STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING _____ B. WING _____	C 01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF FOREST GLENN	1101 HARTWELL STREET GARNER, NC 27529

(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 221 SS=G	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility restrained 1 of 3 residents (Resident #169) without medical necessity. The findings included: Resident #169 was admitted to the facility on 5/17/12, and then re-admitted on 1/14/13. Her cumulative diagnoses included: Alzheimer's disease, hypertension, agitation, anxiety and arthritis. On the annual Minimum Data Set (MDS) dated 5/24/12, she was assessed as being severely cognitively impaired, with no limitations to her range of motion, nor a history of falls. A chart review was conducted and revealed in the nurse's notes on 5/19/12 that a lap buddy device was ordered for Resident #169 per family request. The admission MDS did not list the lap buddy as a restraint. A physician's telephone order on 6/19/12 stated to discontinue the lap buddy and to use a lap tray for wheelchair safety and positioning. A Physician's Report of Consultation, 6/19/12, did not address any treatment through the use of a lap tray, for positioning in either the diagnosis or findings.	F 221	The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its allegations of compliance. Our alleged compliance date is 02/26/2013. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F221 The facility is not in agreement with the alleged deficiency and has invoked its right to dispute the citation through the informal dispute resolution process. Resident #169 was reassessed by the interdisciplinary team (IDT) on 2/6/13 to determine appropriate fall interventions. The care plan for resident #169 was revised by the Director of Nursing on 2/6/13 and reflects her current safety measures of bed pad alarm, restraint free	2-26-13

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

Administrator 4-8-13

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 221	Continued From page 1 On Resident 169's most recent quarterly MDS, dated 11/16/12, she was remained cognitively impaired, needing extensive assistance with transfers, walking and locomotion. Her balance was listed as unsteady and she had limitations on both sides of her lower extremities. Resident #169 was receiving restorative nursing exercises for her range of motion skills. She had not experienced any falls. The lap tray was not listed on the MDS as a restraint. Her most recent Fall Risk Assessment, dated November 2012 had reduced her from a high risk fall with a score of 11 to a non-high risk with a score of 9, due to improvements with her mental status. The assessor stated that she went from intermittent confusion to disoriented x3 at all times. Further, she required the use of an assistive device and used a walker and a wheelchair. A care plan was developed for Resident #169 on 11/26/12 noted that she had developed a tendency to get out of her chair or bed unattended. The goal was listed as keeping her free from injury during the next 90 days review period. Approaches to be used included supervising and assisting her with transfers as well as using a lap tray for positioning. The chart revealed that between 5/17/12 until 11/4/12, Resident #169 received supports from occupation and physical therapies. In an interview with the occupational therapist #1 (OT) on 1/24/13 at 2:48 pm, she stated that she used to provide services to Resident #169 but	F 221	alarm to wheel chair, bed in low position, two person transfer, fall mat at bedside, and do not leave unattended in bathroom. Residents utilizing restraints have the potential to be affected. Unit managers reviewed residents that currently have safety devices to ensure there have been appropriate assessment, orders, consents, care planning, and Certified Nursing Assistant (CNA) care card documentation for use by 2/7/13. Nurses will utilize the Pre Restraint Intervention Evaluation form. Variances will be corrected as identified. The MDS coordinator completed an MDS correction for 7 residents whose safety device was assessed to be a restraint. Licensed Nurses were re-educated by the Assistant Director of Nursing on Care Plan requirements related to MDS guidelines for safety devices on 2/11/13. The MDS Coordinator will review 3 residents per week for 4 weeks for appropriate care plans using an audit tool to provide ongoing compliance. Results of this review will be provided to the Director of	

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F 221	Continued From page 2 had to stop because her cognition impairments, and because she had reached her full potential. She shared that Resident #169 did not require any support to sit still. However, she noted that she would easily lose her balance once she became distracted with another task, such as trying to pick something up from off the floor. Further, she didn't think that Resident #169 could sit unsupervised because of her cognitive deficits and poor safety awareness. She required visual supervision, not to prevent her toppling over, but to cue her due to her cognition. The MDS nurse was interviewed on 1/25/13 at 9:35 am. She stated that Resident #169's lap tray was considered an enabler not a restraint, because she had the tendency to lean forward. The Enabler Assessment, dated 6/9/12 had stated that Resident #169 couldn't attempt to stand, whereas notes in the therapy summaries stated that she could use a walker to ambulate and could stand during ADL (activities of daily living) care. The chart also contained a Pre-Restraint Intervention Evaluation completed by the Unit Nurse on 6/19/12 stating that Resident #169 as unable to maintain body alignment and couldn't understand safety during standing or transfers. The Unit Nurse was interviewed on 1/25/13 at 9:55 am about other least restrictive devices explored for Resident #169 before the use of a lap buddy and lap tray. She clarified that Resident #169 didn't lean forward in her chair, but actually scooted herself to the edge of the chair, attempting to stand up. She shared that she has been known to slouch down in her wheelchair,	F 221	Nursing and concerns will be reported to the quality assurance committee during the monthly meeting. New orders and changes in condition are reviewed by the IDT (Nursing, Therapy, Dietary, Activities, and Social Service) during the morning clinical meeting. The MDS Coordinator/Unit Managers will ensure that safety devices are reflected in the care plan for identified residents when indicated. The behavior management committee is responsible for ensuring a review of restraints and to make recommendations for restraint reduction where applicable. The MDS and care plan quarterly review process also helps ensure that the resident is in the most appropriate, least restrictive restraint/enabler. On-going compliance will be monitored through record review during the MDS assessment process by the MDS coordinator and Social Worker during the monthly behavior management meeting. All residents with safety devices are reviewed monthly during the behavior management meeting. In addition a review of new orders and changes in	

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F 221	Continued From page 3 even with the lap tray in place, trying to be free of it. The Unit Nurse acknowledged that the restraint was in place solely at the request of a family member. In a Psychiatric Follow Up Note, 11/30/12, it was written that staff reported that Resident #169 had became agitated in the evening, trying to knock her tray off of her wheelchair and was combative. Taking a medication to relieve her agitation was noted to be helpful. The Nurse's notes on 12/11/12 at 2:15 pm recorded that Resident #169 had refused to stay in wheelchair, attempting to remove the lap tray 3 times. She was given medication to reduce her agitation, which was prescribed for as needed purposes. During an interview with Nurse #2 on 1/24/13 at 3:19 pm, she stated that when the lap tray was applied to Resident #169's wheelchair, it needed to be fastened well, if not she would try to remove it or slide underneath it. She stated that she made a point to visually supervise Resident #169 whenever she was on the hall in her wheelchair, often removing the tray. NA #3 was interviewed on 1/24/12 at 5:20 pm. She demonstrated how she used to apply the lap tray to Resident #169's wheelchair, before she fractured her hip on 1/9/13. She stated that there were two Velcro straps on the sides of the device that were used to wrap several times around the arms of the chair. A long belt was snapped in place behind the chair, however, she had witnessed Resident #169 unwrap the straps, slide the snapped belt to the front, where she could	F 221	condition are reviewed during the morning clinical operations meeting. Continued compliance will be monitored through the facility's Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns.	

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F 221	Continued From page 4 then unhook it. She shared that if Resident #169 wasn't successful, unhooking the belt, she would either loosen the side straps enough to lift the lap tray over her head or she would have it lose enough to slide underneath the tray, trying to get out of the chair. She was always able to redirect her. NA #3 commented that Resident #169 did not like the device and would say to her, "Why y'all tying me up like that, you're treating me like a dog." Resident #169 was present during the demonstration and acknowledged that she did not like the lap tray. OT #2 and the Physical Therapy Assistant came to the room to transfer Resident #169 out of her bed on 1/25/13 at 10:40 am. Resident #169 was sitting up in the bed, demonstrating good trunk control. She was alert, oriented and in a pleasant mood. She was able to follow short simple commands and was able to scoot herself to the edge of the bed then allowed the therapist to place a gait belt around her waist to help her stand. She held onto her rolling walker to support, then was able to pivot and turn, with many instructions, until she was able to sit down in her wheelchair. The therapist stated that Resident #169's cognition remained the biggest factor in getting her to do things safely. The OT #2 shared that he has come down the hall before to see Resident #169 trying to get up from her wheelchair, before she was injured. He even recalled seeing her, unfasten the Velcro straps on her lap tray and lift the tray, attempting to stand. Both of the therapists said that the presence of the tray helps to agitate her. When in therapy, the device was not used, since she was supervised	F 221		

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F 221	Continued From page 5 by staff.	F 221		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to supervise 1 of 3 cognitively impaired residents with a history of falls and who required extensive assistance with toilet use. The findings included: Resident #169 was admitted to the facility on 5/17/12, and then re-admitted on 1/14/13. Her cumulative diagnoses included: Alzheimer ' s disease, hypertension, agitation, anxiety and arthritis. On the annual Minimum Data Set (MDS) dated 5/24/12, she was assessed as being severely cognitively impaired, with no limitations to her range of motion, nor a history of falls. On Resident 169's most recent quarterly MDS, dated 11/16/12, she was still assessed as being cognitively impaired, needing extensive assistance with transfers, walking, locomotion and toilet use. Her balance was listed as unsteady and she had limitations on both sides of	F 323	F323 The facility is not in agreement with the alleged deficiency and has invoked its right to dispute the citation through the informal dispute resolution process. The physician for resident #169 was notified by the nurse of the incident and received orders for care. The unit managers reviewed all residents who are toileted and have cognitive deficits for safety on the toilet on 2/6/13. Residents identified as not safe on the toilet will have "do not leave unattended" on his/her care card and care plans will be updated by nurses when indicated. All Licensed nurses and nursing assistants will receive education to include required supervision for residents with dementia related to toileting. This was provided by Assistant Director of Nurses and completed on 2/11/13. To monitor compliance (10) certified nursing assistants and licensed nurses will be audited utilizing the audit tool by unit managers weekly for 4 weeks, monthly for three months and quarterly for one quarter to determine knowledge of	2-26-13

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F 323	Continued From page 6 her lower extremities. Resident #169 was receiving restorative nursing exercises for her range of motion skills. She had not experienced any falls. Her most recent Fall Risk Assessment, dated November 2012 had reduced her from a high risk fall with a score of 11 to a non-high risk with a score of 9, due to improvements with her mental status. The assessor stated that she went from intermittent confusion to disoriented x3 at all times. Further, she required the use of an assistive device and used a walker and a wheelchair. Resident #169's chart was reviewed and revealed the following information. An undated Nursing Care Card stated that she was a fall risk and should have a pad alarm to the bed used for safety equipment. She needed the assistance of 1 and received therapeutic supports. She remained oriented to person. In an interview with the Unit Nurse on 1/24/13 at 3:36 pm, she stated that the care guard was developed at the time of admission and was based on the hospital summary and the initial nursing admission assessment. Then the care cards are amended as new needs present themselves. Staff can find the care card in the closet of each resident or at the nurse's station in a book. A care plan was developed for Resident #169 on 6/6/12 identifying Falls as a problem area due to her unsteady gait, impaired mobility and Dementia. On 11/26/12 it was noted that she had also developed a tendency to get out of her chair	F 323	required supervision with toileting and other ADLs for identified residents, knowledge of where to access this information and protocol for moving a resident after a fall. This training will be incorporated into new employee orientation. The results of the auditing will be reported to the Director of Nursing weekly for 4 weeks, monthly for three months and quarterly for one quarter. Re-education and counseling will occur as needed. Concerns will be reported to the quality assurance committee during the monthly meeting. Ongoing compliance will be monitored through the clinical operations meeting to ensure that documentation is correct and complete and that the plan of care was followed. Variances will be promptly corrected. Continued compliance will be monitored through the facility's Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns.	

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F 323	Continued From page 7 or bed unattended. The goal was listed as keeping her free from injury during the next 90 days review period. Approaches to be used included supervising and assisting her with transfers. In addition, on 5/30/12 another problem area to be care planned for Resident #169 reflected her cognitive deficits. She was noted to have short and long term memory problems. Approaches to be used included encourage her to converse during care and provide prompting, cues and/or reminders as needed. Also, staff should attempt to minimize distractions. The chart revealed that between 5/17/12 until 11/4/12, Resident #169 received supports from occupation and physical therapies. In an interview with the occupational therapist #1 (OT) on 1/24/13 at 2:48 pm, she stated that she used to provide services to Resident #169 but had to stop because her cognition impairments, and because she had reached her full potential. She shared that Resident #169 was able to sit on a toilet well and depending on how she felt, would determine if she could maintain her balance. She mentioned that Resident #169 did not require any support to sit still on a toilet up to 5 minutes. However, she noted that she would easily lose her balance once she became distracted with another task, such as trying to pick something up from off the floor. The OT #1 stated that determining the supports to assist Resident #169 with transfers varied on if she needed one person (minimum) or two persons (moderate) depending on what she could	F 323		

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F 323	Continued From page 8 understand at the time. She didn ' t think that Resident #169 could sit on the toilet for a minute unsupervised because of her cognitive deficits and poor safety awareness. She required visual supervision, not to prevent her toppling over, but to cue her due to her cognition. On 1/9/13 at 7:45 am, the nurse's notes documented a fall that Resident #169 sustained in her bathroom. She was found lying down on her right side on the bathroom floor. She complained of left hip pain, no bruises were noted. At 8:14 am, she was transported by ambulance to the hospital for treatment and evaluation. The Incident Report, 1/9/13 further stated that Resident #169 was known to remove her alarm. Nurse Aide #1 had assisted her to the bathroom then went into the room to get clothes out of her closet. She was found on the bathroom floor by NA#1 a few minutes later. Nurse Aide #1 was interviewed on 1/23/13 at 2:38 pm. She stated that Resident #169 was her regular assignment since her admission and she was familiar with her needs. She described her as someone who was able to verbalize but who had dementia, often speaking about past events. She recalled that on 1/9/13, Resident #169 was not having a good morning. She was using foul language and had torn her brief off, throwing it on the floor. Immediately, NA #1 said she knew that Resident #169 would not be cooperative and she went to get assistance from NA #2 to transfer her out of bed to the bathroom. Once NA #2 entered the room, they placed	F 323		

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F 323	Continued From page 9 Resident #169 in a wheelchair and took her to the bathroom and placed her on the toilet. NA #2 then left the room, leaving NA #1 with Resident #169. NA #1 said that she was expecting Resident #169 to have a bowel movement, because she began passing gas, so she left her sitting on the toilet, to give her privacy, leaving the two bathroom doors open. She shared that as she left her on the toilet, she continued to converse with her, which was her practice to keep her engaged and focused on task. She stated that she stayed inside of her room but walked over to the closet, which was along the same wall as the bathroom. She began to remove clothes from the closet and personal hygiene supplies, when she noticed that Resident #169 was no longer talking so she went to check on her in the bathroom and found her on the floor. She stated that she fell on her left side and was lying along the wall. She commented that Resident #169 had a habit of reaching down to pick things off of the floor. When she approached Resident #169 and touched her, she screamed out in pain. NA #1 said that she had witnessed the family members of Resident #169 leave her on the toilet unsupervised and there was never a problem, however, after she fell, she was counseled by the Director of Nursing (DON) to gather her supplies first, before transferring a resident, to prevent leaving her unattended in the bathroom. On 1/24/13 at 11:10 am, NA #2 was interviewed. She stated that she assisted NA#1 transfer Resident #169 from her bed to the wheelchair on 1/9/13. She stated that she provided restorative exercises to Resident #169 and was familiar with her abilities. She shared that on that particular	F 323		

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F 323	Continued From page 10 morning, Resident #169 was uncooperative, confused and wouldn't follow directions. She had thrown her legs over the bed, attempting to get out without assistance, when she entered the room. NA #2 stated that Resident #169 had good posture. The Director of Nursing was interviewed on 1/24/13 at 11:33 am. She stated that there are some residents in the facility who do not need to be supervise entirely while they are in the bathroom and to her knowledge, Resident #169 did not require that kind of supervision. She stated that she re-educated NA #1 not to leave Resident #169 unsupervised in the bathroom after the accident, despite what might be witnessed from family members providing care to her. The Hospital Transfer Summary, 1/14/13 was reviewed. It recorded that Resident #169 was admitted to the hospital for a hip fracture.	F 323		