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 _____	03/24/2016

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 3/24/16.Event ID# 6VB611.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		4/21/16

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

Electronically Signed | 04/08/2016

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F 278	Continued From page 1 Based on medical record review and staff interview, the facility failed to code thyroid disease/thyroidectomy on the Minimum Data Set for 1 of 5 residents investigated for unnecessary medications (Resident # 154). Findings included: Resident #154 was admitted to the facility on 8/11/15 with no listed diagnosis for the use of Levothyroxine 150 micrograms daily (a medication used for low thyroid levels), which was started on 8/14/15. A review of the medical record indicated that the physician was actively monitoring the thyroid levels and making necessary changes to the Levothyroxine dose, as indicated by ordering thyroid panels on 10/26/15 and 2/25/16, and writing an order to decrease the dose on 3/8/16. A review of the hospital discharge diagnoses did not list thyroid disease as either an admission or discharge diagnoses, but did include Levothyroxine on the discharge medication list and discussed the resident's status as having had a thyroidectomy as a past surgery. All Minimum Data Sets (MDS) (periodic assessments used to monitor and guide the care of residents) for Resident #154 were reviewed. These included the admission MDS on 8/18/15, and the quarterly MDS dated 11/16/15 and 1/19/16. None indicated that the resident had any issues with thyroid disease. The MDS Nurse #1 was interviewed on 3/23/16 at 11:30 AM. She stated "I did not see thyroid disorder on the hospital discharge diagnosis list. Someone should have requested a clarification from the physician for the use of Levothyroxine	F 278	F278 MDS Coordinator has corrected identified errors for guests #154. MDS nurse #1 has received one to one counseling/education on the policy "Resident Assessment" from the Director of Nursing on 04/11/2016. MDS staff will receive in-servicing on the proper coding of MDS assessments to ensure all diagnosis are properly coded on the MDS on 04/11/2016 by Regional MDS Coordinator. Director of Nursing and Assistant Director of Nursing will audit (4) four MDS assessments weekly for (8) eight weeks to monitor for proper coding of the MDS. Any variances will be corrected at the time of observation and continued education provided. Results of audits will be reported to the Regional MDS Coordinator. The Director of Nursing will report any variances to the Quality Assurance committee during the monthly meeting. Continued monitoring will occur through routine chart audits by the Director of Nursing and will be reported to the Regional MDS Coordinator.	

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F 278	Continued From page 2 and then it should have been put on the MDS .... I missed it; (the resident) should have been coded for a thyroidectomy on the active diagnosis section of the MDS." The Director of Nursing was interviewed on 3/23/16 at 2:50 PM. She stated "The MDS is usually very comprehensive and very detailed. Occasionally things get missed that should not have been missed."	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 279	F279	4/21/16

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F 279	Continued From page 3 interview, the facility failed to address in care plan the respiratory status/ condition of one of one residents reviewed for respiratory care (Resident #139). The findings included: Resident #139 was admitted to the facility 12/28/15. Cumulative diagnoses included: myasthenia gravis (a chronic autoimmune neuromuscular disease characterized by varying degrees of weakness of the skeletal muscles of the body), chronic hypoxic respiratory failure and oxygen dependence. A hospital discharge summary dated 12/28/15 stated Resident #139 had a history of myasthenia gravis, pulmonary hypertension on chronic home oxygen at two (2) liters. Chest x-ray results from the hospital noted bibasilar opacities, likely atelectasis (complete or partial collapse of a lung or a lobe of the lung). Physician admission orders dated 12/28/15 indicated oxygen at two liters via nasal cannula. An Admission Minimum Data (MDS) dated 1/4/16 indicated Resident #139 was cognitively intact. No shortness of breath was noted. The MDS indicated Resident #139 received oxygen therapy prior to and while she was a resident in the facility. Diagnoses included myasthenia gravis and dependence on supplemental oxygen. A review of the admission care plan dated 12/28/15 and care plan dated 1/6/16 did not address any concerns with Resident #139's respiratory status/ oxygen use. A nursing care card for Resident #139 (card used by nursing assistants to assist them in caring for	F 279	Guest #139 has been discharged from the facility on 01/17/2016. Director of Nursing and Unit Mangers reviewed care plans of all guests with oxygen have been reviewed on 04/07/2016 to ensure proper care planning. 6 out 30 care plans were found to be in error. These corrections have been corrected. MDS staff received education on the RAI instructions for Care Planning to include proper elements for Care Planning 04/11/2016 by the Regional MDS Coordinator. Director of Nursing and Unit Managers will review new admission care plans during Clinical Operation meeting to ensure interim care plans for oxygen are written and in the medical record weekly for (8) eight weeks. Any variances will be corrected at the time of observation and continued education provided. Results of audits will be reported to the Regional MDS Coordinator. The Director of Nursing will report results to the Quality Assurance committee during the monthly meeting. Continued monitoring will occur through routine chart audits by the Director of Nursing and Unit Managers and will be reported to the Regional MDS Coordinator.	

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F 279	Continued From page 4 the resident) was reviewed and use of oxygen was not noted on the care card. On 3/23/2016 at 2:29PM, an interview was conducted with MDS #1. She stated the record was reviewed and stated the care plan did not include a care plan that addressed Resident #139's respiratory condition and problems. MDS #1 Stated it was overlooked and the care plan should have included the respiratory status.	F 279		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, family interview and record review, the facility failed to apply resting hand splints to bilateral hands as ordered by the physician for 1 of 1 residents (resident #35) reviewed for Range of Motion (ROM). Findings included: Resident #135 was admitted on 2/3/2012 with a diagnosis of advanced dementia, hypertension, osteoporosis, osteoarthritis, coronary artery disease, and chronic kidney disease. She also had contractures in her hands bilaterally.	F 318	F318 Resident #35 was re-evaluated on 3/23/16 by therapy and is currently on case load. The Administrative Nurse Team consists of the Director of Nursing, Assist Director of Nursing, 3 Unit Managers, and 2 MDS Coordinators. The Administrative Nurse Team will complete a 100% audit of all current residents that have limited range of motion is receiving appropriate treatment	4/21/16

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F 318	Continued From page 5 A review of the Minimum Data Set (MDS) dated 2/10/2016 showed that the resident was severely cognitively impaired and needed " extensive assist " with activities of daily living. On 03/21/2016 at 12:37:16 PM, the responsible party (R.P.) said the splint was sent to the laundry to be washed back in late September or early October and it never came back to the resident ' s room. She spoke with the aide on the hall and with nurse #2, the unit manager, and they said they would check with laundry services. She went and spoke with the laundry staff herself and they said they had not seen it. She has been told nothing else about the missing splint. On 03/21/2016 at 2:47:25 PM, an interview was conducted with the unit manager. She stated that the resident had contractures in both hands and wore splints that were applied by the restorative aide. On 03/22/2016 at 9:53:03 AM, an observation of the resident revealed no hand splint on resident. On 03/22/2016 at 2:30:03 PM, Resident #135 was observed lying on back in bed sleeping with no splint on either hand. On 03/22/2016 at 3:24:01 PM, an interview was conducted with the restorative Aide: The aide stated that the resident used to be one of hers ' but she no longer provided restorative services for the resident. The resident ' s splints were now supposed to be applied by the staff who assisted the resident with her activities of daily living on the hall. She stated that, in the case of missing items, usually the family told the aides on the hall and then the aides on the hall would check with the laundry staff. If the laundry staff had not found the missing items then they would report it to the supervisor of the laundry department. On 03/22/2016 at 4:23:27 PM, Medical record review: There was no care plan related to a splint	F 318	to increase range of motion on 04/14/2016. _ of _ residents found to need corrections. All variances will be corrected and continued education provided. Licensed staff and restorative aides (prn/weekend staff will be in-serviced before working next shift) will receive in-serving from the Assistant Director of Nursing on assessing residents to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion on 04/19/2016. Unit Managers will conduct audits on orders for assistive devices on 04/14/2016 and will be done weekly for (3) three months. All variances will be corrected at the time of observation and continued education provided. Results of audits will be reported to the Regional QA Nurse and to the Quality Assurance Committee during the monthly meeting by the Director of Nursing. Continued monitoring will occur through routine audits of devices by the Director of Nursing. All variances will be corrected and reported to the Quality Assurance Committee.	

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F 318	Continued From page 6	F 318		

or range of motion (ROM) in the chart. The medication administration record (MAR) lists "Pt to wear both resting hand splint for 5-6 hours" with a start date of 2/1/15.
On 03/22/2016 at 5:20:28 PM, an interview was conducted with the 3p-11p nursing assistant (CNA #1). She remembered the resident having a splint on her hand a long time ago but she hadn't seen it in several months. She stated that first shift would have put it on, when they had it, and the nurse would tell her when to take it off at night.
On 03/23/2016 at 8:24:10 AM, Resident #135 was out of bed in wheelchair being fed by aide. No splint was noted on resident.
On 03/23/2016at 09:54:52 AM, Resident #135 was in her wheelchair. There was a roll in her right hand. Hands appeared to be clean.
On 03/23/2016 at 10:55:25 AM, Resident #135 was observed sitting in her wheelchair with a roll in her right hand.
On 03/23/2016 at 11:01:59 AM, an interview was conducted with the Occupational Therapist #1 (OT). She stated that the resident was seen by OT in 2014 and ordered bilateral resting hand splints, which is not the same thing as a hand roll. When OT stopped seeing the resident, the restorative program would have started seeing her regarding the hand splints. She has not seen the resident since 2014 and cannot comment as to the resident ' s current plan of care.
On 03/23/2016 at 11:40:46 AM, an interivew was conducted with nurse #3, nurse for resident #135. She stated that the nurses and nurse aides on the hall did not apply the splints ordered on the medication administration record, the restorative aide did that. She was unaware of where it would be documented.
On 03/23/2016 at 2:11:20 PM , an interivew was

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F 318	Continued From page 7 conducted with the director of Nursing (DON). She stated that restorative aide #1 discussed the resident ' s care with the previous restorative aide, who worked at facility last year, and they decided to discontinue the splints and had not used them on the resident since that time. She stated that she had been through the thinned chart and the current chart on the unit and could not find any documentation to support that the splint had been applied to the resident. She stated she would ask OT to re-evaluate the resident today. On 03/23/2016 at 2:35:22 PM, an interview was conducted with the DON. She stated a new order had been initiated for a splint per OT's most recent evaluation of the resident (completed today). She had a resting hand splint with her and said that OT would start putting the new splint on today but would have to order the splint for the resident ' s second hand. On 03/24/2016 at 8:48:04 AM, Resident #135 was observed in her room up in the wheelchair wearing a resting hand splint on the left hand.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		4/21/16

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F 325	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a nutritional supplement as ordered for 1 of 4 residents (Resident #8) reviewed for nutrition. The findings included: Resident #8 was admitted to the facility on 2/23/16 with multiple diagnoses including chronic renal insufficiency and aphasia. The admission Minimum Data Set (MDS) assessment dated 3/1/16 indicated Resident #8 had significant cognitive impairment. Review of Resident #8's medical record revealed the following weight documentation: 2/24/16: 129 pounds 3/01/16: 127 pounds 3/10/16: 126 pounds 3/17/16: 125 pounds The initial nutritional assessment for Resident #8 dated 2/29/16 indicated the nutritional supplement med pass (fortified nutritional shake) 120 milliliters (ml) was to be provided twice daily due to poor nutritional intake. Resident #8's Nutrition at Risk (NAR) monitoring record dated of 2/29/16 indicated an average meal consumption of less than 50% for five or more consecutive days. A physician's order dated 2/29/16 indicated med pass 120ml twice daily for Resident #8. The February 2016 Medication Administration Record (MAR) for Resident #8 was reviewed. It indicated med pass 120ml twice daily was added	F 325	F325 Resident #8's order for Med-Pass was clarified on 03/22/2016 for nutritional supplement by the Dietitian. There was no negative outcome. The Administrative Nurse Team consists of the Director of Nursing, Assist Director of Nursing, 3 Unit Managers, and 2 MDS Coordinators. The Administrative Nurse Team will complete a 100% audit of all current residents that are on nutritional supplements on 04/15/2016. All variances will be corrected and continued education will be provided. Licensed staff (prn/weekend staff will be in-serviced before working next shift) will receive in-serving on end of the month change over regarding physician order's being accurate on 04/19/2016 by the Assistant Director of Nursing. The Administrative Nurse Team will complete a 100% monthly audit of all physician orders to ensure that all orders including nutritional supplements have been transcribed on 04/15/206. All variances will be corrected at the time of observation and continued education provided. The Administrative Nurse Team will	

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F 325	Continued From page 9 to the MAR on 2/29/16 and was administered as ordered. The March 2016 MAR for Resident #8 was reviewed. It did not indicate an order for med pass 120ml twice daily. There were no nutritional supplements on the March 2016 MAR for Resident #8. The NAR monitoring record dated 3/7/16 indicated Resident #8 was on 120ml med pass twice daily. It also revealed a 2 pound weight loss in less than one week. The NAR monitoring record dated 3/22/16 indicated Resident #8 was on 120ml med pass twice daily. It also revealed Resident #8's weight was trending down with no significant change. An interview was conducted on 3/22/16 at 11:15 AM with the Dietician. She reviewed her dietary notes and the physician's orders for Resident #8. The Dietician stated an order was written for med pass 120ml twice daily for Resident #8 on 2/29/16. She reviewed the February 2016 MAR and the March 2016 MAR for Resident #8. The Dietician revealed the order for med pass 120ml twice daily was not transcribed onto the March 2016 MAR. She indicated this was an error. An interview was conducted on 3/22/16 at 11:20 AM with Nurse Unit Manager #1. She reviewed the physician's order dated 2/29/16 for med pass 120ml twice daily for Resident #8. She reviewed the February 2016 MAR and the March 2016 MAR for Resident #8. Nurse Unit Manager #1 revealed the order for med pass 120ml twice daily was not transcribed onto the March 2016 MAR. She indicated this was an oversight.	F 325	conduct audits on orders to ensure that all orders including nutritional supplements have been transcribed on the Medication Administration Record (MAR), this will be reviewed at Morning Clinical on all order changes weekly for (3) three months. All variances will be corrected at the time of observation and continued education provided. Results of audits will be reported to the Regional QA Nurse and to the Quality Assurance Committee during the monthly meeting by the Director of Nursing. Continued monitoring will occur through routine audits of devices by the Director of Nursing. All variances will be corrected and reported to the Quality Assurance Committee.	

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F 325	Continued From page 10 A follow up interview was conducted on 3/23/16 at 9:50 AM with Nurse Unit Manager #1. She stated the next month's MARs are completed several days prior to the end of the current month. She stated this allowed staff time to re-check the MARs before the end of the month. She indicated the final checks had to be completed prior to midnight on the final day of the month. She stated they tried to have the final check completed a day or two before that deadline. Nurse Unit Manager #1 indicated Resident #8's order for med pass 120ml twice daily was written on the final day of the month (2/29/16). She stated the March MARs were completed prior to 2/29/16. She additionally indicated the final checks of the March MARs were most likely completed prior 2/29/16. She stated the nurse who transcribed the order by hand onto the February MAR should have also transcribed the order by hand onto the March MAR for Resident #8. She revealed that this did not occur and Resident #8 had not received med pass 120ml twice daily from 3/1/16 through 3/22/16. She indicated the order for med pass 120ml twice daily was transcribed by hand onto Resident #8's March MAR on 3/22/16.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		4/21/16

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F 329	Continued From page 11 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to prevent the administration of an unnecessary medication for 1 of 5 residents reviewed for unnecessary medication (Resident #70). Findings included: Resident #70 was admitted to the facility on 10/1/15 with diagnoses that included hyperlipidemia for which she received Pravastatin 10 milligrams (mg) (a medication used to lower cholesterol levels) by mouth at bedtime. The pharmacist conducted a monthly pharmacy review on 11/1/15. Based on the resident's lipid panel dated 10/2/15, the pharmacist recommended to discontinue Pravastatin. The pharmacist generated a recommendation sheet on which the physician had the option to 'Agree', 'Disagree', or 'Other' and provide an explanation.	F 329	F329 Resident #70's medication was discontinued on 03/23/2016 with no negative outcomes. The Administrative Nurse Team consists of the Director of Nursing, Assist Director of Nursing, 3 Unit Managers, and 2 MDS Coordinators. The Administrative Nurse Team will complete an audit of all pharmacy recommendations to ensure any changes have been made to reflect new physician orders in order to prevent unnecessary medications on 04/15/2016. All variances will be corrected and continued education provided by the Assistant Director of	

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F 329	Continued From page 12 It was noted that the physician checked the 'Agree' box on this pharmacist-generated recommendation form, handwrote "D/C" (discontinue) on the recommendation and signed the form, indicating that the pharmacy-generated recommendation was now an official physician order. A review of the Medication Administration Records since November 2015 to March 22, 2016 showed that the Pravastatin 10 mg was signed as administered to the resident every evening at bedtime. Nurse Unit Manager #2 was interviewed on 3/23/16 at 9:50 AM. She stated "It seems to have been missed. The correct process is for pharmacy to make recommendations, put those recommendations in a folder, the physician reviews the recommendations and puts them back into the folder, and then the nurse makes the necessary changes and then files it into the resident's medical record. It seems that the nurse filed it before the changes were made but there is no way of saying which nurse did this." Nurse Unit Manager #2 later returned at 2:00 PM on 3/23/16 with updated physician orders that stated "D/C Pravastatin." The Director of Nursing was interviewed on 3/23/16 at 2:52 PM. She acknowledged that the Pravastatin D/C order got missed.	F 329	Nursing. Licensed staff (prn/weekend staff will be in-serviced before working next shift) will receive in-serving on changes have been made to reflect new physician orders in order to prevent unnecessary medications on 04/19/2016 by the Assistant Director of Nursing. The Administrative Nurse Team will complete a 100% monthly audit of all physician orders to ensure changes have been made to reflect new physician orders in order to prevent unnecessary medications on 04/15/2016. All variances will be corrected at the time of observation and continued education provided. The Administrative Nurse Team will conduct audits on orders to ensure that all orders including changes have been made to reflect new physician orders in order to prevent unnecessary medications on the Medication Administration Record (MAR), this will be reviewed at Morning Clinical on all order changes weekly for (3) three months. All variances will be corrected at the time of observation and continued education provided. Results of audits will be reported to the Director of Nursing. The Director of Nursing will report results to the Quality Assurance Committee. Continued compliance will be maintained through facility monthly changeover process and pharmacy drug regimen	

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F 329	Continued From page 13	F 329	reviews. All variances will be corrected at the time of observation.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and staff interview, the facility failed to maintain a medication administration rate below 5% (7.4%, 2 of 27 opportunities, Residents #9 and #134). Findings included: 1. Resident #9 was admitted to the facility on 10/8/11. A physician order dated 10/8/11 instructed nursing to administer Docusate 100 milligrams (mg) daily as a stool softener. During medication administration observation conducted at 8:30 AM on 3/23/16, Nurse #1 was observed giving all medications but omitting the administration of the Docusate. Nurse #1 was interviewed at 9:15 AM and stated "I thought I gave it to (the resident)." The Director of Nursing was interviewed on 3/23/16 at 9:45 AM. She indicated that her expectations are that medications are not omitted. 2. Resident #134 was admitted to the facility on 11/18/14. A physician order dated 11/18/14 instructed nursing to administer Simethicone	F 332	F332 Resident #9 and #134 received their medications as ordered. The resident has no negative outcomes documented. The Assistant Director of Nursing educated nurse #1 and #2 on the 5 rights of medication administration on 4/13/16. The Assistant Director of Nursing will complete education to all Licensed Nursing Staff (prn/weekend staff will be in-serviced before working next shift) on ensuring all guests receive appropriate medications as ordered and the 5 rights of medication administration on 04/19/2016. Current residents receiving medications have the potential to be affected. The Administrative Nurse Team will conduct med pass observations to include a minimum of 25 opportunities on facilities current med pass observation tool randomly 3x/week for 4 weeks on all shifts	4/21/16

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F 332	Continued From page 14 liquid 80 mg twice daily for flatulence/gas pain. At 9:00 AM on 3/23/16, Nurse #2 was observed putting the Simethicone bottle with the dropper in her right uniform pocket. She was observed to administer all medications except Simethicone, which remained in her pocket. Nurse #2 was interviewed at 9:20 AM on 3/23/16. She realized that the Simethicone was still in her pocket and stated "I forgot." She indicated that she did not know at what point she would have realized that the Simethicone was still in her pocket. The Director of Nursing was interviewed on 3/23/16 at 9:45 AM. She indicated that her expectations are that medications are not omitted.	F 332	to include weekends for all licensed staff (prn/weekend staff will be observed on their next working shift). Variances will be corrected at the time of observation. Additional education and/or administrative action will be initiated when indicated. Concerns will be reported to the Director of Nurses weekly for the next (4) four weeks. The Director of Nurses will report results to the quality assurance committee during the monthly meeting.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334		4/21/16

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F 334	Continued From page 15	F 334		

documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second

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F 334	Continued From page 16 pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow up and administer influenza vaccine to 1 of 5 residents reviewed (resident # 63). Findings included: The resident was admitted on 10/10/2008 with diagnosis of cerebral vascular accident. Medical record review: The resident ' s diagnoses consist of cerebral vascular accident with aphasia, left above knee amputation, diabetes mellitus type 2, peripheral artery disease, peripheral vascular disease, hypertension, hyperlipidemia, atrial fibrillation, congestive heart failure, and chronic obstructive pulmonary disease. A review of the MDS quarterly review dated 12/11/2015 shows a BIMs score of 14 and a quarterly review dated 2/9/2016 shows a BIMs score of 15; both indicate normal cognition for the resident. 03/23/2016 3:59:44 PM Medical record review: There is no documented record of the resident receiving the flu vaccine during the 2015-2016 flu season. In the upper right corner of a copy of the "Vaccine Information Statement" from the CDC	F 334	F334 Resident #63 received the flu vaccine with no negative outcomes on 03/24/2016. All residents have the potential to be affected by this practice. All licensed staff (prn/weekend staff will be in-serviced before working next shift) that perform pneumococcal vaccines/ flu vaccines will receive education regarding the benefits and side effects of the pneumococcal vaccines to ensure that all residents or the residents' legal representatives have been given information/education regarding the benefits and side effects of the pneumococcal vaccine on 04/19/2016 by the Assistant Director of Nursing. Assistant Director of Nursing and Unit Managers will complete a complete audit of all charts to ensure that all residents or residents' legal representative have been provided documentation regarding the flu vaccine and it is recorded in the medical chart by 04/15/2016.	

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F 334	Continued From page 17 on the chart there is a hand-written note that states "mailed consent & info. to R.P. 10/2015". The last flu vaccine documented in the chart was on 10/20/2014. 03/23/2016 4:07:02 PM Interview with ADON: The ADON states that resident #63 did not receive a flu vaccination for the 2015-2016 flu season. She mailed a consent form to the responsible party (R.P.) "10/2015". She states she always follows the same process of administering the vaccine and documenting it in the chart, so if she had given it, it would be documented in the chart. She states the R.P. is very involved in the resident ' s care and visits frequently and recalls her saying that she didn't want the resident to consent to any form of treatment and wanted all treatment decisions to go through her. The ADON did not receive a refusal of the vaccine. 03/24/2016 10:02:19 AM Interview with DON and the administrator. The DON ' s expectation is to offer flu vaccines to all residents. She expects staff to call family members or the responsible party (R.P.) to offer the vaccine. The ADON is responsible for the vaccinations.	F 334	Assistant Director of Nursing and Unit Managers will conduct an audit 10 residents (1) once weekly for (4) four weeks for documentation regarding the flu vaccine recorded in the resident's medical chart. Any variances will be corrected at the time of observation and continued education provided. The results of audits will be reported to the Director of Nursing. The Director of Nursing will report results to the Quality Assurance committee during the monthly meeting. Continued monitoring will occur through routine chart audits conducted by Unit Managers. Results will be reported to the Director of Nursing.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		4/21/16

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F 371	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observations, the facility failed to discard 6 blueberry muffins dated 1/25/16 from one of one walk in refrigerator and one ham dated 8/22/14 from one of one walk in freezer. The findings included: A review of the Storage of Food policy dated August 2012 was conducted. Frozen cooked ham was to be discarded after 1 to 2 months. Muffins stored in the refrigerator were to be discarded after 7 days. On 3/21/16 at 10:30 AM six blueberries muffins dated 1/25/16 were observed in the walk in refrigerator. On 3/21/16 at 10:32 AM one ham labeled with date prepared of 8/22/14 was observed in the walk in freezer. An interview was conducted with the Administrator on 3/21/16 at 10:33 AM. The Administrator stated the dietary manager was expected to monitor the refrigerators and freezers for expired food items. He stated at present the facility did not have a dietary manager. The Administrator stated he expected the blueberry muffins and the ham to be discarded per the facility policy.	F 371	F371 The blue berry muffins that were located in the freezer were within the shelf life of the company's policy and procedure were discarded 03/21/2016. The ham that was located in the freezer that was dated improperly was discarded on 03/21/2016. Administrator will educate dietary staff (prn/weekend staff will be in-serviced before working next shift) on the storage, preparation, distributing, and serving food under sanitary conditions by 04/19/2016. The Dietary Manager will complete an audit of food storage and labeling (4) four times weekly for (3) months to ensure ongoing compliance with proper food storage, labeling and dating. All variances will be corrected at the time of observation and continued education provided. Results of audit will be reported to the Administrator. The Administrator will report results to the Quality Assurance committee during the monthly meeting. Continued compliance will be monitored through random audits by the Dietary Manager and reported to the Quality Assurance Committee.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		4/21/16

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F 520	Continued From page 19 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 03/05/15 recertification survey. This was for four recited deficiencies in the areas of assessment accuracy (F278), comprehensive care plans (F279), medication error rate (F332), and food procurement/storage (F371). These	F 520	F520 MDS staff will receive in-servicing on the proper coding of MDS assessments to ensure all diagnosis are properly coded on the MDS on 04/11/2016 by Regional MDS Coordinator. Director of Nursing and Assistant Director of Nursing will audit (4) four MDS	

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F 520	Continued From page 20 deficiencies were cited again on the current recertification survey of 03/24/16. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. F278 - Assessment Accuracy: Based on medical record review and staff interview, the facility failed to code thyroid disease/thyroidectomy on the Minimum Data Set (MDS) for 1 of 5 residents investigated for unnecessary medications (Resident #154). During the recertification survey of 3/5/15 the facility was cited F278 for failing to accurately assess residents in the areas of urostomy (surgical opening through which urine passes), swallowing, pressure ulcers, diagnosis of mood disorder, and Preadmission Screening and Resident Review on the MDS. On the current recertification survey of 3/24/16, the facility failed to code thyroid disease/thyroidectomy on the MDS. 2. F279 - Comprehensive Care Plans: Based on medical record review and staff interview, the facility failed to address in the care plan the respiratory status/condition of one of one residents reviewed for respiratory care (Resident #139). During the recertification survey of 3/5/15 the facility was cited F279 for failing to develop a care plan with goals and approaches for urostomy. On the current recertification survey of 3/24/16, the facility failed to address in the care plan respiratory status/condition. 3. F332 Medication Error Rate: Based on observations, medical record review, and staff interview, the facility failed to maintain medication	F 520	assessments weekly for (8) eight weeks to monitor for proper coding of the MDS. Any variances will be corrected at the time of observation and continued education provided. MDS staff received education on the RAI instructions for Care Planning to include proper elements for Care Planning 04/11/2016 by the Regional MDS Coordinator. Director of Nursing and Unit Managers will review new admission care plans during Clinical Operation meeting to ensure interim care plans for oxygen are written and in the medical record weekly for (8) eight weeks. Any variances will be corrected at the time of observation and continued education provided. The Assistant Director of Nursing will complete education to all Licensed Nursing Staff (prn/weekend staff will be in-serviced before working next shift) on ensuring all guests receive appropriate medications as ordered and the 5 rights of medication administration on 04/19/2016. The Administrative Nurse Team will conduct med pass observations to include a minimum of 25 opportunities on facilities current med pass observation tool randomly 3x/week for 4 weeks on all shifts to include weekends for all licensed staff (prn/weekend staff will be observed on their next working shift). Variances will be corrected at the time of observation. Additional education and/or administrative	

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F 520	Continued From page 21 administration rate below 5% (7.4%, 2 of 27 opportunities, Residents #9 and #134). During the recertification survey of 3/5/15 the facility was cited F332 for failing to maintain a medication error rate of 5% or below (24.1%) and failed to administer medications as ordered by the physician. On the current recertification survey of 3/24/16, the facility failed to maintain a medication administration rate below 5% (7.4%). 4. F371 - Food Procurement/Storage: Based on record review, staff interviews, and observation, the facility failed to discard 6 blueberry muffins dated 1/25/16 from one of one walk in refrigerator and one ham dated 8/22/14 from one walk in freezer. During the recertification survey of 03/05/15 the facility was cited F371 for failing to date opened and unopened food items, failing to label and date refrigerated food items, failing to label and date refrigerated meat, and failing to discard expired food. On the current recertification survey of 3/24/16, the facility failed to discard expired foods from the walk in refrigerator and walk in freezer. An interview was conducted with the Administrator on 3/24/16 at 10:10 AM. He stated he was the head of the facility's QAA Committee. He stated the QAA Committee consisted of the Medical Director, Director of Nursing (DON), Dietary Manager, Recreation Services Manager, Social Worker, Environmental/Laundry Manager, Maintenance Director, Rehabilitation Director, and the Pharmacist. He stated the committee met monthly. The Administrator indicated he was aware assessment accuracy was a repeat deficiency from the previous recertification survey. He stated they had been auditing assessments since their previous action plan. He stated they	F 520	action will be initiated when indicated. Concerns will be reported to the Director of Nurses weekly for the next (4) four weeks. The Director of Nurses will report results to the quality assurance committee during the monthly meeting. Administrator will educate dietary staff (prn/weekend staff will be in-serviced before working next shift) on the storage, preparation, distributing, and serving food under sanitary conditions by 04/19/2016. The Dietary Manager will complete an audit of food storage and labeling (4) four times weekly for (3) months to ensure ongoing compliance with proper food storage, labeling and dating. All variances will be corrected at the time of observation and continued education provided. Results of audits will be reported to the Director of Nursing and to the Quality Assurance Committee during the monthly meeting. Continued monitoring will occur through routine audits of devices by the Director of Nursing. Any variances will be corrected and reported to the Quality Assurance Committee.	

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currently audited two random MDS assessments per week. He stated there were two MDS Coordinators and they completed the audits on each other. He indicated the DON was responsible for monitoring the audits and the results were brought to their clinical meetings. He stated the facility additionally ran an MDS error report and he stated their accuracy had greatly improved. He stated he was unsure what caused the deficiency, but indicated an increase in the number of audits may be needed.
The Administrator indicated he was aware comprehensive care planning was a repeat deficiency from the previous recertification survey. He stated they had been auditing care plans since their previous action plan. He stated they currently audited two random care plans per week. He stated there were two MDS Coordinators and they completed the audits on each other. He indicated one of the MDS Coordinators was fairly new to the facility and believed that could be the reason for the deficiency. He indicated an increase in the number of audits may be needed.
The Administrator indicated he was aware the medication error rate was a repeat deficiency from the previous recertification survey. He stated they had been auditing medication passes since their previous action plan. He stated they currently audited two random medication passes per week. The Unit Managers and the Assistant Director of Nursing (ADON) complete the audits. He indicated the medication error rate was improved from the previous recertification survey. He stated he believed one of the errors was due to the nurse's nervousness.
The Administrator indicated he was aware that food procurement/storage was a repeat deficiency from the previous recertification

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 _____	03/24/2016

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 520	Continued From page 23 survey. He stated daily audits had been completed since their previous action plan. He indicated he personally completed daily audits of the refrigerator, freezer, and dry storage. He also stated that there were staffing changes with the dietary manager since the previous recertification survey. He indicated he had a hard time believing they had another deficiency in this area.	F 520		