PRINTED: 08/01/2024 FORM APPROVED OMB NO. 0938-0391

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345389	B. WING		C 06/26/2024	
	ROVIDER OR SUPPLIER	NN		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	1 00/20/2024	
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F 000	INITIAL COMMENT	S	F 00	0		
F 604 SS=J	from 6/19/24 through information was obta and onsite validation removal plans was of Therefore, the exit of The following intake NC00218345. Two resulted in a deficie resulted in immediati jeopardy was identificated for (J) CFR 483.12 at tag For (J) CFR 483.35 at tag For (J) CFR 483.35 at tag For (J) Tags F604 and F689 Quality of Care Immediate Jeopardy removed on 6/22/24 was conducted. Right to be Free from CFR(s): 483.10(e)(1) \$483.10(e) Respect The resident has a rand dignity, including \$483.10(e)(1) The riphysical or chemical purposes of discipling information was obtained by the second content of the property of the p	(2) of the 2 allegations ncy. Intake NC00218345 e jeopardy. Immediate ied at: (604 at a scope and severity fe89 at a scope and severity fe90 constituted Substandard began on 6/12/24 and was labeled A. A partial extended survey m. Physical Restraints has 1, 483.12(a)(2) and Dignity. ight to be free from any restraints imposed for lee or convenience, and not resident's medical symptoms,	F 60	4	7/22/24	
ADODATODY	DIDECTOR'S OR PROVINCE	/SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE	(X6) DATE	

Electronically Signed 07/22/2024

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 604			F 6	i04			
	neglect, misappropria and exploitation as d includes but is not lin corporal punishment	involuntary seclusion and ical restraint not required to					
	from physical or cher purposes of disciplinare not required to transpurposes. When the indicated, the facility alternative for the lead document ongoing re- restraints.	e that the resident is free nical restraints imposed for e or convenience and that eat the resident's medical					
	Based on observation Party (RP), Medical I Practitioner #1 (NP) and record review, we resident's bed against from getting out of the this as a restraint, fair assessment, failed to and failed to obtain the fair of a restraint. When the bed she was wedged wall. Resident #1 was and found to not have Cardiopulmonary Restarted by the facility	ons and staff, Responsible Director (MD), Nurse and Paramedic #1 interviews hen the facility moved the set the wall to prevent her se bed, they failed to identify led to complete a restraint so obtain a physician order the RP's consent for the use he resident fell out of the set between the bed and the set assessed by facility staff set a pulse or respirations. Suscitation (CPR) was staff and assumed by staff expired on 6/12/24.		Resident #1 expired on 6/12/24. The Director of Nursing (DON) or Assistant Director of Nursing (AE completed an audit of residents of bed against the wall for a physic physical device evaluation, currectors and care plan on 6/20/2 items identified in the audit were corrected. In the event a similar is identified, corrective actions as above will be completed to secur maintain compliance. The DON completed an audit of with behaviors of attempting to good bed, to identify residents that have	or DON) with their cian order, ent signed 24. All es situation s stated re and		

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
F 604	Continued From page	÷ 2	F 6	504				
	This was for 1 of 3 re restraints (Resident #	1).			bed placed against the wall as a behave management intervention and none we observed on 6/21/2024.			
	Resident #1 was four and the wall after bein Jeopardy was remove facility implemented a immediate jeopardy remain out of complia severity of D (no actuminimal harm that is resure monitoring systems of the findings included Resident #1 was admidiagnoses including of chronic obstructive purspecified psychosis. The quarterly Minimulindicated Resident #1 cognitive impairment,	nitted on 10/11/23 with congestive heart failure, ulmonary disease, anxiety,			The facility implemented the immediate actions to ensure that policies and systems were in place to investigate, implement effective interventions, document, ensure training and competencies for all nursing staff, Registered Nurse (RN), Licensed Practical Nurse (LPN) and Medication Aides (MA) and Certified Nursing Assistants (CNA) who would place a residents' bed against the wall to preve future accidents and or injuries. No revisions to the restraint management policy were required. The Licensed Nursing Home Administrator (LNHA) and the DON received education from the Regional Clinical Coordinator (RCC) on 6/20/24 regarding the restraint management policy, incidents and accidents policy a the abuse policy to include injuries of unknown origin. The education was	ent		
	to side, no impairment lower extremities, a was of restraints. Resident #1 was care risk for falls related to motion and pain. The intervention of assist attached to the side of approximately at short assist a resident with repositioning more earned.	e planned on 10/12/23 as a her decreased range of care plan included the bars (narrow type of side rail			provided, in person, verbally with opportunity for discussion and /or clarification, and contained the definition of a restraint, the required evaluation put to application of a restraint, identification of the risks of using the restraint, physician order for the bed against the wall prior to initiation of the restraint and that a bed placed against the wall as a behavior management intervention is considered a restraint with alternative behavior management interventions. The facility nursing staff currently work	rior on		

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F 604	Continued From page	÷ 3	F 60	4			
F 604	from the bed to anoth not full weight bearing movement up or dow care plan did not inclupushing her bed agai from getting out of bed. Review of Resident # orders included an or Oxygen at 2 liters per shortness of breath, Fo.25 milligrams (mg) and an order dated 5 bars up on both sides mobility. There was a for Hydroxyzine (antil hours as needed for increase of the labout 2 to 3 hours. We needed help for, she continue to monitor. A telephone Interview at 1:25 PM with Nursworked with Resident through 7:00 AM on 6 experiencing behaviors shift around 2:40 AM were yelling out, calling keeping her awake, rout of the bed and as stated the staff could	er surface as well but are g. They are not capable of an and are stationary). The ude the new intervention of anst the wall to prevent her d. 1's June 2024 Physician der dated 5/27/24 for minute as needed for Risperdal (antipsychotic) at bedtime for psychosis (28/24 for bilateral assist of the bed to increase bed also an order dated 5/29/24 anistamine) 25 mg every 8 restlessness/anxiety. Inote written by Nurse #1 AM, read Resident #1 was to out of bed, calling out to ou. This behavior went on for	F 60	in the facility received education DON or the ADON verbally, in positive discussion a clarification, regarding the restration and accidents policy and the abuse princlude injuries of unknown origi 6/20/2024 and contained the dear restraint, the required evaluation application of a restraint, identification of a restraint, porder for the bed against the was completed prior to initiation of the restraint, that a bed placed again wall, as a behavior management intervention, is considered a restraint remaining facility nursing staff withis education from the DON prior returning to work at the facility. The deducation will also be provided to nursing staff during orientation. All staff currently working in the received education, abuse policy include injuries of unknown origi 6/20/2024. The remaining facility receive this education from the DO to returning to work at the facility education will also be provided to returning to work at the facility receive this education from the DO to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to work at the facility education will also be provided to returning to wor	erson, nd /or int nd colicy, to n, on finition of con prior to cation of hysician Il to be e nst the t traint and nt nt. The ill receive or to This o new facility N or the rbally, in ussion y, to n, on ry staff will DON prior y. This o new		
	Resident #1's bed fro	m its regular position in the having the right side of the		(ADON) will complete and audit admissions/readmissions for the being placed against the wall, fo	bed		

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F 604	Continued From page	e 4	F 6	504			
F 604	bed up against the wakeep Resident #1 from Nurse #1 stated he di order, complete a resconsent from her RP. do the things associar estraint because a barestraint. Nurse #1 the June 2024 Medica (MAR), on 6/9/24 seche came in at 7:00 Phedid not administer needed Hydroxyzine and restlessness. He bed had bilateral assi administer her prescribusion for an antia #1's only explanation it. A telephone interview at 3:10 PM with Nursi confirmed working on shift with Resident #1 in the middle of the ni 6/9/24, Resident #1 wroommate, keeping orepeatedly attempting stated Nurse #1 decided from the center of wall so the right side of the wall. NA #8 stated Resident #1 from trying because she tended in the stated in the middle of the wall. NA #8 stated Resident #1 from trying because she tended in the stated in the wall. Na #8 stated Resident #1 from trying because she tended in the stated in the wall.	all. He stated he did this to m getting out of the bed. Id not obtain a physician traint assessment or get a Nurse #1 stated he did not ted with implementing a ed against the wall was not confirmed that according to ation Administration Record ond shift starting from when M and third shift on 6/10/24, Resident #1's prescribed as (antihistamine) for anxiety was unable to recall if the st bars, why he didn't ibed Hydroxyzine or call the anxiety medication. Nurse was that he did not think of was completed on 6/20/24 ing Assistant (NA) #8. He is 6/9/24 and 6/10/24 on third and Nurse #1. NA #8 stated ight of the 11-7 shift of was yelling, bothering her ther residents awake and go to get out of her bed. He died to move Resident #1's if her room up against the of her bed was blocked by it this was done to keeping to get up out of her bed to throw her legs off the bed reffort to get up. He stated	F	604	restraint evaluation, physician order, R consent and appropriate care plan intervention daily for five days, then weekly for three weeks and then month for three months to validate continued compliance. The DON or Assistant Director of Nursi (ADON) will complete an audit of residents with a new behavior of attempting to get out of bed, for the bebeing placed against the wall as a behavior management intervention dail for five days, then weekly for three wee and then monthly for three months to validate continued compliance. Audits will presented to the QAPI Meet monthly by the DON and or ADON for review of Audit Findings to assess if additional actions need to be implement to maintain compliance.	ng d bks	
	he was not aware tha restrained Resident #	t in doing that, Nurse #1 had 1 because he thought that it ause the facility did it for					

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F 604	that made her bed not rather it "stuck out mather it "200 PM of Nurse #4 stated Nurse morning that Residen night, yelling out and She stated Nurse #1 #1's bed against the wher from falling out of she was aware that for there had to be perm Nursing (DON) and the had to be revised. She Resident #1 bed posithe time. Nurse #4 stated with Resident #1 worked with Resident #1 on 6/10/24. An interview was com PM with MA #1. He so Resident #1 on 6/10/24. An interview was com PM with MA #1. He so Resident #1 on 6/10/24. An interview was com PM with MA #1 stated Resident anxiety, agitation and difficult to redirect and aware. MA #1 stated attempt to get out of I fallen at the facility be reported to him on 6/10/24 worked on night shift if get up out of the bed other facilities he worked a restraint but he considered a restraint but he considered a restraint.	I have bilateral assist bars at flush against the wall but aybe an inch." I was completed on 6/20/24 I #4. She stated she worked on 6/10/24 with Resident #1. I was up most of the trying to get out of the bed. reported he moved Resident wall during his shift to keep the bed. Nurse #4 stated or the use of a restraint, ission from the Director of the RP and the care planned the stated she didn't think of the ton change as restraint at atted Medication Aide (MA) tent #1 on first shift on I pleted on 6/19/24 at 244 tated he was assigned 24 and 6/11/24 on first shift. In the flush of the trying to t	Fé	504				

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F 604	6/10/24 7:00 AM the She stated she not been moved up ago told her that the work from getting out of Resident #1 was a oxygen on multiple unusual. MA #1 rest the reclining chair stated Resident # chair from lunch the she assisted her the Resident #1 begand at her and her bed She stated the MA 4:45 PM and that else because it was resident #1 events she felt it was safe. A telephone intervat 7:25 PM with Now Resident #1 on 6/PM. She stated she was bed had been more assumed it was bed up out of the bed. being emotional and #10 stated she was bed against the work she wanted to. A telephone intervat 2:14 PM with Now the Resident #1 on 6/11/2 PM and on 6/11/2	A #9. She stated she worked o 7:00 PM with Resident #1. biticed Resident #1's bed had gainst the wall and that MA #1 eekend staff did it to keep her if the bed. NA #9 stated anxious and she removed her e occasions but this was not ecommended getting her up to which settled her down. NA #9 if stayed up in her reclining me till right after dinner then to bed. She stated at this time in yelling, screaming, swinging if was still up against the wall. A #1 gave her a Hydroxyzine at the could not give her anything as too early. NA #9 stated to leave the room. If was completed on 6/20/24 A #10 who worked with 10/24 from 7:00 PM to 11:00 the immediately noticed that her wed up against the wall and the ecause of her attempts to get. She recalled Resident #1 as and confused on her shift. NA as not aware that Resident #1's all was considered a restraint with the other side of her bed if the was completed on 6/19/24 turse #3. She confirmed working on 6/10/24 from 3:00 PM to 7:00 PM. The reported to her the Resident #1 are ported to her the Resident #1.	F	604			

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F 604	were two occasions RP was contacted at Nurse #3 stated ther left in the psychiatric the Physician's notel anxiety but so far on ordered as needed. received psychiatric there had been no si her confusion and be later in the afternoon noticed that Residen but it never occurred considered a restrain between the bed and dying. Nurse #3 state created a dangerous given her cognitive sanxiety and behavior. A telephone interview at 7:55 AM with NA# 11:00 PM on 6/10/24 stated she noticed R moved. She stated F to get out of the get, yell and strike at staff aware that having he wall was considered restraint training but last received that tra. A telephone interview at 7:30 PM with NA# on 6/11/24 from 7:00 Resident #1 and not moved up against the	ing anxiety of late and there the week before when her and came to sit with her. e had been communication providers notebook and in book regarding her increased by Hydroxyzine had been She stated Resident #1 services and talk therapy but gnificant changes and that ehaviors seemed to worsen is. Nurse #3 stated she it #1's bed had been moved to her that it could be not until Resident #1 fell in if the wall and ended up ed the bed against the wall is situation for Resident #1 tatus with her increased is. In was completed on 6/20/24 #12. She stated she worked it o 7:00 AM on 6/11/24. She esident #1's bed had been Resident #1 was known to try crawl out of the bed, disrobe, if. NA #12 stated she was not er bed pushed up against the a restraint. She confirmed could not recall when she ining. w was completed on 6/20/24 #11. She stated she worked	F 6	04			

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F 604	Continued From page	ge 8	F 6	04			
	NA #9 stated that w Resident #1 nap on her. She stated that wall was not conside knew. Review of psychiatr the reason for her v regarding anxiety, ir reported the Reside yelling out to be put	as where she typically let the days she was assigned to moving the bed against the ered a restraint as far as she ic NP note dated 6/11/24 read isit was due to staff request asomnia and psychosis. Staff and the to bed or taken out of the Hydroxyzine was prescribed 24.					
	at 10:37 AM with the when she saw Resibecause it was at the documented the rearestlessness. She is Resident #1's medicate MD had already her anxiety (Hydrox stated she reviewed and read that after the administered, the number of the floor staff or recent behaviors, the electronic medicate 7:00 PM with Nur on 6/11/24 from 7:0	tated when she reviewed cal record, she noted that that prescribed a medication for yzine). The psychiatric NP d Resident #1's nursing notes the Hydroxyzine was urses documented that it was d this was why she did not to else for her anxiety or questioned if she interviewed f about Resident #1's anxiety , she stated she only reviewed					

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F 604	the bed then she we bed. She stated she positioned against the tried to get out of the stated Resident #1's also had bilateral as mobility. A telephone interview at 12:41 PM with Nowerked 6/11/24 from Resident #1. She strest better sitting up when she was place attempt to get out obehaviors. NA #13 she ped had been move one to two inches in due to assist bars. If on her bed did not reaffixed to the bed from the she was considered with NA #1. She recently a she ped had been move one to two inches in due to assist bars. If on her bed did not reaffixed to the bed from the she was considered with NA #1. She recently asked NA #2 to assist back to bed using the with giving her a bars.	1 would want to get up out of buld want to get back in the er assumed the bed was he wall because she often er bed unassisted. Nurse #5 is bed was a bariatric bed that exist bars to help with bed easy was completed on 6/11/24 A #13. She confirmed she in 3:00 PM to 11:00 PM with exated Resident #1 seemed to be in her reclining chair and ead in the bed, she would if the bed and exhibit more extated when she left at 11:00 as sleeping in her reclining the noticed that Resident #1's ead against the wall with maybe in between the wall and the bed NA #13 stated the assist bars move up or down but were	F 6	04		
	PM with NA #2. She transfer Resident #' the bed on 6/12/24	ompleted on 6/19/24 at 1:16 e stated she helped NA #1 1 using the mechanical lift into at approximately 1:30 PM and th and completed her personal				

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F 604	to get out of the bed so. She also said Ridisplay agitation and extremely difficult to also was the first da #1's bed pushed up she did not consider Resident #1 could so other side. NA #2 st to try to get out of the do so. She also said display agitation and extremely difficult to also was the first da #1's bed pushed up there were bilateral bed that left about obetween her bed and A review of an incided 4:38 PM read Reside and called out for as out for additional stawas seen lying on her ight side of her was turned over where furniture out of the wand blood sugar we request for someone Services (EMS) and (full code for presun started and taken or present in the room. A telephone interview at 2:11 PM with NA scheduled to work for someone and the source of the second services (EMS) and (full code for presun started and taken or present in the room.	Resident #1 was known to try and she was unsafe to do esident #1 was known to danxiety at times and was redirect. NA #2 stated that by she had observed Resident against the wall. She stated that a restraint because till get out of her bed on the ated Resident #1 was known to danxiety at times and was redirect. NA #2 stated that by she had observed Resident against the wall. She stated assist bars on Resident #1's one to two inches of room did the wall. The treport dated 6/12/24 at the treport dated 6/12	F	04			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION (X3) DA CO		
		345389	B. WING _			C 06/26/2024	
	ROVIDER OR SUPPLIER	NN		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 604	her sleeping in her begave another reside check on Resident #PM and 3:45 PM. It Resident #1's door the assumed her RP was stated she was awas been pushed up agaget out of the bed on tended to throw her the bed when trying would not have consugainst the wall and a A telephone intervie at 2:51 PM with MA working on 6/12/24 Resident #1. She stout for help saying FShe stated she respher face down in beind MA #2 stated the beind H1 and Nurse #2 we she had not question up against the wall be interdisciplinary tear place as a fall intervient at 1:30 PM with Resident H1. She stout for help saying FShe stated the beind H1 and Nurse H2 we she had not question up against the wall beinterdisciplinary tear place as a fall intervient to the stated when he obsclosed, he assumed care and would be continued within a few minutes within a few minutes.	coom around 3:20 PM and saw bed. NA #3 stated she then int a shower and returned to a sometime between 3:30 was at this time she observed to her room closed so she is in the room visiting. NA #3 are that Resident #1's bed had ainst the wall so she could not in the right side because she legs over to the right side of to get up. NA #3 stated she sidered Resident #1's bed accident hazard. We was completed on 6/19/24 #2. She stated she was from 7:00 AM to 7:00 PM with lated she heard NA #4 calling Resident #1 was on the floor. Conded to the room and saw tween the bed and the wall. In the dome the sident #1's bed being because she assumed the in (IDT) team had put it in	F	504			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		I' /	(X3) DATE SURVEY COMPLETED			
		345389	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, ZIP C	•	6/26/2024
THE LAU	RELS OF FOREST G	LENN		1101 HARTWELL STREET GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 604	since he assumed He said he was chresidents in the hawaited too long for assisting Resident around 4:15 PM with door and gently of stated that was with Resident #1's right and could not see he knew something head outside her help. He stated he away from the way from the called for the room and took her over and start they were unable approximately how between the bed approximately how between the bed approximately how between the wall be bilateral assist bath with UM #1. Shistory of throwing bed trying to get unwas reported to he #2 that Resident # anxiety and behave	but he didn't think much of it a staff were in the room with her natting with a few other allway when he decided he had a staff to be in the room to the staff to be in the room to the decided to knock on the pen the door to peek inside. He hen he saw the bottom of the foot on top of her mattress the rest of her body. He stated any was wrong so he stuck his room and asked staff to get then attempted to pull the bed all to see Resident #1. He said to be been locked because it was to the got the end of the bed to the head of the bed out slightly at Resident #1 was not the color didn't look right. The RP or help and then staff entered to over. He stated they turned to revive her. When asked we much space did he think was and the wall when he found her, we inches. The RP stated I had never seen her bed uperfore and Resident #1 had	F	504		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25			(c	
		345389	B. WING			06/	26/2024	
	ROVIDER OR SUPPLIER	:NN	•	STREET ADDRES 1101 HARTWEL GARNER, NC				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	F ((EA	PROVIDER'S PLAN OF CORRECTION ICH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 604	the bed unassisted. #1 reported to her to the center of her rowith the headboard hallway door. UM # the bed being move bed against the wal questioned regarding being moved up ag was to keep her fro falling. When asked of a restraint, UM # on 6/12/24 at approx NA #4 calling for her room. NA #4 stated the floor between the summoned Nurse # retrieve the crash of supplies and equipples and equipples and equipples and equipples and turn her over to Resident #1 was blof any pulses or resinitiated. A telephone interview at 1:10 PM with NA walking down the hopened her door are because Resident #1 she could not see F. She stated once she walked over to the design of the stated once she walked over to the see the see the stated once she walked over to the	her and trying to get up out of Nurse #2 stated that Nurse hat he moved her bed from om to be flush against the wall against the wall near the 1 stated she did not question and nor did she consider the I as a restraint. When not the touch a time that the wall, UM #1 stated it is getting out of the bed and I if that could be the definition 1 stated "yes". UM #1 stated eximately 4:15 PM, she heard she heeded in Resident #1 on the bed and the wall. She the RP found Resident #1 on the bed and the wall. She to assist and asked staff to the art (a cart that contains all the ment need in the event of a trest) requiring CPR and call upon entry to the room, the RP of the bed and the wall to the the wall to the the wall to the the wall to the warm to the touch, absent the price of the bed and the wall to the warm to the touch, absent the price of the bed and the wall to the warm to the touch, absent the price of the bed help the was on the floor. She stated the needed help the was on the floor. She stated the red the room and the the price of the bed, she could see the floor in between the bed in the floor in the fl	F	504				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
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	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	<u> </u>	00/20/2024
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 604	Continued From pag	ge 14	F6	504		
	pulled out the foot or assisted him in pulling for staff to roll her are stated she did not know between the bed and stated once CPR was room. An interview was concessed by with NA #6. She second shift on 6/12 Resident #1. She stated display agitation, trying to get out of her Resident #1's door to was in the room for not aware that he was found her on the flow wall. NA #6 stated so Resident #1, she unbed against a wall confirmed that Resident Resi	if the bed some but stated she ing out the bed more to allow and perform CPR. NA #4 now how much space was did the wall prior to her fall. She is initiated, she exited the impleted on 6/19/24 at 2:30 confirmed she was working /24 but was not assigned atted Resident #1 was known disrobe and continuously er bed. NA #6 recalled being closed thinking her RP a visit. She stated she was easn't in the room until he or between the bed and the ince this incident with derstood better how putting a bould be a restraint. She also				
	at 3:00 with Nurse # 6/12/24 7:00 AM to she responded to Re #1. Nurse #2 stated room, Resident #1 w between her bed an had already been pu and UM #1 could rol Nurse #2 stated Res get out of the bed ur have the cognition n would end up falling	2. She stated she worked 7:00 PM on another cart but esident #1's room with UM when she arrived in the vas lying on the floor in d the wall. She stated the bed illed out enough so that she				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
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	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 604 Continued From page 15 fall. A telephone interview was completed on 6/21/24 at 4:07 PM with NA #5. She stated she was working second shift on 6/12/24 and she was in another residents room when she heard the RP say outside Resident #1's door that she was on the floor. She stated she entered the room to see Resident #1 on the floor in between the right side of her bed and the wall and the RP was pulling the bed out some to allow for the staff to help Resident #1. That's when UM #1 and Nurse #2 entered and rolled Resident #1 over and we saw she was not breathing and blue so they began CPR then she exited the room. A telephone interview was completed on 6/20/24 at 12:59 PM with NP #1. She stated she was not notified that Resident #1's bed was being used as a restraint and would have not ordered it due to the risk associated with Resident #1's known behaviors of attempting get out of her bed unassisted and the risk of injuries and possible entrapment. On 6/20/24 at 3:40 PM, in the presence of the DON, ADON and the Regional Clinical Coordinator, UM #1 provided a description of what occurred on 6/12/24 involving Resident #1's fall. This description was done in an empty room with a non-bariatric bed that was placed against			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	, , , , , , , , , , , , , , , , , , ,	3012012024
PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 604	fall. A telephone intervie at 4:07 PM with NA working second shift another residents ro say outside Resider the floor. She stated Resident #1 on the of her bed and the with the bed out some to Resident #1. That's entered and rolled Fishe was not breathi CPR then she exite. A telephone intervie at 12:59 PM with NI notified that Reside a restraint and would the risk associated behaviors of attemp unassisted and the entrapment. On 6/20/24 at 3:40 DON, ADON and the Coordinator, UM #1 what occurred on 6/fall. This description with a non-bariatric the wall in the same bed would have bee described entering to fithe bed had beer approximately 8 incomplete.	w was completed on 6/21/24 #5. She stated she was it on 6/12/24 and she was in bom when she heard the RP int #1's door that she was on d she entered the room to see floor in between the right side wall and the RP was pulling o allow for the staff to help when UM #1 and Nurse #2 Resident #1 over and we saw ing and blue so they began d the room. We was completed on 6/20/24 P #1. She stated she was not int #1's bed was being used as d have not ordered it due to with Resident #1's known iting get out of her bed risk of injuries and possible PM, in the presence of the e Regional Clinical provided a description of 12/24 involving Resident #1's it was done in an empty room	F 6	04		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345389	B. WING		C 06/26/2024	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529		00/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 604	slightly leaning into nonresponsive. UM the bed out of the M Resident #1 onto he breathing and had. An interview was common AM with the ADON aware that Resider repositioned agains 7:00 AM shift 6/10. A telephone interviat 2:12 PM with Pathe code at the fact He recalled that who room, the facility stoperforming CPR. He Resident #1 was for bed near the wall be the bed. He stated pulse and only a big before asystole (no code was called at An interview was common AM with the DON. 4:05 PM on 6/10/26 for a visit but stopp to Unit Manager (Uthe hall to Residen closed. He stated he room providing per he was waiting in the state of the man and the stated he room providing per he was waiting in the stated in the stated he was waiting in the stated of the stated he was waiting in the stated he was	the base board of the floor the wall. She described her as if #1 stated somebody moved way further and they rolled er back and noted she was not no pulse. completed on 6/19/24 at 10:48 . She stated she was not if #1's bed had been st the wall on the 11:00 PM to if #1's bed had been st the wall on the 11:00 PM to if #1's no for the process of the stated staff reported that build on the right side of the build that she had not fallen off of Resident #1 never regained a rief rhythm change was seen to heart beat) again. He said the 5:00 PM. completed on 6/19/24 at 9:30 She stated at approximately 4, the RP came to the facility led at the nurses station to talk the process of the said the down that the had not fallen off of the said the said the first process of the said the first process of the stated at approximately the facility the facility the facility the facility the facility the facility that the nurses station to talk the facility that the nurses station to talk the facility that the nurse station to talk the facility that the facility that the nurse station to talk the facility that the facility that the nurse station to talk the facility that t	F 60	4		
	the hall to Residen closed. He stated he room providing per he was waiting in the residents until he eand stuck his head when the RP reportations.	t #1's room and noted the door ne assumed staff were in the sonal care. The DON stated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345389	B. WING _		0.0	C 5/26/2024
	ROVIDER OR SUPPLIER	ENN		STREET ADDRESS, CITY, STATE, Z 1101 HARTWELL STREET GARNER, NC 27529		3/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 604	stated he stuck his yelled for help. NA hallway and ran to in another room but DON stated next Uthe room where the bed out to allow over to assess her stated EMS and the stated when EMS. Resident #1 and p 5:00 PM. The DON Resident #1's bed the wall until 6/12/2 investigation included the wall until 6/12/2 investigation included the incident and She stated at no time moving Resident # a restraint. The DO being used to prevany manner, it had Physician order had consent obtained for A telephone interviat 11:07 AM with the being found on the the wall, it would not death. He stated sembolism (a suddearteries) or died du The MD stated her of suffocation or st her weight of 280 p #1's bed being plan subsequent fall did	head out of the room and #4 was walking down the get the nurses and NA #5 was it responded to the room. The IM #1 and Nurse #2 arrived in the RP had pulled the foot end of with the nurses to roll Resident #1 and initiate CPR. The DON the police were notified. She arrived, they assumed care of the room and the room a	F	504		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345389	B. WING _			C 06/26/2024	
	ROVIDER OR SUPPLIER	IN .		STREET ADDRESS, CITY, STATE, ZIP CO 1101 HARTWELL STREET GARNER, NC 27529	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BI E APPROPRIA	DATE	
F 604	Continued From pag	e 18	F 6	04			
	The Administrator wa Jeopardy on 6/20/24	as notified of Immediate at 11:55 AM.					
		the following credible ate jeopardy removal with a 3/22/24:					
		nts who have suffered, or serious adverse outcome as mpliance.					
	failed to have license that were able to den skills and techniques behavior and attempt restrained Resident #1 the bed against the wother staff who subse Resident #1 recogniz resident's movement life-threatening hazal unconscious and we the bed. Resident #1 Based on the investig analysis completed by	rd. Resident #1 was found dged between the wall and expired on 6/12/24. gation and the root cause by the Licensed Nursing					
	Clinical Coordinator (Company on 6/20/24 staff education relate management policy, policy and the abuse unknown origin is wh forementioned.	incidents and accidents policy to include injuries of at led to the incident e entity will take to alter the					
		ilure to prevent a serious					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		OMPLETED	
		345389	B. WING _			C 06/26/2024	
	ROVIDER OR SUPPLIER	NN		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 604	when the action will The facility implement ensure that policies investigate, implement document, ensure trail nursing staff who against the wall to prinjuries. No revisions policy were required On 6/20/2024 the LN Laurel Health Care of analysis of the incident of the resulting interversionally in the RCC on 6/20/24 management policy, policy and the abuse unknown origin. The	om occurring or recurring, and be complete. Inted the immediate actions to and systems were in place to ent effective interventions, aining and competencies for would place a resident's bed revent future accidents and or is to the restraint management	F	604			
	of a restraint, the recapplication of a restraint of using the restraint against the wall prior and that a bed place behavior manageme a restraint with alterninterventions. The facility nursing some Aides, and CNA facility received eductions.	and contained the definition quired evaluation prior to aint, identification of the risks and physician order for the bed or to initiation of the restraint and against the wall as a sent intervention is considered native behavior management staff (to include LPN, RN, As) currently working in the cation from the DON or the Nursing verbally, in person,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		OATE SURVEY OMPLETED
		345389	B. WING _			C 06/26/2024
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	- '	
PRÉFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 604	with opportunity for or clarification, regarding policy, incidents and abuse policy, to including origin, on 6/20/2024 of a restraint, the recapplication of a restroint against the wall to be of the restraint, that as a behavior management intervers as a behavior management intervers. The remaining facility this education from the work at the facility. The provided to new nurse all staff currently we education from the Educatio	discussion and /or any the restraint management accidents policy and the ade injuries of unknown and contained the definition quired evaluation prior to aint, identification of the risks a physician order for the bed a completed prior to initiation a bed placed against the wall, gement intervention, is at and alternative behavior antions that is not a restraint. Any nursing staff will receive the DON prior to returning to this education will also be sing staff during orientation. Triking in the facility received DON or the Assistant Director on person, with opportunity for arification, abuse policy, to known origin, on 6/20/2024. Any staff will receive this DON prior to returning to work	F	504		
	The DON or Assistant (ADON) completed a bed against the wall physical device evaluations and care plant the DON completed behaviors of attempt identify residents that	ant Director of Nursing an audit of residents with their for a physician order, uation, current signed an on 6/20/24. I an audit of residents with ing to get out of bed, to at have the bed placed behavior management				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE S	ETED
		345389	B. WING		06/2) 26/2024
				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	1 00/20/2024	
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	6/21/2024. The facility alleges the removed on 6/22/2022. An onsite validation of removal plan was consumere interviewed to verificate to the resincidents and accider include injuries of undefinition of a restrain completed by the DO their bed against the were confirmed to be audits completed by the behaviors of attemptic confirmed to be compeducation completed regarding the restrain incident and accident policy that included in confirmed to be compof 6/22/24 was validated Free of Accident Haze CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensure \$483.25(d)(1) The resident free of accident has \$483.25(d)(2) Each resident facility must ensure \$483.25(d)(2) Each resident facility f	e immediate jeopardy was 4. of the immediate jeopardy impleted on 6/26/24. Staff alidate in-services were traint management policy, into and the abuse policy to know origin and included the int. A review of the audits in a physician order completed. A review of the completed. A review of the interpretation of the completed. A review of the interpretation of the completed. A review of the by the LNHA and DON interpretation of the completed. The lJ removal date interpretation of the lJ removal date interpretation.	F 68			7/22/24
	accidents. This REQUIREMENT by:	is not met as evidenced		Resident #1 expired on 6/12/24.		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 BOILE	_		، ا	С
		345389	B. WING				26/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	101 HARTWELL STREET		
THE LAUF	RELS OF FOREST GLEN	N		G	SARNER, NC 27529		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)		COMPLETION DATE
F 689	Continued From page	a 22	F	689			
	· -	Responsible Party (RP), Bed		000			
		edical Director (MD), Nurse			Other residents that may be at risk for t	he	
		Police Officer #1, Paramedic			same deficient practice include those		
		niner (ME) #1 the facility			residents with behaviors identified with		
		nt #1 free from accident			attempts to get out of bed unsafely. The	е	
		er bed against the wall and			Director of Nursing (DON) and nurse		
	trying to restrict her fr	rom getting out of bed and			managers evaluated like residents on		
		entions ensuring Resident			6.21.24, residents that are fall risk and		
	#1's bed remained in				attempting to get out of bed unassisted	, to	
		of the right side of her bed in			ensure no other beds were pushed		
		the wall where there was			against the wall, creating a safety haza		
	Resident #1 was disc	three inches of space.			There were no other residents with the		
		the bed lying face down			behaviors that had beds pushed agains the wall.) L	
		er body slightly leaning			uic waii.		
		rd on the wall keeping her			The Director of Nursing and Nurse		
	_	y flat on the floor. Resident			Managers implemented education to		
		facility staff and found not to			licensed nurses and certified nurses		
	have a pulse or respi	rations so cardiopulmonary			assistants on the fall management ,		
	resuscitation (CPR) v	vas started by the facility			restraint management, and behavior		
		/ paramedics. Resident #1			management policies, with a focus on t	.he	
		his deficient practice was for			potential creation of safety hazard of		
		wed for accidents (Resident			pushing a bed against the wall, and the		
	#1).				potential of the bed against the wall be		
	Immediata isanardu k	agan an 6/12/24 when			a restraint on 6.21.24. Additionally, the		
		pegan on 6/12/24 when covered wedged between the			is a focus on Behavioral Interventions t utilize for residents displaying behavior		
		e down without pulse and			attempts to self exit beds unsafely. Any		
		e jeopardy was removed on			nursing staff not educated will receive t		
	6/22/24 when the fac				education prior to their next scheduled		
		illegation for immediate			shift and will be included in the orientat	ion	
		e facility will remain out of			of new nursing staff.		
		e and severity level grid of D					
		potential for more than			The Director of Nursing (DON) or		
		not immediate jeopardy) to			Assistant Director of Nursing (ADON) v		
		stems put in place are			complete an audit of incident and accid		
	effective and all staff	have been in-serviced.			reports for falls with a new intervention	of	
					placing the residents with their bed		
	The findings included	l:			against the wall daily for five days, ther	1	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345389	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	343303		STREET ADDRESS, CITY, STATE, ZIP COI	•	6/26/2024	
THE LAU	RELS OF FOREST GLEN	IN		1101 HARTWELL STREET GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	diagnoses including chronic obstructive p and dementia. Resident #1 was car full code and for a ris decreased range of r plan included the intebed as of 11/15/23 a her bed in the lowest 5/13/24. Resident #1's June 2 included an order da liters per minute as r breath. Risperdal (ar milligrams (mg) at be order dated 5/28/24 both sides of the bed A Physical Device As read Resident #1 wa for bilateral assist ba mobility on readmiss The quarterly Minimulating from side to sino restraints and code A progress note writt 6/10/24 at 2:41 AM r wanting to get out of roommate for help. Tabout 2 to 3 hours. V	nitted on 10/11/23 with congestive heart failure, ulmonary disease, psychosis e planned on 10/12/23 as a sk for falls related to her motion and pain. The care ervention of assist bars to her and the intervention to keep exposition was added on 2024 Physician orders ted 5/27/24 for Oxygen at 2 seeded for shortness of attipsychotic medication) 0.25 addime for psychosis and an for bilateral assist bars up on a to increase bed mobility. Seessment dated 5/28/24 as re-evaluated and approved rs to increase her bed ion. Im Data Set dated 5/31/24 1 had severe cognitive partial staff assistance de, a weight of 275 pounds,	F 68	weekly for three weeks and the for three months, starting on validate continued compliance. The Audits will be submitted QAPI Committee by the DON ADON for review and further indicated to sustain compliance.	6/21/24, to ce. monthly to N and or actions as		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED: ` ´		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345389	345389 B. WING		06/26/2024		
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN				STREET ADDRESS, CITY, STATE, ZIP CO 1101 HARTWELL STREET GARNER, NC 27529		00/20/2024	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	continue to monitor. A telephone Interview at 1:25 PM with Nurs was assigned Reside PM to 7:00 AM on 7/ experiencing extreme stated her behaviors roommate's name, ke repeatedly trying to gasking for her son. No could not sit with her decided to move Resided to move Resided to find the regular position in the right side of the bed as tated he did this to be getting out of bed an potential accident ha could not recall if Resided to the right side of her recalled one assist but A telephone interview at 3:10 PM with NA #6/9/24 and 6/10/24 on NA #8 stated on 6/9/2 was yelling, bothering other residents awak to get out of her bed. To move Resident #1 room to up against the room to up against the red was blocked this was done to kee get up out of her bed throw her legs over the facility of the stated he thous because the stated he thous because the stated he the stated he thous because the stated he thous because the stated he the stated	w was completed on 6/19/24 te #1. Nurse #1 stated he tent #1 on 6/9/24 from 7:00 10/24 when she was te behaviors that night. He were yelling out, calling her	F 68				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345389	345389 B. WING		,	C 06/26/2024	
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN			STREET ADDRESS, CITY, STATE, ZIP COD 1101 HARTWELL STREET GARNER, NC 27529		012012024	
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page	e 25	F 68	39			
	at 3:02 PM with Nurs 7:00 AM to 7:00 PM or Nurse #4 stated Nurse morning that Resider night, yelling out and She stated Nurse #1 #1's bed up against to keep her from falling not consider it unusuresidents with their board of the consider it unusuresidents with Resident #1 was sittle the hallway around 1 Resident #1 was sittle the hallway around 1 Resident #1 stated the asked NA #2 to assist back to bed using the with giving her a bath Resident #1 was tired take a nap. NA #1 stated the hallway around 1 Resident #1 was tired take a nap. NA #1 stated the low recall Resident #1's to bars attached to her low recall Resident #1's to bars attached to her low recall Resident #1 was con PM with NA #2. She stransfer Resident #1 the bed on 6/12/24 at PM. NA #2 stated the raised to approximate #1 was going to take Resident #1 was kno bed and she was unstated.	inpleted on 6/19/24 at 1:00 lled working first shift on the #1. She stated after lunch, and up in her reclining chair in the incomposition of the working up in her reclining chair in the incomposition of the work better in her reclining on the properties of the position of the work					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345389	345389 B. WING			C 06/26/2024	
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN			STREET ADDRESS, CITY, STATE, ZIP COI 1101 HARTWELL STREET GARNER, NC 27529	•	35/25/2024	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	redirect. NA #2 states she had observed Re against the wall. She was not left in the low recollection since it wand moved away from provided. NA #2 did regainst the wall and leaving the room. She assist bars on Reside 1-2 inches of room be and she did not conson an accident hazard. A telephone interview at 2:51 PM with MA # working on 6/12/24 fr. Resident #1. She stated the respective of the provided states out for help saying R. She stated she respective face down in betw. MA #2 stated UM #1 on her. MA #2 stated position when she was stated she did not question when she was stated by the stated of the provided she was stated to	was extremely difficult to d that this was the first day esident #1's bed pushed up stated Resident #1's bed west position based on her was raised to provide care in the wall while care was recall placing the bed back locking the brakes prior to be stated there were bilateral ent #1's bed that left about etween her bed and the wall lider the bed against the wall was completed on 6/19/24 #2. She stated she was from 7:00 AM to 7:00 PM with the she heard NA #4 calling esident #1 was on the floor. Indeed to the room and saw ween the bed and the wall, and Nurse #2 were working the bed was not in a low as in the room earlier. She estion Resident #1's bed wall because she assumed eam (IDT) team had put it in	F 68	39			

AND PLAN OF CORRECTION IDENTIFICATION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345389	B. WING			C	
NAME OF PR	ROVIDER OR SUPPLIER	04000		STREET ADDRESS, CITY, STATE, ZIP CODE		6/26/2024	
				1101 HARTWELL STREET			
THE LAURELS OF FOREST GLENN			GARNER, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page	e 27	F 6	89			
F 689	3:45 PM. It was at this Resident #1's door to assumed her RP was stated she was award been pushed up againg get out of the bed on tended to throw her let the bed when trying the would not have consing against the wall an accordance of the assumed stated when he obsectored, he assumed stated when he assumed sher. He said he leaned opposite Resident #1's her call out his name it since he assumed sher. He said he leaned opposite Resident #1 other residents when too long for staff to be Resident #1. The RP PM when he decided gently open the door that when he saw the right foot on top of her	e between 3:30 PM and s time she observed her room closed so she in the room visiting. NA #3 e that Resident #1's bed had nst the wall so she could not the right side because she egs over to the right side of o get up. NA #3 stated she dered Resident #1's bed	F 6	89			
	outside her room and stated he then attemp from the wall to see F	g, so he stuck his head I asked staff to get help. He Dited to pull the bed away Resident #1. He said the en locked because it was					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345389	B. WING _			C 06/26/2024
	ROVIDER OR SUPPLIER RELS OF FOREST GLEN	N		STREET ADDRESS, CITY, STATE, ZIP COL 1101 HARTWELL STREET GARNER, NC 27529	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	
F 689	pulled out and the he enough to see that R responsive and her c stated staff entered th stated they turned he EMS arrived, but they When asked approxinhe think was between he found her, he stated Resident #1's position when he four seen her bed up againstated Resident #1 hand her bed. A telephone interview at 1:10 PM with NA # walking down the hal opened her door and because Resident #1 she could not see Reshe stated once she walked over to the error Resident #1 lying on and the wall. She stated she did not know the head of the wall and the foot of assisted him in pulling for staff to roll her and stated she did not know the wall and the foot of Resident #1 on the flebed was not in its low. An interview was comp. Method was comp. With NA #6. She details are stated to the state of the wall and the foot of Resident #1 on the flebed was not in its low.	e got the end of the bed ad of the bed out slightly esident #1 was not olor didn't look right. The RP ne room and took over. He rover and started CPR until were unable to revive her. mately how much space didn't he bed and the wall when ed just a few inches. The RP bed was not in the lowest nd her and that he had never nst the wall before. He ad bilateral assist bars on was completed on 6/26/24 4. She stated she was lway when Resident #1's RP stated he needed help was on the floor. She stated sident #1 from the doorway, entered the room and ad of the bed, she could see the floor in between the bed ted the RP had already the bed some, but she gout the bed more to allow diperform CPR. NA #4 bow how much space was the wall prior to her fall but see to four inches between of the bed when she saw bor. She also recalled the	F	689		

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345389	B. WING _			C 06/26/2024
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529		00/20/2024
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
		F 6	889		
was known to displacontinuously tried to her bed was supposed when she was in it. It door being closed the room for a visit. She that he wasn't in her the floor between the the floor f	y agitation, disrobe and get out of her bed. She said ed to be in the lowest position NA #6 recalled Resident #1's inking her RP was in the stated she was not aware room until he found her on a bed and the wall. Impleted on 6/19/24 at 9:45 e stated Resident #1 had a er feet over the side of the unassisted. UM #1 stated it on 6/10/24 by Nurse #4 that berienced increased anxiety t shift on 6/10/24 and that ling, calling out for her ner and trying to get up out of Nurse #4 stated that Nurse hat he moved her bed from m to be flush against the wall hagainst the wall near the stated she did not question d nor did she consider the as an accident hazard. When a rationale for the bed being he wall, UM #1 stated it was to to get out of the bed and all on 6/12/24 at approximately NA #4 calling for help to NA #4 stated the RP found alloor between the bed and the did Nurse #2 to retrieve the lat contains all the supplies alled in the event of a				
to the room, the RP	was standing at the foot of				
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENT REGULATORY OR Continued From page assigned Resident # was known to displa continuously tried to her bed was suppose when she was in it. I door being closed the room for a visit. She that he wasn't in her the floor between the floor be	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ROVIDER OR SUPPLIER RELS OF FOREST GLENN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 assigned Resident #1. She stated Resident #1 was known to display agitation, disrobe and continuously tried to get out of her bed. She said her bed was supposed to be in the lowest position when she was in it. NA #6 recalled Resident #1's door being closed thinking her RP was in the room for a visit. She stated she was not aware that he wasn't in her room until he found her on the floor between the bed and the wall. An interview was completed on 6/19/24 at 9:45 AM with UM #1. She stated Resident #1 had a history of throwing her feet over the side of the bed trying to get up unassisted. UM #1 stated it was reported to her on 6/10/24 by Nurse #4 that Resident #1 had experienced increased anxiety on the previous night shift on 6/10/24 and that Resident #1 was yelling, calling out for her roommate to assist her and trying to get up out of the bed unassisted. Nurse #4 stated that Nurse #1 reported to her that he moved her bed from the center of her room to be flush against the wall with the headboard against the wall near the hallway door. UM #1 stated she did not question the bed being moved nor did she consider the bed against the wall as an accident hazard. When questioned as to the rationale for the bed and falling. UM #1 stated on 6/12/24 at approximately 4:15 PM, she heard NA #4 calling for help to Resident #1's room. NA #4 stated the RP found Resident #1 on the floor between the bed and the wall. She summoned Nurse #2 to retrieve the crash cart (a cart that contains all the supplies and equipment needed in the event of a cardiopulmonary arrest). UM #1 stated upon entry to the room, the RP was standing at the foot of	A BUILDING 345389 ROVIDER OR SUPPLIER RELS OF FOREST GLENN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY THE PROVIDER'S PLAN OF CORRECTIVE ACTION & CROSS-REFERENCED TO THE ACTION OF CREDIC CROSS-REFERENCED TO THE	A BUILDING 345389 ROWDER OR SUPPLER RELS OF FOREST GLENN SUMMARY STATEMENT OF DEFICIENCES GLOAD DEFICIENCY MUST REPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 assigned Resident #1. She stated Resident #1 was known to display agitation, disrobe and continuously tried to get out of her bed. She said her bed was supposed to be in the lowest position when she was in it. NA #6 recalled Resident #1's door being closed thinking her RP was in the room for a vistl. She stated she was not aware that he wasn't in her room until he found her on the floor between the bed and the wall. An interview was completed on 6/19/24 at 9-45 AM with UM #1. She stated Resident #1 had a history of throwing her feet over the side of the bed trying to get up unassisted. UM #1 stated it was reported to her on 6/10/24 by Nurse #4 that Resident #1 had experienced increased anxiety on the previous night shift on 6/10/24 and that Resident #1 had experienced increased anxiety on the previous night shift on 6/10/24 and that Resident #1 had experienced increased anxiety on the previous night shift on 6/10/24 and that Resident #1 had experienced increased anxiety on the previous night shift on 6/10/24 and that Resident #1 was welling, calling out for her roommate to assist her and trying to get up out of the bed unassisted. Nurse #4 stated that Nurse #1 reported to her that he moved her bed from the center of her room to be flush against the wall with the headboard against the wall to Wall that the hallway door. UM #1 stated she did not question the bed being moved on paginst the wall uM #1 stated it was to keep her from trying to get out of the bed and falling. UM #1 stated on 6/12/24 at approximately 4.15 PM, she heard NA #4 calling for help to Resident #1 on the floor between the bed and the wall. She summoned Nurse #2 to retrieve the crash cart (a cart that contains all the supplies and equipment needed in the event of a cardiopulmonary arrest). UM #1 stated upon entry to the room, the RP was standi

AND PLAN OF CORRECTION IDENTIFICATION NU		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345389	B. WING _			C 6/26/2024	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN			STREET ADDRESS, CITY, STATE, ZIP COI 1101 HARTWELL STREET GARNER, NC 27529	•	0/20/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	bed and the wall and Resident #1. She sta lowest position at the and she could not recon the side of the bed wall. UM #1 stated R to the touch, absent as CPR was initiated. A telephone interview at 3:00 with Nurse #2 6/12/24 from 7:00 AN but she responded to UM #1. Nurse #2 star room, Resident #1 with between her bed and had already been pull and UM #1 could roll. She stated the staff k position, but it was the of this fall. A review of an incided 4:38 PM read, Resided (RP) opened her door assistance. An aide staff assistance. Resher right-side face do her bed on the floor. while her RP moved the way. Resident #1 were requested along to call emergency meannounce a "code blicardiac arrest). Cardia (CPR) started and tall	them to get between the turn her over to assess ted the bed was not in the time she entered the room, call if there was an assist bar d (right) that was against the esident #1 was blue, warm of any pulses or respirations	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345389	B. WING		C 06/26/2024	
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	1 00/20/2027	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 689	at 2:23 PM with the stated Resident #1's he could not make at the bed and when it had bilateral assist to the bed and when it had bilateral assist to the bed at 3:18 PM with the stated when Reside picked up on 6/13/2 good condition and attached to the bed. On 6/20/24 at 3:40 FDON, ADON and the Coordinator, UM #1 what occurred on 6/fall. This description with a non-bariatric the wall in the same bed would have bed described entering to of the bed had been approximately 18 to approximately 8 inch observed Resident #1 body lying against the slightly leaning into a nonresponsive. UM the bed out of the wall and had not have bed out of the wall and had not have bed out of the wall and had not have bed out of the wall and had not have bed out of the wall and had not had not bed out of the wall and had not had not bed out of the wall and had not had not bed out of the wall and had not had not bed out of the wall and had not had not bed out of the wall and had not be a state of the wall an	Maintenance Director. He is bariatric bed was a rental so any alterations or repairs to was picked up on 6/13/24, it bars in place. We was completed on 6/25/24 Bed Supplier Manager. He int #1's bariatric bed was 4, the bed was received in returned with assist bars PM, in the presence of the Regional Clinical provided a description of 12/24 involving Resident #1's was done in an empty room bed that was placed against position as Resident #1's in in on 6/12/24. UM #1 the room and noting the foot pulled away from the wall 20 inches at the foot and the at the head when she with the right side of her for while the left side of her for while the left side of her for while the left side of her for wall. She described her as #1 stated somebody moved any further and they rolled for back and noted she was not to pulse.	F 68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE COI IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMP	SURVEY PLETED	
						1 ,	С
		345389	B. WING				26/2024
NAME OF P	ROVIDER OR SUPPLIER	!	l		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2024
				,	1101 HARTWELL STREET		
THE LAUF	RELS OF FOREST GLI	ENN			GARNER, NC 27529		
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From pa	age 32	F	689			
	·	1's room and noticed her door					
		stated this was between 3:30					
		e DON stated NA #3 assumed					
	Resident #1's RP v	vas in the room for a visit. The					
	DON stated at appr	roximately 4:05 PM, the RP					
	came to the facility	for a visit but stopped at the					
		alk to Unit Manager (UM) #1					
	first. She stated he	then walked down the hall to					
	Resident #1's room	and noted the door closed					
	assuming staff wer	e in the room providing					
	•	DON stated he was waiting in					
		g with other residents until he					
		l on the door and stuck his					
		stated that was when the RP					
		esident #1 on the floor in					
		nd the wall with her right foot					
		the bed. The DON stated he					
		of the room and yelled for					
		alking down the hallway to get #5 was in another room but					
		noom. The DON stated next UM					
		rrived in the room with the					
		pulled the foot end of the bed					
		rses to roll Resident #1 over to					
		iate CPR. The DON stated					
		al Services (EMS) and the					
		fied. She stated when EMS					
		ned care of Resident #1 and					
	pronounced her de	ceased at 5:00 PM. She stated					
	when Police Office	r #1 arrived, he never entered					
	the room but rather	r, once the code was over,					
	Police Officer #1 sp	ooke with the RP at that time.					
	The DON stated sh	ne was not aware that Resident					
		moved up against the wall.					
		er investigation included staff					
		me of the incident and review					
	of the incident repo	ort. She stated that was the					
		's investigation and at no time					
	did the facility cons	ider moving Resident #1's bed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345389	B. WING _			C 06/26/2024	
	ROVIDER OR SUPPLIER	NN		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529		00/20/2024	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From pag	ge 33	F 6	89			
	DON stated she did assist bars were inve	as an accident hazard. The not investigate whether her olved in the events nt #1's fall and subsequent					
	PM with Police Offic arrived at the facility Resident #1's RP dis down with the right I mattress. Police Offi with the RP in the ha he contacted Medica that there were no si	mpleted on 6/19/24 at 5:00 er #1. He stated when he , staff reported to him that scovered her on the floor face eg still partially on the cer #1 stated after he spoke allway after the code ended, al Examiner #1 and reported uspicious circumstances #1's death and he did not warranted.					
	at 2:35 PM with Med recalled Police Office 6/12/24 regarding Rereport that Police Off Resident #1 was four and not on the floor. was nothing suspicite to be from natural castated had she known how Resident #1 was up to the RP if he would have a state of the RP	w was completed on 6/21/24 dical Examiner #1. She er #1 contacting her on esident #1. She read from her ficer #1 stated to her that and unresponsive in her bed She read he reported there bus and her death appeared auses. The Medical Examiner on about the actual details of its found, it would have been build have wanted an autopsy. w was completed on 6/25/24 amedic #1 who responded to					
	the code at the facili He recalled that whe room, the facility sta performing CPR. He Resident #1 was fou	ty on Resident #1 on 6/12/24. en he arrived at Resident #1's ff were in the process of e stated staff reported that and on the right side of the at the facility staff did not					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345389	B. WING			C 06/26/2024
	ROVIDER OR SUPPLIER	NN		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529		1012012024
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	never regained a puchange was seen be beats) again. He states 5:00 PM. A telephone intervie at 12:59 PM with NF aware that Resident up against the wall a approved it because behaviors of attemp unassisted along wipossible entrapmen. A telephone intervie at 11:07 AM with the being found on the fithe wall, it would not death. He stated she embolism (a sudder arteries) or due to h MD stated her death.	arallen. He stated Resident #1 Ise and only a brief rhythm efore asystole (no heart ited the code was called at w was completed on 6/20/24 P #1. She stated she not #1's bed had been moved to and likely would not have of fears of her known ting to get out of her bed th the risk of injuries and	F 6			
	subsequent fall did in because she could be bed on the left side. The Administrator with jeopardy on 6/20/20. The facility provided allegation of immediate competition date of light left.	as notified of the immediate 24 at 11:55 AM. the following credible ate jeopardy removal with a 6/22/24: ents who have suffered, or a serious adverse outcome as				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345389	B. WING		C 06/26/2024	
	ROVIDER OR SUPPLIER	ENN		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	1 00/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 689	Continued From pa	ge 35	F 68	9		
	failed to have licens that were able to de skills and technique behavior and attem restrained Resident the bed against the other staff who subsesident #1 recogn resident's movemer life-threatening haz unconscious and with bed. Resident # An incident and accompleted by the liginitiated by the Dire Other residents that deficient practice in behaviors identified bed unsafely. The Enurse managers ev 6.21.24, residents to get out of bed unbeds were pushed a safety hazard. Ther these behaviors that the wall. Specify the action the process or system of adverse outcome from when the action will.	ard. Resident #1 was found edged between the wall and edged on 6/12/24. Sident report form was beensed nurse at the time of the edgetion of the incident was cotor of Nursing on 6/13/24 at may be at risk for the same clude those residents with with attempts to get out of Director of Nursing (DON) and aluated like residents on that are fall risk and attempting assisted, to ensure no other against the wall, creating a re were no other residents with the had beds pushed against the entity will take to alter the failure to prevent a serious om occurring or recurring, and the complete.				
		by the Licensed Nursing r (LNHA), DON, Regional				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345389	B. WING _		_		26/2024	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN				STREET ADDRESS, CITY, ST 1101 HARTWELL STREET GARNER, NC 27529	ATE, ZIP CODE	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECT CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	determined that the larelated to the potential to the deficient praction nurse not using alternaddressing the reside the bed unsafely. The Director of Nursi implemented education certified nurses assist management, restrain behavior management the potential creation a bed against the wallowed against	RCC) on 6/20/24, it was ack of staff knowledge al safety hazard contributed ce, as well as the licensed native methods of ents behavior of self exiting and Nurse Managers on to licensed nurses and stants on the fall nt management, and nt policies, with a focus on of safety hazard of pushing ll, and the potential of the being a restraint on 6.21.24. It is focus on Behavioral erfor residents displaying is to self exit beds unsafely. It is educated will receive this ein next scheduled shift and er orientation of new nursing on the education was verbally with opportunity for arification regarding the transagement policy and investigation guidelines for is, how to develop a root the implementation of se for incidents. Additionally, received education from the ral management policy with	F	589				
	time.	avioral interventions at that ne immediate jeopardy was						

	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
				_		С	
		345389	B. WING			06/	26/2024
	ROVIDER OR SUPPLIER	N		1	STREET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	removal plan was conwere interviewed to vompleted on the fall management and behinclude the potential subed against the wall. Tocus on behavioral in displaying behaviors bed unsafely was conreview of the education Licensed Nursing Holand DON regarding the management policy, gubehavioral management be completed. The implementation of 6/22/24 was worked to competent Nursing SCFR(s): 483.35(a)(3) Section 18483.35 Nursing Service The facility must have the appropriate computer provide nursing and resident safety and at practicable physical, well-being of each resident assessments and considering the indiagnoses of the faciliaccordance with the faciliaccordance with the faciliaccordance nurses have	ne immediate jeopardy npleted on 6/26/24. Staff alidate in-services were management, restraint navior management to safety hazard of pushing a The in-service included a nterventions for residents of attempting to self-exit the firmed to be completed. A on completed by the me Administrator (LNHA) ne incident and accident general investigations and ent policy were confirmed to mediate jeopardy removal alidated. taff (4)(c) vices e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care number, acuity and ity's resident population in accility assessment required		726			7/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED	
	345389		B. WING		C 06/26/2024		
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	, 00	1/20/2024	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 726	§483.35(a)(4) Provided limited to assessing, implementing resider to resident's needs. §483.35(c) Proficience The facility must ensite to demonstrate complete facility. Based on record revinterviews with staff, Medical Director (MD (NP), Police Officer # Medical Examiner (MI) the Bed Supplier Mar demonstrate compete putting the bed again cognitively impaired registation and restless accident hazard. Nur #1's right side of her prevent her from gett #1 fell out of the right the bed and the wall by her RP on the flood body slightly leaning keeping her from bein floor. She was found respirations. Cardiop (CPR) was started by	recorded in the plan of care. Ing care includes but is not evaluating, planning and at care plans and responding by of nurse aides. In the that nurse aides are able etency in skills and y to care for residents' incough resident escribed in the plan of care. It is not met as evidenced are is not met as evidenced are, observations and responsible Party (RP), have Practitioner #1 and responsible Party (RP), have Practitioner #1 and responsible plant for a severely esident with anxiety, and and are	F 7:	Resident #1 expired on 6/12/24 Other residents that may be at a same deficient practice include residents with behaviors identificattempts to get out of bed unsate Director of Nursing (DON) and a managers evaluated like reside 6.21.24, residents that are fall reattempting to get out of bed unsate mosure no other beds were pussagainst the wall, creating a safe. There were no other residents where the wall. Nurse # 1 received 1:1 education 6/19/24 by Director of Nursing (the restraint and abuse policy a procedure with a focus on a beat the wall needing to be evaluated as options to address residents attempting to get out bed.	risk for the those ed with fely. The nurse nts on sisk and assisted, to hed ty hazard. with these d against on on DON) on and d against d as well	et Page 30 of 45	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	i			
		345389	B. WING		,	C 06/26/2024	
NAME OF P	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP COD	•	012012024	
				1101 HARTWELL STREET			
THE LAUF	RELS OF FOREST GLEN	IN					
				GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG				
F 726	Continued From page	e 39	F 72	6			
	residents reviewed for		' ' '	On 6/21/24, the Director of N	ureina wae		
	residents reviewed id	or restraints.		provided education on the res			
	Immediate Jeopardy	hogan 6/12/24 whon		abuse policy with a focus on			
		ind on the floor wedged		the wall potentially being a re			
	between the bed and			well as addressing residents'			
		lid not identify the position of		to get out of bed and options			
	the bed as a restraint	·		this behavior, by the Regiona			
		was removed on 6/22/24		Coordinatorn(RCC). The edu			
	when the facility impl			provided, in person, verbally			
		ate jeopardy removal. The		opportunity for discussion and			
		t of compliance at a lower		clarification.			
		f D (no actual harm with a		On 6/20/24, the Director of N	ursing and		
		harm that is not immediate		the Nurse Managers initiated	•		
	•	nonitoring systems put in		the restraint, abuse, and beha			
	place are effective.			for licensed nurses and aides	with an		
				emphasis on the potential of	pushing a		
	The findings included	d:		bed against the wall being a r	estraint. The		
				education was provided, in pe	erson,		
	This tag is cross refe	renced to:		verbally with opportunity for d	liscussion		
				and/or clarification. Licensed	nurses and		
		ervations, staff, Responsible		nursing assistants will continu			
	Party (RP), Medical [this education prior to their ne			
		and Paramedic #1 interviews		scheduled shift until all have			
		hen the facility moved the		educated. This education will also be			
	_	st the wall to prevent her		provided to new nursing staff	-		
		e bed, they failed to identify		orientation. The Director of N	-		
		led to complete a restraint		Assistant Director of Nursing			
		o obtain a physician order		Managers have conducted ob			
		ne RP's consent for the use		audits of residents in bed, wit			
		the resident fell out of the		whether the bed is pushed ag			
	_	between the bed and the		wall. This was completed on	6/21/24.		
		s assessed by facility staff		TI D: (() ()	15		
		e a pulse or respirations.		The Director of Nursing (DON	,		
		suscitation (CPR) was		Assistant Director of Nursing			
		staff and assumed by		complete an audit nursing sta	-		
	-	nt #1 expired on 6/12/24.		recognize that the bed being			
	This was for 1 of 3 re			against the wall as a behavio			
	restraints (Resident #	<i>†</i> 1 <i>)</i> .		management intervention car			
				restraint and an accident haz	ard. This Will		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			D. MAILING			1	C
345389			B. WING			06/	26/2024
	ROVIDER OR SUPPLIER RELS OF FOREST GLEN	N		11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET 6ARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROPRIES OF CROSS-REFERENCED TO THE APPROPRIES OF CROSS-REFERENCED TO THE APPROP			(X5) COMPLETION DATE
F 726	F689: Based on reconnectivities with staff, Supplier Manager, Meractitioner #1 (NP), #1 and Medical Examfailed to keep Reside hazards by placing he trying to restrict her frimplement fall interver #1's bed remained in Resident #1 fell out obetween her bed and approximately two to Resident #1 was discipled between the wall and with the left side of he against the base boar from being completel #1 was assessed by have a pulse or respiresuscitation (CPR) was assumed by expired on 6/12/24. Tof 3 residents revier #1). Review of the facility indicated the most received #1. Review of the facility indicated the most received #1. Review of the facility indicated the most received #1. Review of the facility indicated the most received #1. Review of the facility indicated the most received #1. Review of the facility indicated the most received #1. Review of the facility indicated the most received #1. Review of the facility indicated the most received #1. Review of the facility indicated the most received #1. Review of the facility indicated the most received #1. Review of the facility indicated the most received #1.	rd review, observations and Responsible Party (RP), Bed edical Director (MD), Nurse Police Officer #1, Paramedic niner (ME) #1 the facility nt #1 free from accident er bed against the wall and rom getting out of bed and entions ensuring Resident the lowest position. If the right side of her bed in the wall where there was three inches of space.	F	726	be completed by nursing staff interview daily for five days, interviews will be completed for three nursing staff daily five days, then three nursing staff weel for three weeks and then nursing staff monthly for three monthly for three months to validate continued complian. The Audits will be submitted monthly to the QAPI Committee by the DON and ADON for review and additional action needed to sustain compliance.	for kly ce. o	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	()	(X3) DATE SURVEY COMPLETED	
		345389	B. WING			С	
NAME OF D	ROVIDER OR SUPPLIER	343309	B. WING	STREET ADDRESS, CITY, STATE, ZIP C		06/26/2024	
	RELS OF FOREST GL	ENN		1101 HARTWELL STREET GARNER, NC 27529	ODL		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 726	stated the facility of Development Coorden filling in with a ensuring certification stated the facility of system that was provided the year and the property of the risk are straint, the different facility's effort to convironment, alternative associated with stated it was not upprestraints but rather team after an asseonder and written of She stated the annual ready set up. She stated the annual ready set up. She stated she had retraining on again was still work to be a new hire on 5/29. Employee Facility of that was completed anything on it regally unable to find any checklist. The Administrator of Jeopardy on 6/20/27. The facility provided the stated provided the facility of the facility provided the facility of	or of Nursing (DON). She id not currently have a Staff dinator (SDC) so she had general orientation and ons were not expired. She tilized an electronic education ogrammed for different training for the staff at certain times of revious restraint training was tated the training included a ssociated with implementing a sent types of restraints, the eate a restraint free natives to restraints and the natives to have a same of side rails. She to the floor nurses to initiate are to the nursing management ssment, obtaining a Physician consent from the resident's RP. Inval training for 2024 was a stated it was clear that the function and clarification on the national accident hazards. It is all the staff completed on 6/19/24 but clearly, there are done. She stated NA #1 was 1/24 and apparently the New General Orientation Checklist is with NA #1 didn't have reding restraints and she was kind of orientation competency	F	726			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345389	B. WING _			1	C 26/2024	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN			•	1101 HA	ARTWELL STREET ER, NC 27529			
(X4) ID PREFIX TAG			ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 726	Continued From page	e 42	F	726				
		nts who have suffered, or serious adverse outcome as npliance:						
	failed to have license that were able to dem skills and techniques behavior and attempt restrained Resident # the bed against the w nor other staff who su for Resident #1 recogresident's movements life-threatening hazar unconscious and weet the bed. Resident #1 Other residents in the of trying to get out of there were no other rehad pushed the bed a residents in bed. This by the Director of Nur Specify the action the process or system fail	d. Resident #1 was found alged between the wall and expired on 6/12/24. It facility that have a behavior bed were reviewed and esidents noted that the staff against the wall to keep the was completed on 6/21/24 asing. It is entity will take to alter the lure to prevent a serious moccurring or recurring, and						
	Director of Nursing or policy and procedure							
	education on the rest	etor of Nursing was provided raint and abuse policy with a st the wall potentially being a						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345389	B. WING		C 06/26/2024	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN			1	STREET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET BARNER, NC 27529	1 00/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 726	attempting to get ou address this behavic Coordinator. The experson, verbally with and/or clarification. On 6/20/24, the Dire Managers initiated eabuse, and behavious and aides with an epushing a bed again. The education was with opportunity for Licensed nurses an continue to receive next scheduled shift. This education will an ursing staff during. The Director of Nurse observational audits focus on whether the wall. This was computed against the wall intervention is a rest to complete prior to against the wall. The facility alleges of immediate jeopardy.	addressing resident's at of bed and options to or, by the Regional Clinical ducation was provided, in the opportunity for discussion ector of Nursing and the Nurse education on the restraint, ral policy for licensed nurses emphasis on the potential of the state wall being a restraint. The provided, in person, verbally discussion and/or clarification. In discussion and/or clarification. In this education prior to their the thin and the second to new orientation. Sing, Assistant Director of Managers have conducted as of residents in bed, with a elebed is pushed against the	F 726			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345389	B. WING			C		
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN				STREET ADDRESS, CITY, STATE, ZIP CO 1101 HARTWELL STREET GARNER, NC 27529	DDE	06/26/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIAT	COMPLETION DATE		
F 726	An onsite validation of removal plan was core of Nurse #1's education abuse policy was correview of the DON's and abuse policy and attempts to get out of completed. Staff were in-services were command behavioral policy against the wall was will also be provided orientation. A review bed with a bed against be completed.	of the immediate jeopardy impleted on 6/26/24. A review on on the restraint and offirmed to be completed. A reducation on the restraint addressing resident's bed was confirmed as interviewed to validate pleted on restraint, abuse to include pushing a bed a restraint. This education to new nursing staff during of the audits of residents in set the wall were confirmed to ardy removal was validated	F	726				