STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345421	A. BUILDING ______ B. WING ______	C 08/05/2019

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

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F 000	INITIAL COMMENTS The survey team entered the facility on 8/2/19 to conduct a complaint investigation and exited on 8/4/19. Additional information was obtained on 8/5/19. Therefore, the exit date was changed to 8/5/19. Twenty-one allegations were investigated and they were all unsubstantiated.	F 000		
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on record review, staff, family, physician, and radiology company staff interviews the facility failed to obtain radiology results to meet the needs for one of three residents (Resident #5) reviewed for accidents. Radiology results for Resident #5 were not obtained stat as ordered. Findings included: Resident #5 had diagnoses of intercranial	F 776	The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is August 16, 2019. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or	8/16/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 08/07/2019

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

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F 776	Continued From page 1 aneurysm and subsequent subarachnoid hemorrhage with residual right sided hemiparesis and aphasia, anxiety, depression, and seizure disorder. Documentation in a quarterly minimum data set assessment dated 7/15/19 coded Resident #5 as cognitively intact with range of motion impairment on one side of both upper and lower extremities. Resident #5 had one fall since her last assessment with no injury noted. Documentation in the care plan dated as last reviewed on 7/22/19 had a focus area for a risk for fall related injury due to unsteady gait, impaired mobility, history of falls, psychotropic medications, and right sided hemiparesis. One of the interventions was to obtain laboratory values/diagnostics per physician orders and report abnormal results to the physician. Documentation in a nursing note dated 7/30/19 at 6:08 PM stated, "[Medical Doctor] order for stat x-ray to right arm (shoulder to fingertips) for bruise to right upper arm and bruise to 3rd finger (right hand). Guardian notified." Documentation on a physician's telephone order for Resident #5 dated 7/30/19 at 6:08 PM stated, "STAT x-ray from shoulder to fingertip. 2 views, to rule out fracture." An interview was conducted on 8/2/19 at 3:37 PM with the nursing unit coordinator (Nurse # 2), who called the radiology company to relay an order for Resident #5 on 7/30/19. Nurse #2 stated that a nurse aide came to her telling her she noticed a bruise on the bicep of Resident #5. Nurse #2 stated she called the physician and received a	F 776	conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F776 Radiology/Other Diagnostic Services Corrective Action We are unable to correct this alleged deficient practice for Resident #5, as she is no longer a resident in our facility. How the facility will identify those who have the potential to be affected At the time of survey, the DON (Director of Nurses) and the Unit Manager nurses audited all charts, for the past 30 days, for any STAT radiology orders to determine if any results were longer than 4 hours. No other resident was found to be affected. Any resident that requires a STAT result for Radiology services has the potential to be affected. Systemic changes Currently the Radiology company has three levels of time requests, Normal, AS Soon As Possible, and STAT. We will now utilize just two levels, Normal and STAT. Stat will require a four-hour turnaround time frame from ordering to receiving results. If a STAT x-ray is ordered, the nurse that is requesting the service will inquire of the X-Ray Tech the approximate time of arrival. In addition, the X-Ray Tech will notify the facility by phone of the approximate time of arrival. This will give the facility the ability to determine if other	

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verbal order for a stat x-ray of the resident's arm. Nurse #2 stated she called the radiology company and relayed the order for Resident #5, requesting an x-ray needed to be done as soon as possible.

Documentation of the x-ray order dated 7/30/19 at 5:59 PM listed the reason for a portable x-ray as "fall risk/ fell (non-ambulatory - transport medically risky)." Documentation of the priority level for the x-ray stated, "STAT."

An interview was conducted on 8/2/19 at 3:54 PM with the nurse (Nurse # 4) who was assigned to Resident #5 on 7/31/19 for the 7:00 AM to 3:00 PM shift. Nurse #4 stated that he received report when he started his shift that Resident #5 had bruising on her arm and fingers for which an x-ray was yet to be done. Nurse #4 stated that the x-ray technician came at approximately 8:00 AM to take an x-ray of the right arm of Resident #5. Nurse #4 stated that a representative of the radiology company was in the building on the morning of 7/31/19 and he asked her why the stat x-ray was not done until the following morning. Nurse #4 stated that the representative of the radiology company told Nurse #4 she would investigate the reason.

Record review of the documentation on the x-ray for Resident #5 showed the completion date and time of 7/31/19 at 8:20 AM.

An interview was conducted with the Director of Nursing on 8/3/19 at 8:05 AM. She stated she received a text from the radiology company on 7/31/19 at 8:41 AM indicating that critical results were pending for one of the residents in the facility.

arrangements need to be made, i.e., send to the hospital. In addition to the current text to the DON and email notification of a positive result, the unit managers of each unit will be notified by text and email. In addition to that notification, if a Positive Report is determined by the physician, the Radiology company will notify the facility by a phone call with information of where the result is being sent to and when to expect it. If the result does not arrive for whatever reason, the nurse will then follow-up with a phone call to the X-Ray company until report is received. The Staff Development Nurse will educate nurses regarding this new procedure and the Director of Operations of the Radiology company will educate his staff to these procedures. New employees of both companies will be educated regarding this procedure during the orientation period.

Monitoring
The Director of Nurses, using a QA auditing tool, will review all STAT Radiology results for timeliness, weekly for the next 2 months, and then will review random STAT Radiology orders, weekly for the next two months to ensure that services are timely. The results will be reported by the DON, to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from the QA committee.

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An interview was conducted on 8/4/19 at 2:30 PM with Nurse # 8. Nurse #8 stated that at 9:00 AM on 7/31/19 she went to the fax machine at Station 1 and did not see the x-ray results for Resident #5. Nurse #8 stated she telephoned the radiology company to inquire about the pending results for Resident #5. Nurse #8 stated she received the response from the radiology company that the report had not yet been completed. Nurse #8 stated she requested the x-ray results be faxed to the facility as soon as possible. Nurse #8 stated she requested the x-ray results be sent the fax machine at Station 2, because the fax machine at Station 1 was not working. Nurse #8 stated the radiology company representative on the phone indicated a special note would be added so that the result would go to the fax number on Station 2. Nurse #8 stated that she went to the facility's electronic medical record system to look for the results and saw that two other x-rays that were completed that morning by the x-ray technician were in the electronic medical record system but the x-ray results for Resident #5 were not. Nurse #8 stated that the x-ray results were always made available to the facility via the facility's electronic medical record system.

Additional information was obtained during an interview conducted with Nurse #2 on 8/2/19 at 3:37 PM. Nurse #2 stated she found out the next day, 7/31/19, that the x-ray for Resident #5 was not completed until that morning. Nurse #2 stated she went to the Station 2 fax machine at approximately 11:00 AM to look for the x-ray results, to find the results had not yet been faxed. Nurse #2 called the radiology company again, with the knowledge another nurse (Nurse #5) had already called the radiology company requesting

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F 776	Continued From page 4 the results be faxed to Station 2. Nurse #2 stated that after the second request was made the x-ray results were faxed to the facility. Record review of the faxed x-ray results revealed the results were faxed to the facility on 7/31/19 at 11:44 AM. Documentation on the x-ray results revealed the completion date and time of 7/31/19 at 9:21 AM. The x-ray results indicated Resident #5 had an acute fracture of her right humerus (long bone in the upper arm) with mild displacement of the humerus neck. Documentation on the Medication Administration Record for Resident #5 revealed she received pain medication on 7/30/19 at 11:13 PM and on 7/31/19 at 9:38 AM for a pain level of 10 on a scale of 1 to 10. Documentation in a nursing note dated 7/31/19 at 1:35 PM stated, "Resident had an x-ray done to [right upper extremity] today, results were fractured humerus, [Responsible party] and [Medical Doctor] made aware. Order obtained to send to [hospital] for [evaluation] and treatment. All appropriate paperwork was sent with resident, [Responsible party] made aware of transfer. Resident did not [complain of] pain as this is her effected side from past cerebral vascular accident." Documentation in the hospital records dated 8/2/19 for Resident #5 revealed the resident would have her fractured arm treated on an outpatient basis without an operation. An interview was conducted with the physician for Resident #5. The physician stated that he was made aware of the fractured arm on 7/31/19. He	F 776		

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F 776	Continued From page 5 stated that the resident had a high tolerance for pain and due to her cognitive deficits was not able to always express herself. An interview was conducted with the guardian of Resident #5 on 8/2/19 at 1:11 PM. He stated he was concerned and did not understand why it took the facility so long to obtain x-ray results when Resident #5 was complaining of pain. An interview was conducted on 8/2/19 at 4:45 PM with the facility representative from the radiology company. The facility representative indicated that after an order for an x-ray was called in, the x-ray should be performed, and the results received by the facility in four hours or less. She stated that she listened to a recording of the nurse calling in the order and heard her state that the order was to be done "as soon as possible." The representative stated that "as soon as possible" orders were not a priority. She stated that "stat" orders were to be completed first and that the facility staff had to be relied on to tell the radiology company the urgency of the x-ray. The representative stated that the order was called in for "as soon as possible" so the x-ray was rolled over until the next morning since the order was relayed in the evening. The facility representative stated that the radiology technician upgraded the order to "stat" when he arrived at the facility on 7/31/19 and saw the arm of Resident #5, so the results would get back to the facility faster. The facility representative stated she did not know why the results were not received by the facility until 7/31/19 at 11:44 AM. She stated that the x-ray, according to her records, was faxed to the facility on 7/31/19 at 9:24 AM. The representative stated was in the process of training the staff in the facility to access x-ray results in the portal	F 776		

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F 776	Continued From page 6 system used by the radiology company. The Director of Nursing was interviewed on 8/2/19 at 4:55 PM. She indicated the radiology company would usually send her a text message to notify her x-ray results were being sent to the facility. She stated that the radiology company would then fax the x-ray results to facility and send the results to the electronic medical record system. The Director of Nursing indicated that at the time of the interview, the radiology company had not put the x-ray results for Resident #5 in the electronic medical record system. The Director of Nursing stated that she would have expected the radiology company to call to make sure the critical x-ray results were received and to put the x-ray results in the electronic medical record system for the nursing staff to access. The Director of Nursing did not think her nursing staff should be expected to look in the portal system for the radiology company to find x-ray results for the residents. The Director of Nursing confirmed that Resident #5 received pain medication while she was waiting on the x-ray results and was provided with a brace for her arm, which she chose not to wear. A simultaneous interview was conducted with the facility Director of Nursing and the Director of Operations (DOO) for the radiology company on 8/3/19 at 8:50 AM. The DOO confirmed that the x-ray results for Resident #5 were faxed to the facility at 9:24 AM to the Station 1 fax machine. The DOO explained that the radiology company had three levels of urgency to triage the x-rays. The DOO stated that the three levels were "Normal," "As Soon As Possible," and "STAT." The DOO indicated that if the physician's order was relayed to the radiology company as	F 776		

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F 776	Continued From page 7 "Normal" then it would have no urgency and the expectation was for the service to be provided within 8 hours. The DOO indicated that "As Soon As Possible" would have a higher urgency that would be completed sooner than "Normal." The DOO indicated the time frame for "As Soon As Possible" was ambiguous. The DOO stated that an x-ray ordered as "STAT" would take priority. The Director of Nursing stated that she and her staff were not aware of the three levels of urgency for the triage of x-rays for the radiology company. The DOO stated that the nurse who called in the order for the x-ray for Resident #5 stated that the x-ray needed to be done as soon as possible, so therefore the x-ray did not take priority. The DOO revealed that a high volume of STAT x-rays needed to be completed on 7/30/19 so the x-ray for Resident #5 was moved to the morning of 7/31/19. The DOO stated that a phone call to the facility should have been made by the radiology company to the facility to let them know the x-ray for Resident #5 could not be completed on the evening of 7/30/19. The DOO could not explain why the fax results were not sent to the Station 2 fax machine as requested by the facility. The DOO stated that a phone call to the facility alerting the nursing staff to a critical x-ray was an option the facility could have put in place in the future. An additional interview was conducted on 8/5/19 at 11:39 AM with the DOO for the radiology company. The DOO stated that the radiology technician changed the order for the x-ray for Resident #5 from ASAP (as soon as possible) to STAT on the morning of 7/31/19 according to a time stamp he was able to view. The DOO also confirmed that Nurse # 8 and Nurse # 2 called the radiology company and both nurses	F 776		

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F 776	Continued From page 8 requested the fax results of the x-ray go to the Station 2 fax machine. The DOO could not confirm if the information regarding the need for the faxed results to go to Station 2 was acknowledged by the radiology company.	F 776		