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	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review, observation, and staff and resident interviews, the facility failed to provide stool incontinence care on night shift for a dependent resident which caused him to feel angry (Resident #59) and failed to communicate with a resident. A reasonable person expects to be provided communication during care and understand what to expect (Resident #15). This deficient practice affected 2 of 3 residents reviewed for dignity. Findings included: 1. Resident #59 was admitted to the facility on [DATE] with the diagnosis of liver failure. Resident #59's Minimum Data Set, dated dated dated [DATE] documented the resident had an intact cognition, was understood and understands others. The resident required staff assistance of one with all activities of daily living. The resident was incontinent of stool. Resident #59's care plan dated 3/29/24 documented he had an activity of daily living deficit. The resident was incontinent of stool and the interventions were to check during routine rounds and as needed for incontinence. On 4/15/24 at 11:47 am an interview was conducted with Resident #59. Resident #59 stated that the Nursing Assistants (NA) on night shift do not always round until the morning about 5:00 am or 6:00 am. The staff on night shift do not answer the call light or take hours to come when the sun is coming up. This happened just last night (4/14/24). I put the call light on and was sitting in stool for more than 2 hours because staff never rounded every 2 hours and had not answered the call light; this made me feel angry. The NA (NA #11) finally came about 5:00 am (was watching TV and could see the time) and helped me. Resident #59 also commented that he was receiving medication for his liver that caused frequent lose stools, and he had to have incontinence care regularly. The Resident stated his skin was fine, but I can smell stool. Sitting in stool that long caused the smell to remain. On 4/16/24 at 2:30 pm contact with NA #11 who was on staff assigned night shift 4/15/24 to Resident #59 was unsuccessful. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 12:15 pm an interview was conducted with the Director of Nursing (DON). The DON stated the facility has had a problem with night shift staff answering call lights and providing care. This was reported by residents individually and during the resident council meeting in March 2024. The DON stated, I thought this was addressed. We provided staff education. 2. Resident #15 was admitted to the facility on [DATE] with the diagnosis of seizure. Resident #15's quarterly Minimum Data Set documented the resident was unable to participate in the brief interview for mental status due to confusion. The resident was rarely understood and rarely understands. The resident had behaviors of yelling and screaming during the 7-day look back period. The active diagnosis was psychotic disorder with delusions. Resident # 15's care plan had a need for crying spells and yelling out. The interventions were to approach in a quiet, calm manner, encourage participation in activities of daily living, report changes in mood or behavior to include anger and harm to others and self, agitation, and feeling threatened by others. The resident was to have consistency in timing of care and caregivers. On 4/14/24 at 11:05 am an observation was done of Resident #15. The resident was receiving care from NA #5. NA #5 was observed to be attempting to place the resident's left arm into her sleeve and the resident was locking her elbow and yelled loud, non-intelligible words while looking at the NA. The resident appeared angry by facial expression and wide eyes. NA #5 had not talked to the resident to inform the resident what care was taking place during this time. The resident was yelling unintelligible words and slapped NA #5 with her hand on her arm after repeated attempts by the NA to place the arm in the sleeve. NA #5 continued to remain silent and had not informed the resident of what care was being provided and what to expect. The surveyor talked to the resident to distract, guide, and redirect. The resident stopped yelling and looked at the surveyor with softer eyes. On 4/14/24 at 12:55 pm an interview was conducted with NA #5. NA #5 stated she spoke to Resident #15 this morning at the start of care to direct her. NA #5 stated the resident talked to her normal. NA #5 stated when she tried to place the resident's left arm in the sleeve the resident resisted by locking her arm/elbow and hit her with that same arm/hand. NA #5 stated she had not further directed the resident at this time to cooperate, she had already let the resident know the care that was taking place and the resident talked to her but was not talking now, she was yelling. On 4/17/24 at 11:55 am an interview was conducted with the Director of Nursing (DON). The DON was informed of Resident #15's behavior and NA #5's lack of communication during care on 4/14/24. The DON stated that she was aware of Resident #15's behaviors and staff should direct the resident during care and if the resident resisted to stop providing care at that time.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review, observation, and staff interview, the facility failed to honor a resident's right to refuse care when Nursing Assistant (NA) #5 attempted to dress the resident in a gown despite the resident's (Resident #15) physical and verbal behaviors resisting this care. This deficient practice affected 1 of 2 residents reviewed for choices. Findings included: Resident #15 was admitted to the facility on [DATE] with the diagnoses of seizure disorder and psychotic disorder with delusions. Resident #15's quarterly Minimum Data Set, dated dated dated [DATE] indicated the resident had severely impaired cognition. The resident had verbal behaviors 1 to 6 times per week during the 7-day look back period. The resident required assistance of one staff member for dressing. The resident was coded for refusal of care. Resident # 15's care plan had a need for crying spells and yelling out. The interventions were to approach in a quiet, calm manner, encourage participation in activities of daily living, report changes in mood or behavior to include anger and harm to others and self, agitation, and feeling threatened by others. The resident was to have consistency in timing of care and caregivers. On 4/14/24 at 11:05 am an observation was done of Resident #15 in her room during morning care. NA #5 was observed to be attempting to place the resident's left arm into her sleeve and the resident was locking her elbow and yelled loud, non-intelligible words while looking at the NA with wide eyes. The resident also appeared angry by facial expression. The resident was yelling unintelligible words and slapped NA #5 with an open hand on her right upper arm after repeated attempts by the NA to place the arm in the sleeve. NA #5 quickly placed the resident's arm in the gown. The resident looked at the NA with an angry stare and started yelling again. NA #5 then placed the sheet on the resident's bare legs and the resident kicked it off with her right leg. The NA placed the sheet again to cover the resident's bare legs and the resident kicked the sheet off her legs. On 4/14/24 at 12:00 pm an interview was conducted with Unit Supervisor #2. Unit Supervisor #2 was informed of the incident with Resident #15 regarding resisting care and verbal and physical behavior. Unit Supervisor #2 stated if the resident resisted care NA #5 should have waited and not dressed the resident at the time. From the incident, it sounded like the resident had not wanted care at the time. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/24 at 12:55 pm an interview was conducted with NA #5. NA #5 stated when she tried to place the resident's left arm in the sleeve the resident resisted by locking her arm/elbow and hit her with that same arm/hand. NA #5 stated the resident had resisted by body language and had not cooperated by refusing to bend her arm and slapped her. NA #5 stated she placed the sheet over the resident's bare legs and the resident kicked it off. NA #5 stated she attempted to place the sheet again for dignity. NA #5 stated once the care was done, the resident stopped hitting and yelling. NA #5 stated she continued with care because the resident was exposed, and visitors frequently came in the room. NA #5 stated the resident was resisting care and had not wanted to place her arm in the gown or have sheets on her legs. This was a form of communication that the resident had not wanted this care at the time. NA #5 stated the resident had the right to refuse care, but in NA #5's thinking, the resident had to be covered to prevent exposure and provide privacy. On 4/17/24 at 11:55 am an interview was conducted with the Director of Nursing (DON). The DON was informed of Resident #15's behavior and NA #5's response to the behavior during care on 4/14/24. The DON stated if any resident resisted care with resulting behaviors and hit staff, the staff member were expected to stop providing care and address why the behavior was occurring.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record reviews, observations, and interviews with the Orthopedic nurse, Orthopedic Physician Assistant, Responsible Party (RP) , and staff, the facility failed to notify the orthopedic provider of a newly acquired pressure ulcer caused by a knee immobilizer and that the knee immobilizer was not being worn as ordered for Resident #102's fractured distal femur (the area of the leg just above the knee joint). The facility also failed to notify the RP of the addition and increase of medication prescribed for Resident #173. This was for 2 of 2 residents reviewed for notification. The findings included: 1) Resident #102 was admitted to the facility on [DATE] with diagnoses that included fracture of the right femur, bullous pemphigoid (an autoimmune disorder that causes itchy raised rashes and large blisters) and psoriasis. The hospital discharge summary dated 3/2/24 indicated Resident #102 was to wear the well-padded knee immobilizer which could be removed for hygiene. A review of Resident #102's physician orders included an order dated 3/2/24 to 3/19/24 for right knee immobilizer to be worn at all times. Remove for hygiene, replace padding if removed every shift. An orthopedic provider progress note dated 3/14/24 indicated Resident #102 was to wear the right knee immobilizer which could be removed for hygiene purposes. A review of Resident #102's physician orders included an order dated 3/19/24 for right knee immobilizer to be worn at all times. Remove for hygiene, check skin integrity. Replace padding if removed every shift. A nursing progress note dated 4/3/24, timed 2:43 PM, and completed by Nurse #3 read that Resident #102 had a new unstageable wound to the ankle area. The wound care nurse and hospice were notified. A skin/wound progress note dated 4/3/24, timed 6:01 PM and completed by the wound nurse indicated there was a sudden onset of a new unstageable wound to the right inner ankle. The area measured 3 centimeters (cm) in length, 2.3 cm in width and 0.3 cm in depth. There was 90% slough tissue and periwound was red. The hall nurse is to notify the family, hospice, and physician and would have the wound provider evaluate on 4/4/24. A wound provider progress note dated 4/4/24 indicated Resident #102 had an orthopedic prescribed leg brace that went down to her right ankle. A right inner ankle wound came on rapidly over the last few days and the facility had been treating the wound. The right inner ankle wound was an unstageable pressure ulcer due to the medical device brace. There was no odor to the wound, however there was drainage and necrotic tissue present. The area measured 4.5 cm in length, 3 cm in width and 0.2 cm in depth. 80% necrotic tissue was present to the wound. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An orthopedic progress note dated 4/4/24 read that Resident #102 had a postop hinged knee brace that was to be removed for skin checks and hygiene purposes. There was no mention of a pressure ulcer to the right inner ankle. A nursing progress note dated 4/4/24 indicated that Resident #102 had been seen at the orthopedic clinic with recommendations for the knee immobilizer to stay on and only removed for hygiene and skin checks. The note read resident has new wound to right inner ankle so knee brace will not be worn. This is to encourage and maintain skin integrity. The note made no reference of contacting the orthopedic provider regarding the new wound or asking if the brace could be discontinued. A review of the April 2024 Treatment Administration Record (TAR) indicated the right knee immobilizer was not used on 4/3/24, 4/4/24, 4/9/24, 4/10/24, 4/11/24 and 4/12/24. A review of the nursing progress notes for Resident #102 from 4/1/24 to 4/15/24 indicated that the right knee immobilizer was not in use 4/3/24, 4/4/24, 4/9/24, 4/10/24, 4/11/24 and 4/12/24 for the following reasons: Held per management Held to maintain skin integrity Not in place per Director of Nursing (DON) Off per management due to wound An interview occurred with Nurse Aide (NA) #1 on 4/16/24 at 9:52 AM, who was assigned to care for Resident #102 on the 7:00 AM to 3:00 PM shift. She stated that the right knee immobilizer was not being used due to the pressure area on the right inner ankle and had been told by management to leave the brace off. An interview occurred with the wound nurse on 4/16/24 at 10:50 AM who stated that she had not called the orthopedic provider regarding the wound that was identified on 4/3/24 or the decision not to use the right knee immobilizer but had gotten the wound care provider involved. The wound nurse stated management decided it was in Resident #102's best interest not to wear the knee immobilizer due to the wound on her right ankle and the increased pressure it may have caused. She thought a note had been sent with Resident #102 to her orthopedic appointment on 4/4/24 by the floor nurse letting them know of the new wound caused by the right knee immobilizer. A phone interview occurred with UNC Orthopedic Nurse on 4/16/24 at 3:00 PM. She stated she had received a call from the facility today reporting Resident #102 had a pressure ulcer to her right inner ankle from the knee immobilizer and that the immobilizer was not being used. She added the clinic was unaware she had developed a pressure ulcer to the ankle on 4/3/24 or that the immobilizer was not being used consistently. On 4/17/24 at 9:25 AM, an interview occurred with Unit Manager #1 who stated she spoke with the orthopedic clinic on 4/16/24 regarding the new wound and decision not to place the immobilizer on the right leg. She was unable to state if the orthopedic provider had been notified verbally prior to 4/16/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #3 was interviewed on 4/17/24 at 9:50 AM. She was the nurse on duty when the right inner ankle wound was identified on 4/3/24. She stated she notified the medical director, family, and hospice of the new wound. Resident #102 had a follow-up with the orthopedic provider on 4/4/24 and she sent a note about the new wound to her right ankle but did not call the provider to let him know. She further stated when Resident #102 returned from her appointment, the right knee immobilizer was in place, but the DON and wound nurse thought it was best for Resident #102 not to wear the splint due to the new pressure area on her ankle. The DON and Regional Nurse Consultant were interviewed on 4/17/24 at 10:03 AM and explained the orthopedic provider was notified on 4/16/24 regarding the new wound identified on 4/3/24 and that the right knee immobilizer was not being used. They were unable to state why the orthopedic provider had not been notified prior to 4/16/24, however the hospice nurse and wound care provider had been made aware when the area was first identified. The DON stated a decision was made not to use the knee immobilizer to prevent further pressure areas to the right leg and they should have inquired further with the orthopedic provider. On 4/17/24 at 5:00 PM, a phone interview occurred with the Orthopedic PA who was familiar with Resident #102. Stated he saw her last in the clinic on 4/4/24, assessed her skin where the brace would have been on the right leg and didn't see any open wounds, but she did have several areas with bandages present. He further stated that Resident #102 had a bad fracture to the right femur but due to her age and fragility conservative management with a knee immobilizer was chosen. He could not recall any communication from the facility regarding the pressure wound to Resident #102's right ankle nor the decision not to put the immobilizer prior to 4/16/24. 31227 2. Resident #173 was admitted on [DATE] with cumulative diagnoses of Alzheimer's Disease, dementia with behaviors, and Bipolar Disease. The Quarterly Minimum Data Set, dated dated dated [DATE] indicated Resident #173 had severe cognitive Impairment and exhibited physical and wandering behaviors. Review of a Physician order dated 9/6/23 for Depakote (anticonvulsant) 125 mg I capsule twice daily for bipolar disorder and a current manic episode. There was no documentation in Resident #173's medical record by nursing or the Physician that Resident #173's RP was notified. Review of another Physician order dated 9/28 /23 for Depakote Extended Release 24 hour 250mg 1 tablet twice daily for bipolar disorder and a current manic episode. There was no documentation in Resident #173's medical record by nursing or the Physician that Resident #173's RP was notified of the increase in the Depakote dose. An interview was completed on 4/15/24 at 3:45 PM with Unit Manager #1. She recalled the incident involving a nurse not notifying Resident #173's RP of the addition of Depakote to her medications causing the RP to become upset and not allowing Resident #173 to return to the facility. She stated the nurse was re-educated at the time along with all the nurses on notification. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed on 4/16/24 at 11:45 AM with the Physician. He stated he did not recall speaking the Resident #173's RP but expected someone from the facility to have notified her RP of the addition of the Depakote. A telephone interview was completed on 4/16/24 at 2:45 PM with Resident #173's RP. She stated Resident #173 was diagnosed with drug induced delirium at the hospital when she went to the hospital for a fall on 10/8/23 and that was how she discovered the addition of the Depakote to Resident #173's medication regimen. The RP stated nobody from the facility notified her so she went to discuss her concerns with the Director of Nursing (DON) when she picked up Resident #173's belongings. The RP stated the DON would complete an investigation to see what failed and it was determined that the nurse did not follow procedure by letting her know of the addition of Depakote or the increase of the Depakote. The RP stated had she known about the new order for Depakote, she would have asked questions about the side effects along with her recently prescribed Seroquel (antipsychotic). An interview was completed on 4/17/24 at 11:00 AM with the Director of Nursing (DON) and the Regional Nurse Consultant. The Regional Nurse Consultant stated it was the expectation of the facility management that the floor nurses notify the RP anytime there was a new or change in a resident medication and then to ensure that it was documented in the residents medical record.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review, observation, and staff and resident interviews, the facility failed to provide dependent residents nail care (Resident #s 59 and 92) and failed to provide hair care and facial hair shaving (Resident #59) for 2 of 7 residents reviewed for activities of daily living. Findings included: 1. Resident #59 was admitted to the facility on [DATE] with the diagnoses of post-traumatic stress disorder and depression. Resident #59's Minimum Data Set, dated dated dated [DATE] documented an intact cognition and no behaviors or rejection of care. The resident required staff assistance of one for bathing and personal care. Resident #59's care plan dated 3/29/24 documented he had an activity of daily living deficit and could refuse care, needs assistance with all activities of daily living, and to keep his nails trimmed. A review of Resident #59's Nursing Assistant (NA) documentation for personal care, including facial and nail care, were documented yes for each day for 4/1/24 through 4/16/24. On 04/15/24 at 11:47am Resident #59 was observed to be in his bed wearing a hospital gown. He had greasy, matted hair, long nails with black soil underneath, and long facial hair (approximately an inch). On 4/15/24 at 11:47 am an interview was conducted with Resident #59. Resident #59 stated he would like to have his hair washed, face shaved, and nail care. He commented he would rather stay in his bed for care. They can wash my hair in bed but had not offered ever in bed or were supposed to come back after morning care. Resident #59 stated it had been weeks since he had nail care. He had refused to take a shower in the past, so a bed bath was offered, and a partial bed bath was provided. His hair was not washed. The NA had no comment about the resident's hair or nails. NA #5 indicated the resident usually refused a shower but accepted all care in his bed. On 4/15/24 at 12:05 pm Unit Supervisor #2 was interviewed and informed of Resident #59's hair, nails, and facial hair and that the resident agreed to receive care in his bed. The Unit Supervisor stated she would have the NA assigned assist the resident with hair wash, nail care, and facial hair trim in his bed. The resident had depression and declined to leave his room. The Unit Supervisor had not observed the resident's hair, facial hair, or nails. On 4/16/24 at 9:30 am Resident #56 was lying in his bed and his hair appeared greasy and clumped. The resident stated he had not had his hair washed in the bed and his facial hair and nails remained the same. The resident stated he would accept care in his bed, he did not want a shower. Resident #56 stated he had not declined care in his bed, but he had asked staff to come back after breakfast. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 9:40 am Unit Supervisor #2 was interviewed. She stated Resident #59 had his hair washed by an NA in his bed yesterday. The Supervisor was not aware if staff offered facial hair or nail care. She stated the resident refused a shower but usually accepted care in his bed. On 4/16/24 at 9:55 am NA #7 was interviewed. NA #7 stated Resident #59 refused a shower but accepted care in his bed. NA #7 stated she noticed the resident's hair was greasy appearing today, but the resident had not wanted a shower. NA #7 stated the resident's hair could have been washed in the bed, but she had not offered. The NA did not comment why hair care was not offered. NA #7 stated the resident had not refused nail care or facial hair care before and she would ask him this morning. NA #7 was not sure why his facial hair was long, and his nails were long and had black soil underneath. On 4/17/24 at 9:30 am an observation was done of Resident #59. His hair was washed, but his facial hair and nails remained the same. On 4/17/24 at 9:50 am an interview was conducted with NA #6. NA #6 stated Resident #59 always accepted care. She explained it was about the approach and the resident's needs. NA #6 had not worked with the resident recently and was not aware of his hair and nails needing care. On 4/17/24 at 11:55 am an interview was conducted with the Director of Nursing (DON). The DON was not aware Resident #59 had not received nail care, facial shaving, and hair care. The DON stated residents that do not get out of their bed can have their care provided in the bed, including hair wash. 46095 2. Resident #92 was admitted to the facility on [DATE] with diagnosis that moderate protein-calorie malnutrition (inadequate intake of food). The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #92 ' s cognition was moderately impaired with no behaviors or rejection of care. He required maximum assistance of 1 for toileting hygiene, shower/bath, and dressing and moderate assistance of 1 for personal hygiene. He had functional limitations with range of motion to both upper extremities. Resident #92 ' s active care plan, last reviewed 02/23/24, revealed a focus that read Resident #92 had a functional ability deficit and required assistance with self-care/mobility related to deconditioning, decline in mobility, blindness, cognition, and wounds. The interventions included that staff were to keep fingernails trimmed and clean. A review of Resident #92's nursing progress notes from 02/15/24 to 04/15/24 revealed no refusals of nail care documented. An observation was conducted on 04/14/24 at 12:49 PM. Resident #92 ' s fingernails on his left hand were discolored (yellowish), thick, jagged, and long. His pointer and pinky nails extended 1/4 of an inch past the tip of finger. The fingernails on his right hand were discolored (yellowish), thick, jagged, and long. His thumb, pointer and pinky fingernails extended 1/4 of an inch past the tip of finger. (continued on next page)

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	04/17/2024

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The Laurels of Chatham	72 Chatham Business Park Pittsboro, NC 27312

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 04/15/24 at 3:42 PM of Resident #92. He was observed in his room in his wheelchair with his bedside table pulled beside him. There were no observed changes in the resident ' s fingernails. The fingernails continued to appear untrimmed, jagged, thick, and discolored. An observation and interview were conducted on 04/16/24 at 10:20 AM with Resident #92. He was observed in his room in his wheelchair. He stated he would like his fingernails to be cut but no one had offered to do so. He stated if someone would offer to cut his fingernails, he would let them. An interview and observation were conducted on 04/16/24 at 10:25 AM with Unit Manager #2. She stated the Nursing Assistants (NAs) were responsible for cleaning and cutting residents nails during showers/baths and/or when they see nails needed to be trimmed. No one had reported Resident #92 ' s fingernails were long or that they needed to be trimmed. She verified Resident #92's nails were discolored (yellowish), thick, jagged, long, and needed to be cut. An interview was conducted on 04/16/24 at 12:11 PM with Nursing Assistant (NA) #4. She indicated she was the NA assigned to Resident #92 for that day and stated she did nail care daily with her residents. The protocol was to do nail care during baths and as needed. She also stated she reported to nursing that Resident #92's nails were too thick to cut on several occasions. An interview was conducted on 04/17/24 at 10:46 AM with the Director of Nursing (DON) and the Regional Nurse Consultant. The DON stated she was unaware Resident #92 ' s nail care had not been performed. She indicated Nursing Assistants (NAs), and Nurses were to perform nail care during showers and as needed. If they are uncomfortable in doing nail care they are to report it to the unit manager.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record reviews, observations and interviews with the Medical Director, Orthopedic nurse, Orthopedic Physician Assistant and staff, the facility failed to apply a right knee immobilizer for a resident with a fractured distal femur (the area of the leg just above the knee joint) as ordered (Resident #102). In addition, the facility transferred a resident with an obvious deformity and pain to the right hip/leg after a fall. (Resident #30). This was for 2 of 3 residents reviewed for well-being. The findings included: 1) Resident #102 was admitted to the facility on [DATE] with diagnoses that included fracture of the right femur. The hospital discharge summary dated 3/2/24 indicated Resident #102 was to wear the well-padded knee immobilizer which could be removed for hygiene purposes. A review of Resident #102's physician orders included an order dated 3/2/24 to 3/19/24 for right knee immobilizer to be worn at all times. Remove for hygiene, replace padding if removed every shift. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #102 had severe cognitive impairment and limited range of motion to one lower extremity. She required maximum assistance with toileting hygiene, bathing, and bed mobility. An orthopedic provider progress note dated 3/14/24 indicated Resident #102 was to wear the right knee immobilizer which could be removed for hygiene purposes. A review of Resident #102's physician orders included an order dated 3/19/24 for right knee immobilizer to be worn at all times. Remove for hygiene, check skin integrity. Replace padding if removed every shift. An orthopedic progress note dated 4/4/24 read that Resident #102 had a postop hinged knee brace that was to be removed for skin checks and hygiene purposes. A nursing progress note dated 4/4/24 indicated that Resident #102 had been seen at the orthopedic clinic with recommendations for the knee immobilizer to stay on and only removed for hygiene and skin checks. The note read resident has new wound to right inner ankle so knee brace will not be worn. This is to encourage and maintain skin integrity. A review of the April 2024 Treatment Administration Record (TAR) indicated the right knee immobilizer was not used on 4/3/24, 4/4/24, 4/9/24, 4/10/24, 4/11/24 and 4/12/24. A review of the nursing progress notes for Resident #102 from 4/1/24 to 4/15/24 indicated that the right knee immobilizer was not in use 4/3/24, 4/4/24, 4/9/24, 4/10/24, 4/11/24 and 4/12/24 for the following reasons: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Held per management Held to maintain skin integrity Not in place per Director of Nursing (DON) Off per management due to wound An interview occurred with Nurse Aide (NA) #1 on 4/16/24 at 9:52 AM, who was assigned to care for Resident #102 on the 7:00 AM to 3:00 PM shift, stated that the right knee immobilizer was not being used due to the pressure area on the right inner ankle and had been told by management to leave the brace off. An interview occurred with the wound nurse on 4/16/24 at 10:50 AM who stated that she had not called the orthopedic provider regarding the decision not to use the right knee immobilizer due to a new wound on Resident #102's right inner ankle. The wound nurse stated management decided it was in Resident #102's best interest not to wear the knee immobilizer due to the wound on her right ankle and the increased pressure it may have caused. She thought a note had been sent with Resident #102 to her orthopedic appointment on 4/4/24 by the floor nurse letting them know of the new wound caused by the right knee immobilizer. A phone interview occurred with UNC Orthopedic Nurse on 4/16/24 at 3:00 PM. She stated she had received a call from the facility today (4/16/24) reporting Resident #102 had a pressure ulcer to her right inner ankle from the knee immobilizer and that the immobilizer was not being used. She added the clinic was unaware she had developed a pressure ulcer to the ankle on 4/3/24 or that the immobilizer was not being used consistently. On 4/17/24 at 9:25 AM, an interview occurred with Unit Manager #1 who stated she spoke with the orthopedic clinic on 4/16/24 regarding the new wound and decision not to place the immobilizer on the right leg. She was unable to state if the orthopedic provider had been notified verbally prior to 4/16/24. Nurse #3 was interviewed on 4/17/24 at 9:50 AM. She was the nurse on duty when the right inner ankle wound was identified on 4/3/24. She stated she notified the medical director, family, and hospice of the new wound. Resident #102 had a follow-up with the orthopedic provider on 4/4/24 and she sent a note about the new wound to her right ankle but did not call the provider to let him know. She further stated when Resident #102 returned from her appointment, the right knee immobilizer was in place, but the DON and wound nurse thought it was best for Resident #102 not to wear the splint due to the new pressure area on her ankle. She was unaware if the orthopedic provider had been made aware. The DON and Regional Nurse Consultant were interviewed on 4/17/24 at 10:03 AM and explained the orthopedic provider was notified on 4/16/24 regarding the right knee immobilizer not being used due to a wound on the right inner ankle. The DON stated a decision was made not to use the knee immobilizer to prevent further pressure areas to the right leg and they should have inquired further with the orthopedic provider. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 5:00 PM, a phone interview occurred with the Orthopedic PA who was familiar with Resident #102, and stated he saw her last in the clinic on 4/4/24. He further stated that Resident #102 had a bad fracture to the right femur but due to her age and fragility, conservative management with a knee immobilizer was chosen. He was made aware 4/16/24 that the facility was not applying the knee immobilizer to Resident #102 due to the pressure area on her right ankle. The Orthopedic PA stated the facility was notified today (4/17/24) the if Resident #102 was not getting out of bed it would be ok to leave the knee immobilizer to the right leg off but careful attention needed to be made when moving her right leg. 46095 2. Resident #30 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, Dementia, history of stroke, osteoporosis, and falls. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #30 ' s cognition was severely Impaired. She was dependent on staff for eating, bed mobility, transfers, toilet hygiene, shower/bath, dressing, personal hygiene, and had limited range of motion impairment to both sides of upper and lower extremities. She was coded for having two or more falls with injury. She was always incontinent of bowel and bladder. Progress note dated 10/18/23 revealed Resident #30 was observed on the floor at 2:15 AM lying on her back. She was lifted back to bed by two staff members with noted pain in her right hip. They noticed Resident #30 ' s right hip was unlike the other hip and was misshaped. The physician was notified, and new orders received to obtain x-ray, administer Tylenol, and apply ice to area. Incident Report dated 10/18/23 revealed Resident #30 was observed on the floor at 2:15 AM lying on her back. Nurse #10 noted pain to right hip and the right hip appeared to be out of alignment and different from the other hip. Resident #30 was lifted back to bed, ice applied, and Tylenol given 650 milligrams (mg) was given. The physician was notified, and new orders received. The eInteract Situation, Background, Assessment, Recommendation (SBAR) dated 10/18/23 revealed Resident #30 was sent to the emergency roiagnom on [DATE] at 4:20 AM due to pain rated at a level 5 on a 1-10 scale with 10 being the worst pain to the right trochanter (hip) area. The physician stated that if Resident #30 was having a lot of pain to send out to the emergency department (ED) and if not much pain, then do hip x-ray stat. Hip x-ray ordered. A Post Falls Evaluation Form, dated 10/18/23, was completed by Nurse #10 indicated Resident #30 was found on the floor beside bed, lying on her back with arms by her side on 10/18/23. The report indicated Resident #30 had been provided incontinence care at 2:00 AM and was observed on the floor at 2:15 AM. It also indicated that she was turning or changing position in bed prior to the fall. An interview was conducted on 04/16/24 at 12:05 PM with the Medical Director (MD). He stated if a resident falls the nurse was to assess them on the floor and if there was pain voiced and/or deformity the resident was to be transferred to the hospital and not moved. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview was conducted on 04/17/24 at 7:48 AM with Nurse #10. She stated she remembers Resident #30's fall on 10/18/23. She explained that the Nursing Assistant had changed the resident at approximately 2:15 AM. Nurse #10 then stated she came up the hall approximately 15 minutes later when she heard a noise coming from Resident #30's room. Upon entering Resident #30 ' s room she observed her lying on the floor on the left side of the bed in a supine position and voiced pain to her right hip area. She also stated she assessed the resident on the floor and noticed her right hip appeared to be out of alignment and looked different from the other hip. She then had the Nursing Assistant (NA) assist her in transferring Resident #30 back into the bed, each had one side of her body lifting her to the bed. Nurse #10 stated she was aware that moving the resident with a possible hip fracture could cause additional damage and pain. She further stated, I didn't want to leave her on the floor with a fractured hip. The physician stated if resident was having a lot of pain to send her to the emergency department (ED) and if not in much pain, then do hip x-ray STAT (order should be prioritized first as it's needed urgently). Nurse #10 indicated she ordered the STAT x-ray, although she did not know why she chose to do so considering the residents pain and hip/leg deformity. The x-ray company was not able to perform the x-ray STAT, so she was transferred to the hospital by emergency medical services (EMS). An interview was conducted on 04/17/24 at 10:46 AM with the Director of Nursing (DON) and the Regional Nurse Consultant. The DON stated If a resident falls the nurse was to assess the resident prior to moving them from the floor. If the resident complains of pain or has obvious deformity the nurse is to contact the Medical Director (MD) and call 911 for transfer and evaluation to the hospital. She was unaware Nurse #10 moved Resident #30 after she noted pain and deformity to the right hip. Multiple attempts were made to contact Nursing Assistant #3 (NA) on 04/16/24 and 04/17/24 with no success. NA #3 was on duty at the time of Resident #30 ' s fall on 3/18/23.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31227 Based on staff, Physician and Consultant Pharmacist interviews and record review, the Consultant Pharmacist failed to identify the lack of documentation for the monitoring of side effects for a resident prescribed antipsychotic medications. This was for 1 (Resident #173) of 7 residents reviewed for unnecessary medications. The findings included: Resident #173 was admitted on [DATE] with cumulative diagnoses of Alzheimer's Disease, dementia with behaviors, and Bipolar Disease. Review of Resident #173's admission Physician orders included an order dated 8/13/23 for Zyprexa (antipsychotic) 2.5 milligrams (mg) every 6 hours as needed for psychotic disorder x 14 days until 8/27/23. Resident #173 was care planned on 8/14/23 for a risk for adverse reactions and side effects related to receiving multiple psychotropic medications which included an antipsychotic. Interventions for the antipsychotic included to observed for sedation, headaches, dizziness, diarrhea, anxiety, tremors, orthostatic hypotension, blurred vision, extrapyramidal (impaired motor control) side effects to include akathisia (inability to stay still) restlessness, dystonia (involuntary muscle contractions) and tardive dyskinesia (chronic condition that results in involuntary, sudden, irregular movement of the face body or both). Review of a Consultant Pharmacist medication review note dated 8/15/23 read there was nothing inconsistent with customary, accepted clinical approaches to providing pharmaceutical products or services or that could reasonably be expected to impede or interfere with the achievement of the intended or reasonably expected outcomes. Review of another Physician order dated 8/16/23 for Seroquel (antipsychotic) 25 mg twice a day for bipolar disorder and a current manic episode. There were no orders or adverse side effect monitoring. Review of Resident #173's behaviors monitoring documentation read she had the following behaviors on the follow days for August 2023: 8/13/23-aggressive behavior 8/15/23-wandering 8/17/23 inappropriate language 8/19/23-wandering 8/22/23-wandering x 2 8/23/23-wandering and aggressive behavior (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/24/23-aggressive behavior 8/26/23-wandering 8/28/23-wandering and aggressive behaviors 8/29/23-aggressive behavior x 2 8/31/23-aggressive behavior Review of Resident #173's nursing notes and medication administration record (MAR) for August 2023 did not include any documentation of monitoring of adverse side effects. Review of Resident #173's September 2023 Physician orders included an order dated 9/5/23 to add Seroquel 100 mg at bedtime. Review of a Consultant Pharmacist medication review note dated 9/7/23 read there was nothing inconsistent with customary, accepted clinical approaches to providing pharmaceutical products or services or that could reasonably be expected to impede or interfere with the achievement of the intended or reasonably expected outcomes. Review of Resident #173's aide behavior monitoring documentation read she had the following behaviors on the follow days for September 2023: 9/1/23-aggressive behavior, rejection of care, wandering 9/5/23-aggressive behavior 9/7/23-rejection of care 9/12/23-aggressive behavior 9/14/23-rejection of care 9/16/23-wandering 9/18/23-rejection of care x 2 9/26/23-wandering 9/27/23-rejection of care 9/29/23-wandering 9/30/23-wandering Review of Resident #173's nursing notes and MAR for September 2023 did not include any documentation of monitoring of adverse side effects. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set, dated dated dated [DATE] indicated Resident #173 had severe cognitive Impairment and exhibited physical and wandering behaviors. Review of Resident #173's behaviors monitoring documentation read she had the following behaviors on the follow days for October 2023: 10/4/23-rejection of care 10/5/23-wandering Review of Resident #173's nursing notes and MAR for October 2023 did not include any documentation of monitoring of adverse side effects. Review of a Consultant Pharmacist medication review note dated 10/5/23 read there was nothing inconsistent with customary, accepted clinical approaches to providing pharmaceutical products or services or that could reasonably be expected to impede or interfere with the achievement of the intended or reasonably expected outcomes. Review of Resident #173's nursing notes from 8/13/23 to 10/8/23 did not include any documentation regarding any observations of her presenting over sedated or difficult to arouse. An interview was completed on 4/15/24 at 3:45 PM with Unit Manager #1. She recalled Resident #173 stating she was admitted from a sister facility. Unit Manager #1 stated while she resided at the facility, Resident #173 was combative, wandered into other residents rooms and frequently refused her medications with resulted in worsening of her behaviors. She did not recall any occasion where Resident #173 was difficult to arouse or appeared over sedated. An interview was completed on 4/16/24 at 8:30 AM with Nurse #11. She stated she was not working at the facility at the time Resident #173 resided there. She stated whenever a resident was admitted , readmitted or newly prescribed a psychotropic medication, there had to be an order for target behaviors monitoring and side effect monitoring. An interview was completed on 4/16/24 at 11:45 AM with the Physician. He stated when Resident #173 was admitted , her behaviors were impeding her care so he prescribed Seroquel, made an increase to the Seroquel and added an anticonvulsant. The Physician stated anytime a resident was prescribed an antipsychotic medication, it was imperative for staff to monitor for adverse side effects such as tardive dyskinesia and over sedation. An interview was completed on 4/16/24 at 9:10 AM with Nurse #12. She stated she did not recall Resident #173. She stated anytime a resident was prescribed an antipsychotic, there should be monitoring of adverse side effects like tremors, sedation and symptoms of tardive dyskinesia. An interview was completed on 4/16/24 at 2:10 PM with Nursing Assistant (NA) #10. She stated Resident #173 refused her medications and was combative during care. NA #10 did not recall any occasion where Resident #173 appeared over sedated or difficult to arouse. (continued on next page)

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	345421	A. Building B. Wing	04/17/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was completed on 4/16/24 at 3:55 PM with the Consultant Pharmacist. He stated he should have noted there were no orders or documentation of monitoring for adverse side effects related to Resident #173's antipsychotic medications. He stated it was an oversight due to the efforts of the facility attempts to regulate Resident #173's behaviors. An interview was completed on 4/17/24 at 11:00 AM with the Director of Nursing (DON) and the Regional Nurse Consultant. The Regional Nurse Consultant stated the Consultant Pharmacist should have identified the need for observation to ensure Resident #173 was not experiencing any adverse side effects associated with taking antipsychotic medications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31227 Based on staff and Physician interviews and record review, the facility failed to identify the lack of documentation for the monitoring of side effects for a resident prescribed antipsychotic medications. This was for 1 (Resident #173) of 7 residents reviewed for unnecessary medications. The findings included: Resident #173 was admitted on [DATE] with cumulative diagnoses of Alzheimer's Disease, dementia with behaviors, and Bipolar Disease. Review of Resident #173's admission Physician orders included an order dated 8/13/23 for Zyprexa (antipsychotic) 2.5 milligrams (mg) every 6 hours as needed for psychotic disorder x 14 days until 8/27/23. Resident #173 was care planned on 8/14/23 for a risk for adverse reactions and side effects related to receiving multiple psychotropic medications which included an antipsychotic. Interventions included to observed for sedation, headaches, dizziness, diarrhea, anxiety, tremors, orthostatic hypotension, blurred vision, extrapyramidal (impaired motor control) side effects to include akathisia (inability to stay still) restlessness, dystonia (involuntary muscle contractions) and tardive dyskinesia (chronic condition that results in involuntary, sudden, irregular movement of the face body or both). Review of another Physician order dated 8/16/23 for Seroquel (antipsychotic) 25 mg twice a day for bipolar disorder and a current manic episode. There were no orders or adverse side effect monitoring. Review of Resident #173's behaviors monitoring documentation read she had the following behaviors on the follow days for August 2023: 8/13/23-aggressive behavior 8/15/23-wandering 8/17/23 inappropriate language 8/19/23-wandering 8/22/23-wandering x 2 8/23/23-wandering and aggressive behavior 8/24/23-aggressive behavior 8/26/23-wandering (continued on next page)

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/28/23-wandering and aggressive behaviors 8/29/23-aggressive behavior x 2 8/31/23-aggressive behavior Review of Resident #173's nursing notes and medication administration record (MAR) for August 2023 did not include any documentation of monitoring of adverse side effects. Review of Resident #173's September 2023 Physician orders included an order dated 9/5/23 to add Seroquel 100 mg at bedtime. Review of Resident #173's aide behavior monitoring documentation read she had the following behaviors on the follow days for September 2023: 9/1/23-aggressive behavior, rejection of care, wandering 9/5/23-aggressive behavior 9/7/23-rejection of care 9/12/23-aggressive behavior 9/14/23-rejection of care 9/16/23-wandering 9/18/23-rejection of care x 2 9/26/23-wandering 9/27/23-rejection of care 9/29/23-wandering 9/30/23-wandering Review of Resident #173's nursing notes and MAR for September 2023 did not include any documentation of monitoring of adverse side effects. The Quarterly Minimum Data Set, dated dated dated [DATE] indicated Resident #173 had severe cognitive Impairment and exhibited physical and wandering behaviors. Review of Resident #173's behaviors monitoring documentation read she had the following behaviors on the follow days for October 2023: 10/4/23-rejection of care (continued on next page)

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	04/17/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/5/23-wandering Review of Resident #173's nursing notes and MAR for October 2023 did not include any documentation of monitoring of adverse side effects. Review of Resident #173's nursing notes from 8/13/23 to 10/8/23 did not include any documentation regarding any observations of her presenting over sedated or difficult to arouse. An interview was completed on 4/15/24 at 3:45 PM with Unit Manager #1. She recalled Resident #173 stating she was admitted from a sister facility. Unit Manager #1 stated while she resided at the facility, Resident #173 was combative, wandered into other residents rooms and frequently refused her medications with resulted in worsening of her behaviors. She did not recall any occasion where Resident #173 was difficult to arouse or appeared over sedated. An interview was completed on 4/16/24 at 8:30 AM with Nurse #11. She stated she was not working at the facility at the time Resident #173 resided there. She stated whenever a resident was admitted , readmitted or newly prescribed a psychotropic medication, there had to be an order for target behaviors monitoring and side effect monitoring. An interview was completed on 4/16/24 at 11:45 AM with the Physician. He stated when Resident #173 was admitted , her behaviors were impeding her care so he prescribed Seroquel, made an increase to the Seroquel and added an anticonvulsant. The Physician stated anytime a resident was prescribed an antipsychotic medication, it was imperative for staff to monitor for adverse side effects such as tardive dyskinesia and over sedation. An interview was completed on 4/16/24 at 9:10 AM with Nurse #12. She stated she did not recall Resident #173. She stated anytime a resident was prescribed an antipsychotic, there should be monitoring of adverse side effects like tremors, sedation and symptoms of tardive dyskinesia. An interview was completed on 4/17/24 at 11:00 AM with the Director of Nursing (DON) and the Regional Nurse Consultant. The Regional Nurse Consultant stated the facility should have identified the need for observation to ensure Resident #173 was not experiencing any adverse side effects associated with taking antipsychotic medications.