

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE LAURELS OF FOREST GLENN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 HARTWELL STREET GARNER, NC 27529</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 600 SS=D	<p>Free from Abuse and Neglect CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews the facility failed to protect a resident from physical abuse inflicted by an employee during incontinent care for 1 of 3 residents (Resident #1) reviewed for abuse.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 11/27/2019 with a diagnosis of hemiplegia following a cerebrovascular accident affecting the right dominant side (partial paralysis of a limb), muscle wasting and atrophy (progressive deterioration of body tissue), muscle weakness, dysphagia, major depression and anxiety.</p> <p>The Admission Minimum Data Set (MDS) dated 12/4/18 indicated Resident #1 was cognitively intact. He was assessed as having some slurred speech but was able to be understood by others.</p>	F 600	<p>The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is November 27, 2019.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.</p> <p>F600 Free from Abuse and Neglect</p> <p>Corrective Action Director of Nursing and Administrator</p>	11/27/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/22/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE LAURELS OF FOREST GLENN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 HARTWELL STREET GARNER, NC 27529</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 600	<p>Continued From page 1</p> <p>The assessment had documentation that the resident required extensive assistance of two staff for bed mobility, transfers, and hygiene and was always incontinent of bowel and bladder.</p> <p>During an interview with Resident #1 on 10/29/19 at 10:40AM, Resident #1 revealed that on the evening shift of 10/6/19, the Nurses Aide (NA) responded to his call light and entered his room to provide incontinent care. After incontinent care was provided by the NA, Resident #1 expressed that he didn't feel clean enough and asked the NA to give him the rag. He stated that the NA refused to give him the rag and said he had already cleaned him. Resident #1 again requested the rag to clean himself further and the NA refused to allow him to clean himself. The NA rolled him over in bed towards the wall and began to provide additional incontinence care. Resident #1 explained he then proceeded to roll onto his back in bed and again asked the NA for the rag. Resident #1 further revealed that the NA stated to Resident #1 he could not clean himself and threw the rag at him with frustration. The rag when thrown contacted Resident #1 groin/scrotum area at this time resulting in a pain described by Resident #1 as stinging. Resident #1 stated he tossed the rag back at the NA in the manner he had received it. He expressed the NA then proceeded to ball up the wet rag soiled with urine and feces and throw it at him, and the rag struck him in the right side of his cheek/ chin area and the NA began mocking his slurred speech from his stroke. He stated he made the hall nurse aware of the interaction, requested to speak to the social worker (SW) and asked that the NA not be assigned to him again.</p> <p>On 10/29/19 at 2:00PM, an interview with the</p>	F 600	<p>termed Nurses Aide (NA) on 10-8-19. Assisted Director of Nursing in-serviced all staff on the facility's Abuse Policy by 10-31-19.</p> <p>Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. Education has been provided to all staff to ensure staff keeps all residents free from abuse. The Social Worker and Social Worker Assistant will perform audits to ensure all residents are free from abuse by 11-26-19.</p> <p>Systemic Changes The Assistant Director of Nursing and nurse manager will educate all staff on the facility's abuse policy by 11-26-19.</p> <p>Monitoring The Director of Nursing and her nurse managers will perform an initial audit of all resident. Those audits will ask questions geared towards residents being free and clear from abuse. Then the Director of Nursing and/or her nurse managers will do audits (5) five times weekly for (1) one month and (3) three times weekly for (2) two months, with all residents geared towards being free and clear from abuse. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible for ensuring any further recommendations are carried out.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE LAURELS OF FOREST GLENN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 HARTWELL STREET</b> <b>GARNER, NC 27529</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 600	<p>Continued From page 2</p> <p>Director of Nursing (DON) revealed she was made aware of the incident in the afternoon on 10/8/19 by the SW. She stated she and the administrator notified the NA immediately via phone that he was being placed on suspension pending investigation of the incident. She stated following the investigation by the SW, the NA was then terminated from his employment. She reported he was hired in August 2019, he was provided education on abuse at that time, and she had no knowledge of any concerns with care provided by the NA prior to the incident. She stated following the incident, she and the SW interviewed all alert and oriented residents on the NA's assignment and no other concerns were voiced. She further stated she did not believe the incident occurred; however, the NA was terminated because the resident reporting the incident was cognitively intact and would be taken for his word. Additionally, she added a root cause analysis was not conducted nor further abuse education provided to staff following the incident as it was felt to be an isolated event.</p> <p>An interview with the social worker conducted on 10/29/19 at 2:27PM revealed that a note was left under her door by Resident #1's hall nurse on second shift on the night of 10/6/19. She stated she received the note on the following morning. She expressed she made several attempts to speak with Resident #1 during the day on 10/7/19 but was unsuccessful due to the resident's request for her to return later. On 10/8/19, the SW reported she went down to speak to the resident and he reported the incident with the NA. She stated Resident #1 expressed his anger and disgust with the treatment he had received by the NA stating he had been hit with the rag in the groin/scrotum area as well as in the face with the</p>	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE LAURELS OF FOREST GLENN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 HARTWELL STREET</b> <b>GARNER, NC 27529</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 600	<p>Continued From page 3</p> <p>rag that had feces on it. She stated Resident #1 expressed he didn't feel as though he would be treated in this manner if he was in better health. He further revealed he felt so disrespected that he would have "mopped the floor with the NA" had he been physically able. She further reported her investigation began immediately following speaking to Resident #1 on 10/8/19 at 12:30pm. She stated she made administrative staff aware of the incident and the named NA was placed on suspension pending investigation. She reported the NA has since been terminated.</p> <p>On 10/29/19 at 2:50PM, an interview with the NA was conducted via phone. He stated he was previously employed as a 3rd shift NA at the facility prior to being terminated on 10/8/19 after an allegation of abuse was made against him. When asked about the incident, he expressed he was shocked when he was made aware and placed on suspension. He stated he went into the resident's room on the night of 10/6/19 to provide incontinent care. He stated he provided Resident#1's normal incontinent care using a warm wet towel which was the resident's preference over a wash rag. He further revealed he felt the resident had been thoroughly cleaned when he was finished. The NA further expressed the resident asked him to clean him further. He then rolled Resident #1 onto his side to attempt to provide further care but the resident refused to allow him to clean his buttocks and rolled himself on his back. The NA stated the resident demanded to clean himself. The NA reported he gave him the towel. He further stated the resident then cleaned his own penis and rolled himself over to attempt to clean his bottom. He stated he placed a brief on the resident and left the room. He denied throwing the rag at any time or the rag</p>	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE LAURELS OF FOREST GLENN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 HARTWELL STREET</b> <b>GARNER, NC 27529</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 600	<p>Continued From page 4</p> <p>contacting the resident's scrotum or face while giving him the rag. He reported he was called on 10/8/19 to make him aware that he was suspended due to the incident.</p> <p>During an interview with Resident #1's hall nurse on 10/29/19 at 3:22 PM revealed she entered the resident's room on her last round of her shift on 10/6/19 between 10-11PM to check on the resident before leaving for the night. She stated Resident #1 made a request to speak to the social worker when she was available. She claimed he initially didn't tell her what he wanted to speak to the social worker; however, she further questioned him, and he proceeded to tell her about the incident with the NA whom he claimed threw the rag at him twice during incontinence care. She stated he told her that he did not feel cleaned after the incontinence care was provided by the NA and had made request to have the rag to clean himself, but the NA wouldn't allow him. She revealed she placed the note under the SW office door on Sunday night before she left the facility.</p> <p>An interview with the Administrator and DON on 10/30/19 at 8AM revealed the NA was terminated after the allegation was made by resident #1.</p>	F 600			