STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345421	A. BUILDING _____ B. WING _____	07/06/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, staff interviews and facility Nurse Practitioner interview, the facility failed to maintain accurate medical records for 2 of 3 residents sampled for wound care (Resident #1 and #2). The findings included: 1) Resident #1 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] indicated Resident #1 was cognitively intact and displayed physical behavior directed towards others 1 to 3 days during the 7 day look back period. He required extensive assistance for personal hygiene, bathing and bed mobility and required total assistance from staff for toileting and transfers. Limited range of motion was present to his bilateral lower extremities. Resident #1 was coded with one stage 3 pressure ulcer present on admission, open [MEDICAL CONDITION] other than ulcers/rashes/ cuts and Moisture Associated Skin Damage (MASD). Review of the active care plan dated 6/24/2020 revealed a care plan for a risk of skin integrity/pressure injury and actual impairment to skin integrity. Interventions included treatments to skin impairments per physician order. A review of the nursing progress notes from 3/1/2020 to present revealed Resident #1 was noncompliant with pressure relief recommendations, remained up in the wheelchair for long periods of time and refused wound care at times. The last documented refusal of wound care was 6/22/2020. A review Resident #1's Physician order [REDACTED]. Change twice a day and as needed for soiling or displacement. -Clean open area to left upper outer thigh with wound cleanser. Apply skin prep (provides protection to intact skin) to peri wound (skin surrounding the wound) and then Silver Alginate (used to decrease risk of infection and promote healing) to the wound bed. Cover with silicone dressing every Monday, Wednesday and Friday. Change as needed for soiling and displacement. -Clean open are blister to right outer knee with wound cleanser. Apply skin prep to peri wound and Silver Alginate to wound bed. Cover with silicone dressing on Monday, Wednesday and Friday. Change as needed for soiling and displacement. -Fill the space on sacrum with Calcium Alginate (used to promote healing and formation of healthy tissue) for moisture control. Change every day and as needed for soiling or displacement. A review of the June 2020 Treatment Administration Record (TAR) revealed the following treatments for Resident #1 were not initialed as completed on the following dates: 1. After cleaning buttocks apply Triad to entire coccyx/sacral/buttocks area and cover with thick dressing. Change twice a day and as needed for soiling or displacement. No initials were present indicating dressing had been changed for 6/3/20 day shift, 6/5/20 day shift, 6/8/20 day shift, 6/12/20 day shift, 6/13/20 evening shift, 6/15/20 evening shift, 6/19/20 day shift, 6/26/20 and 6/30/20 day shift) 2. Clean open area on the left upper outer thigh with wound cleanser. Apply skin prep to peri wound and Silver Alginate to the wound bed. Cover with dry dressing and change every Monday, Wednesday, Friday and as needed for soiling or displacement. No initials were present indicating dressing had been changed for 6/8/20, 6/12/20, 6/26/20 and 6/30/20. 3. Clean open blister to right outer knee with wound cleanser. Apply skin prep to peri wound and Silver Alginate to wound bed. Cover with dry dressing and change every other day and as needed for soiling or displacement. No initials were present indicating dressing had been changed for 6/3/20, 6/5/20, 6/8/20, 6/12/20, 6/19/20, 6/26/20 and 6/30/20. 4. Fill space on sacrum with Calcium Alginate for moisture control. Change every day and as needed for soiling or displacement. No initials were present indicating dressing had been changed for 6/3/20, 6/5/20, 6/8/20, 6/12/20, 6/19/20, 6/26/20 and 6/30/20. 5. Clean open area to left heel with wound cleanser. Apply skin prep to peri wound and Silver Alginate to wound bed. Cover with foam dressing. Change every Monday, Wednesday, Friday and as needed for soiling or displacement. No initials were present indicating dressing had been changed for 6/3/20, 6/5/20, 6/8/20, 6/12/20 and 6/19/20. Review of the June 2020 TAR revealed Resident #1 had refused treatments to be completed on 6/16/20 and 6/22/20. On 7/1/2020 at 11:10 AM an observation of wound care was conducted with the Treatment Nurse. Moisture Associated Damage was observed to the groin area as well as left and right buttocks of Resident #1. The area was clean and free from odor. There were no signs of infection noted. There was a small crevice on his sacrum where a Stage 4 pressure ulcer had healed and is treated for [REDACTED]. She explained the resident liked to have his dressing change completed in the morning before getting up to the wheelchair. She went onto say Resident #1 would refuse treatments at times and she would mark the TAR as refused wound care when that occurred. Resident #1 was interviewed on 7/1/2020 at 11:45 AM and stated he was pleased with his wound care and the Treatment Nurse made sure his dressings were changed daily during the week. He confirmed there were times he didn't want his wounds attended to because he wasn't feeling well or not ready to go back to bed in the evening. On 7/1/2020 at 12:45 PM the Optum Nurse Practitioner was interviewed and aware of the multiple areas of sink breakdown Resident #1 had. She explained due to his diabetes, poor compliance with recommendations for wound healing, sitting up for long periods of time and refusals of wound care, the areas were slow healing. In addition, he had multiple areas of scarred tissue from previous skin breakdown that impeded the healing process. The Nurse Practitioner stated she liked to observe Resident #1's wounds with the Treatment Nurse at least weekly and felt like they were healing with no signs of infection. She was only aware of treatments not being completed as ordered when the resident had refused. Multiple phone calls were placed to Nurse #1 on 7/6/2020 from 11:56 AM until 2:26 PM with no answer or ability to leave a message. A phone interview was completed with Nurse #2 on 7/6/2020 at 11:57 AM. She worked 3:00 PM to 11:00 PM shift at the facility and was normally assigned to Resident #1. She explained Resident #1 was normally up in his wheelchair when she came on duty and would go to bed between 8:00 PM to 10:00 PM. After he was placed in bed she would go in and perform his wound care to the groin and buttocks area. Nurse #2 stated she always completed his wound care and forgot to sign the TAR on 6/15/2020. On 7/6/2020 at 2:11 PM, a phone interview was completed with the Treatment Nurse. She stated she was responsible for wound care on the day shift Monday thru Friday. She verified the day shift dates in question were when she was on duty, that she had completed the wound care as ordered but had forgotten to sign them as completed. The Treatment Nurse stated she and the Administrator had discussed it and she would complete an audit of all TAR's at the end of her shift daily to ensure all wound care had been signed off appropriately. The Administrator was interviewed via telephone on 7/6/2020 at 4:00 PM and stated he had discussed the missing documentation on the June 2020 TAR's for Resident #1 with the Treatment Nurse and she would complete a daily audit of all TAR'S for missing documentation. 2) Resident #2 was originally admitted to the facility on [DATE] with a readmission date of [DATE]. Her [DIAGNOSES REDACTED]. The annual Minimum Data Set ((MDS) dated [DATE] indicated Resident #2 was cognitively intact and displayed rejection of care 1 to 3 days during the 7 day look back period. She required extensive assistance for dressing, personal hygiene, and eating and required total assistance from staff for bed mobility, transfers, toileting and bathing. Limited range of motion was present to bilateral lower extremities and she was always incontinent of bowel and bladder. Resident #2 was coded with three stage 4 pressure ulcers that were present on admission/readmission. A Nurse Practitioner progress note dated 5/27/2020 revealed Resident #2's wounds to her sacrum and left and right ischium (the rounded bone that extends from the bottom of the pelvis), continued to heal despite a history of osteo[DIAGNOSES REDACTED] (infection of the bone). Review of the active care plan dated 6/23/2020 revealed problem areas

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

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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) for actual impaired skin integrity related to pressure. The interventions included treatments as ordered. A review Resident #2's Physician order [REDACTED]. Apply skin prep to the peri-wound and Collagen and Calcium Alginate to the wound bed. Cover with silicone dressing. Change every day and as needed for soiling or displacement. - Clean open area to left ischial with wound cleanser. Apply skin prep to the peri-wound and Collagen and Calcium Alginate to the wound bed. Cover with silicone dressing. Change every day and as needed for soiling or displacement. - Clean open area to right ischial with wound cleanser. Apply skin prep to the peri-wound and Collagen and Calcium Alginate to the wound bed. Cover with silicone dressing. Change every day and as needed for soiling or displacement. A review of the nursing progress notes from 3/1/2020 to present revealed Resident #2 refused medications and wound care to be completed at times. The last documented refusal of wound care was 6/22/2020. A review of the June 2020 Treatment Administration Record (TAR) revealed the following treatments for Resident #2 were not initialed as completed on the following dates: 1. Clean open area on the coccyx with wound cleanser. Apply skin prep to the peri-wound, Collagen and Calcium Alginate to the wound bed and cover with a silicone dressing. Change every day and as needed for soiling or displacement. No initials were present indicating the dressing had been changed for 6/3/20, 6/5/20, 6/8/20, 6/12/20, 6/19/20, 6/26/20 and 6/30/20. 2. Clean open area on the left ischium with wound cleanser. Apply skin prep to the peri-wound, Collagen and Calcium Alginate to the wound bed and cover with a silicone dressing. Change every day and as needed for soiling or displacement. No initials were present indicating the dressing had been changed for 6/3/20, 6/5/20, 6/8/20, 6/12/20, 6/19/20, 6/26/20 and 6/30/20. 3. Clean open area on the right ischium with wound cleanser. Apply skin prep to the peri-wound, Collagen and Calcium Alginate to the wound bed and cover with a silicone dressing. Change every day and as needed for soiling or displacement. No initials were present indicating the dressing had been changed for 6/3/20, 6/5/20, 6/8/20, 6/12/20, 6/19/20, 6/26/20 and 6/30/20. Review of the June 2020 TAR revealed Resident #2 had refused treatments to be completed on 6/7/20. On 7/1/2020 at 10:50 AM, an observation of Resident #2's wound care was conducted with the Treatment Nurse. Pressure areas to the left and right ischium and sacrum were small in size and light pink and white in color to indicate healing. There was no drainage, odor or signs of infection. An interview occurred with the Treatment Nurse on 7/1/2020 at 11:30 AM. She explained Resident #2 preferred to have her treatments completed in the morning before getting up to her wheelchair and normally accepted the wound care. On 7/1/2020 at 12:45 PM the Optum Nurse Practitioner was interviewed and was aware of the pressure areas Resident #2 had. She explained the resident had been admitted with the pressure ulcers and exposed bone at that time and now the areas are closed and almost healed up. The Nurse Practitioner stated she liked to observe Resident #2's wounds with the Treatment Nurse at least weekly and felt like they were healing well. She was only aware of treatments not being completed as ordered when the resident had refused. On 7/6/2020 at 2:11 PM, a phone interview was completed with the Treatment Nurse. She stated she was responsible for wound care on day shift Monday thru Friday. She verified the dates in question were when she was on duty, that she had completed the wound care as ordered but had forgotten to sign them as completed. The Treatment Nurse stated she and the Administrator had a discussion and she would complete an audit of all TAR's at the end of her shift daily to ensure all wound care had been signed off appropriately. The Administrator was interviewed via telephone on 7/6/2020 at 4:00 PM and stated he had discussed the missing documentation on the June 2020 TAR's for Resident #2 with the Treatment Nurse and she would complete a daily audit of all TAR'S for missing documentation.