621**

(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 520	Continued From page 93 maintain implemented procedures and monitor interventions that the committee put into place following the 12/15/2016 recertification survey. This was for one recited deficiency that was originally cited in December 2016 and was subsequently recited on the current recertification survey of 09/29/17. The repeated deficiency was in the area of Services Provided Meet Professional Standards. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings include: This tag is cross referenced to: F281: Services Provided Meet Professional Standards: Based on observations, staff and physician interviews and medical record review, the facility failed to clarify an admission order for a tabs monitor or bed alarm for 1 of 4 residents (Resident #150) reviewed for accidents. During the recertification survey of 12/15/2016 failed to obtain physician ordered urine tests to diagnose an infection for one of three residents with urine incontinence. An Interview was conducted with the facility's Administrator on 9/29/2017 at 2:35 PM. When asked about how the facility planned to handle physician orders, she stated all the telephone orders written the day before were reviewed every morning by the team and that the order missed for the bed/chair alarm was an oversight. She stated they would continue to pull reports from their computer system and compare to written doctor's orders to ensure there were no gaps.	F 520	cited; a. The order for the Resident 150□s tab / bed monitor was written by the hospital physician who was unaware that the facility does not use alarms. The order was not transcribed to the facility orders because the nursing staff was aware of no alarm policy. The order was discontinued on 9/26/17 by the facility physician. b. Resident 150 has not experienced any falls since readmission on 9/16/17 due to not having the alarm. c. Review of the cited deficiency was reviewed by the facility administrative team (QAPI committee members) and determined to be caused human error in not following protocol for order clarifications. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a. Corporate Director of Clinical Reimbursement provided training to MDS/medical record on clarifying orders from the hospital on 10/20/17. b. Any newly admitted/ re-admitted resident is reviewed by the administrative nurses/ medical records for 5 Day Chart Review post admission for clarification/ completion of actions needed. This practice will continue with the facility Executive Director providing oversight for compliance. c. Any clarifications will be noted in the resident□s medical record for review by the administrative nurses during clinical morning meeting. 3. The monitoring procedure to ensure that the plan of correction is effective and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	**700 JOHNSON RIDGE ROAD ELKIN, NC 28621**

(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 520	Continued From page 94	F 520	that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; a. Results of the 5 Day Chart Review will be brought to the morning administrative meeting weekly X 4 weeks by the Medical Records Director and as needed. b. Random observations by the Executive Director monthly X 2 months, and as needed. Results of compliance will be brought to the monthly QAPI meeting X 2 months, and as needed. c. Discussion by the QAPI committee members regarding outcomes, and/or any revision to the said plan will be documented in the QAPI meeting minutes. d. The Executive Director/ appropriate designee will provide re-inservicing as needed to any revision of plan. e. Any revision of said plan will require monitoring to begin again at step 3(a). 4. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.	