	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	PLE CONSTRUCTION G		ATE SURVEY
			A. BUILDIN	G		С
		345389	B. WING _			02/18/2022
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
	ELS OF FOREST GLEN	N		1101 HARTWELL STREET		
		in a second seco		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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		EO	00		
	was conducted on 02 found in compliance	OVID-19 Focused Survey 2/18/2022. The facility was with 42 CFR §483.73 (6), Subpart-B-Requirements Facilities. Event ID#				
F 000	INITIAL COMMENTS	; ;	F 0	00		
		VID-19 Focused Infection omplaint investigation were 2022.				
	One of the nine comp substantiated resulting	-				
	Administration CFR(s): 483.70		F 8	35		3/17/22
	enables it to use its r efficiently to attain or practicable physical, well-being of each re	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial				
	Based on observation interview and record provide effective over testing supplies were	n, family interview, staff review the facility failed to rsight to ensure COVID-19 available for testing ts and put transmission		The Laurels of Forest Glen have this submitted Plan of stand as allegation of comp date of compliance is 3/17/2	Correction to liance. Our	
	based precautions in of COVID-19 sympto Resident #12, Reside	place upon the identification ms for 5 (Resident #3, ent #13, Resident #14, and ampled residents. Findings		Preparation and/or execution of Correction does not const admission to, nor agreement the existence of, or the scop of, any of the cited deficient	titute nt with, either pe and severity	
	A. Cross refer to F88	6: Pasad on observation		conclusions set forth in the Deficiencies. This plan is pr	Statement of	

Electronically Signed

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.

02/28/2022

ATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	` '		(X3) D	NO. 0938-039 ATE SURVEY OMPLETED	
			A. BUILDING			C	
		345389	B. WING			02/18/2022	
IAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
HE LAUR	ELS OF FOREST GLE	NN		1101 HARTWELL STREET GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 835	Continued From pag staff interview, family	je 1 y interview, and record review	F 8	35 executed to ensure contir	nued compliance		
	upon the appearance	rovide COVID-19 testing e of symptoms for 5 #13, #14, #15) of 5 sampled		with regulatory requireme	ent.		
		positive for COVID-19		F835 Administration			
		/ID-19 outbreak. This		Upon discovery of the 5/5			
	occurred during a co	pronavirus pandemic.		were already covid recover intervention was needed			
	B Cross refer to F88	30: Based on staff interview		residents.	ior these		
		e facility failed to implement					
		ission based precautions		All residents have the pot	ential to be		
	upon the appearance			affected. Immediately, up			
	•	#13, #14, #15) of 5 sampled		alleged deficiency, The D			
		l positive for COVID-19		Nursing and Assistant Dir			
		/ID-19 outbreak. This pronavirus pandemic.		Nursing/Infection Control verified that covid testing			
		ionavirus pandemie.		immediately available and			
				that were symptomatic fo			
				immediately tested and			
				transmission-based preca			
				if applicable. No other co	ncerns identified.		
				Through our Quality Apou	ranaa		
				Through our Quality Assu Performance Improvement			
				potential root cause analy			
				identified as insufficient s			
				therefore, the Regional C			
				Coordinator educated The			
				Director of Nursing and A			
				of Nursing/Infection Contr on 2/18/2022 regarding s			
				symptoms of covid, notific			
				licensed nurse on duty, h			
				utilizing current testing su	ipplies,		
				immediate testing of resid			
				transmission based preca			
				applicable, location of tes	ang supplies and		

Facility ID: 923173

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY			
AND PLAN O	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED			
		0.45000	B. WING		C			
		345389		STREET ADDRESS, CITY, STATE, ZIP CODE	02/18/2022			
NAME OF P	ROVIDER OR SUPPLIER							
THE LAU	RELS OF FOREST GLEN	NN		1101 HARTWELL STREET GARNER, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION			
F 835	Continued From pag	e 2	F 83	Then, education was provided to a care staff by The Director of Nursing/Infect Preventionist by 2/28/2022 regard signs and symptoms of covid, not to the licensed nurse on duty, how utilizing current testing supplies, immediate testing of resident and transmission-based precautions w applicable, location of testing supplication if none available. Additionally, new hirers providing care will be educated upon hire ar least annually regarding signs and symptoms of covid, notification to licensed nurse on duty, how to test utilizing current testing supplies, immediate testing of resident and transmission-based precautions w applicable, location of testing supplies, immediate testing of resident and transmission-based precautions w applicable, location of testing supplies, immediate testing of resident and transmission-based precautions w applicable, location of testing supplicable. The Director of Nursing and/or De will ensure testing supplies are av to staff in the designated location accessible to staff in the event a r presents with signs and symptoms covid and needs to be tested. More of testing supplies will be complet times per week for two weeks, the weekly for four weeks, and then a determined by the Quality Assurance Meeting. Any variance identified will be addressed immediate integements.	ng and ction ling ification v to test initiating vhen blies and direct nd at d the st initiating vhen blies and esignee tailable esident s of nitoring ed five en three en s nce d/or Quality s			

Event ID: L6W311

Facility ID: 923173

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/14/2022 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345389	B. WING				C 18/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF FOREST GLEN	N		11	101 HARTWELL STREET		
				G	ARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From page	23	F	835	 indicated. Continued compliance will b monitored through the facility □s Qualit Assurance Program. The Administrator, Director of Nursing, and other staff members as assigned winterview at least 10 direct care staff members on their knowledge of where testing supplies are located if a resider presents with signs and symptoms of covid and needs to be tested and who contact if none available. Interviews will be completed five times per week for tweeks, then three times per week for tweeks, then weekly for four weeks, an then as determined by the Quality Assurance Committee □The administration and additional education provided where indicated. Continued compliance will b monitored through the facility □s Qualit Assurance Program. The Administrator, Director of Nursing, and other staff members as assigned winterview and/or observe 10% of reside for new signs and symptoms of covid at fapplicable, five times per week for tweeks, then three times per week for tweeks, then three times per week for tweeks, then three times as assigned winterview and/or observe 10% of reside for new signs and symptoms of covid at fapplicable, five times per week for tweeks, then three times	y will to ill wo wo d ator he nces ly en e y will ents and ce, vo wo d ator he	

Event ID: L6W311

Facility ID: 923173

If continuation sheet Page 4 of 58

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/14/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345389	B. WING		C 02/18/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
THE LAU	RELS OF FOREST GLEN	Ν		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 835	CFR(s): 483.80(a)(1) §483.80 Infection Cor The facility must esta infection prevention a designed to provide a comfortable environm development and trar diseases and infection	& Control (2)(4)(e)(f) htrol blish and maintain an nd control program a safe, sanitary and hent and to help prevent the hsmission of communicable	F 835	identified will be addressed immediate and additional education provided whe indicated. Continued compliance will b monitored through the facility □s Quali Assurance Program. The Administrator, Director of Nursing and other staff members as assigned interview at least 10 direct care staff members for new signs and symptoms covid of residents and if symptomatic, ensure they □re immediately tested an transmission-based precautions in pla if applicable, five times per week for tw weeks, then three times per week for tw weeks, then weekly for four weeks, an then as determined by the Quality Assurance Committee □The administra and/or Director of Nursing will take to Quality Assurance Meeting. Any varial identified will be addressed immediate and additional education provided whe indicated. Continued compliance will b monitored through the facility □s Qualit Assurance Program.	en be ty , will s of d ce, vo two id ator the nces en be

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345389	B. WING			C 02/18/2022	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF FOREST GLEN	Ν		1101 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	and control program (a minimum, the follow §483.80(a)(1) A syster reporting, investigatin and communicable di staff, volunteers, visite providing services und arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how isco resident; including bu (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possible circumstances. (v) The circumstances	blish an infection prevention IPCP) that must include, at ving elements: Im for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and bgram, which must include, lance designed to identify le diseases or can spread to other in possible incidents of se or infections should be smission-based precautions ent spread of infections; lation should be used for a t not limited to: attion of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the is under which the facility we with a communicable cin lesions from direct or their food, if direct	F	88			

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	O. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		345389	B. WING			C 02/18/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 •-	
				1	101 HARTWELL STREET		
THE LAU	RELS OF FOREST GLEN	IN		G	GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL 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 000		<u>^</u>	Í _				
F 880	1 0			880			
		e procedures to be followed irect resident contact.					
	§483.80(a)(4) A syste identified under the fa	em for recording incidents acility's IPCP and the					
	corrective actions tak	-					
	§483.80(e) Linens.						
		dle, store, process, and					
	infection.	s to prevent the spread of					
	§483.80(f) Annual rev						
		uct an annual review of its					
	This REQUIREMENT	ir program, as necessary. F is not met as evidenced					
	by: Based on staff interv	view and record review the			The Laurels of Forest Glenn wishes to		
	facility failed to imple				have this submitted Plan of Correction		
	transmission based p				stand as allegation of compliance. Our		
		toms for 5 (Residents #3,			date of compliance is 3/17/2022.		
		of 5 sampled residents who					
	tested positive for CC	OVID-19 during a facility			Preparation and/or execution of this PI	an	
		This occurred during a			of Correction does not constitute		
	coronavirus pandemi	ic. Findings included:			admission to, nor agreement with, eith		
					the existence of, or the scope and seve	erity	
	Documentation in the	-			of, any of the cited deficiencies or	of	
		oolicy, dated as last reviewed in part, "If a guest/resident			conclusions set forth in the Statement Deficiencies. This plan is prepared and		
		or symptoms consistent with			executed to ensure continued complia		
		est/resident in Transmission			with regulatory requirement.		
		nd test for SARS-CoV." The					
		Il recommended Covid-19					
		ctive equipment) should be			F880 Infection Prevention & Control		
		guests/residents under			Upon discovery of the 5/5 residents, the	iey	
	observation or in Trai				were already covid recovered, so no		
		ncludes use of an N95 or			intervention was needed for these		
		or (or surgical if a respirator is			residents.		
	not avallable), eye pr	otection (ie. goggles or a					

Facility ID: 923173

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TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DA	ATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED		
						С		
		345389	B. WING			02/18/2022		
NAME OF PF	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STAT	E, ZIP CODE			
	ELS OF FOREST GLEN	N		1101 HARTWELL STREET				
	ELS OF FOREST GLEN	N		GARNER, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIC DATE		
F 880	Continued From page	e 7	F 88	D				
	face shield that cover	s the front and sides of the		All residents have the	e potential to be			
	face), gloves and gov	vn."			y, upon notification of			
				alleged deficiency, T				
		ISN vaccination summary		Nursing and Assistar				
	data for the week of 1			Nursing/Infection Co				
		Il staff were fully vaccinated, vaccinated, vaccinated, and 7.33 % were		verified that covid tes	0 11			
		ocumentation in the NHSN		immediately available that were symptomate	-			
		dated for the week of		immediately tested a				
	-	also revealed 85.83% of the		transmission-based				
	residents were fully v	accinated, 2.5% were		-	er concerns identified.			
	partially vaccinated, and 11.6							
	unvaccinated.			Through our Quality	Assurance			
				Performance Improv				
		he vaccine administration		potential root cause				
		l record revealed, Resident		identified as insufficie				
	#3 was up-to-date wit	n all recommended Resident #3 resided in a		therefore, (re)educat				
	semi-private room at			all direct care staff by Nursing and Assistar				
	semi-private room at	the facility.		Nursing/Infection Pre				
	Documentation in the	medical record of Resident		2/28/2022 regarding	-			
		2 in an electronic MAR -		of covid, notification	÷ · ·			
		ion note dated 1/10/2022 at		on duty, how to test u				
	12:27 AM stated, "Co	ugh, ADON (Assistant		testing supplies, imm	nediate testing of			
	•,	ware, resident will be tested		-	g transmission-based			
		when supplies [available]."		precautions when ap				
		lso revealed the note was		testing supplies and	notification if none			
	to, "show on shift report."	ort" and "show on 24-hour		available.				
	iopoit.			Additionally, new hire	ers providing direct			
	Nurse #2 was intervie	ewed on 2/17/2022 at 7:17		care will be educated	· •			
		ed she worked weekends at		least annually regard	•			
		0 PM to 7:00 AM shift. Nurse		symptoms of covid, r	0			
		evening of 1/9/2022 into the		licensed nurse on du	ty, how to test			
	morning of 1/10/2022	-		utilizing current testir				
		ents of the residents on her			resident and initiating			
	-	nt Nurse #2 discovered		transmission-based				
	several of the residen	nts, whose names she could		applicable, location c	of testing supplies and			

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		MEDICAID SERVICES				NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	DATE SURVEY	
						С	
		345389	B. WING			02/18/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE LAUF	RELS OF FOREST GLEN	N		1101 HARTWELL STREET 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
F 880	Continued From page	- 8	F 88	30			
		-19 and concluded the whole	1.00				
		for COVID-19. Nurse #2		The Administrator, Director o	f Nursing		
		ble to test the residents due		and other staff members as a	-		
		and therefore the residents		interview and/or observe 10%	•		
	were not placed on tr			for new signs and symptoms	of covid and		
	precautions or isolate	ed during her shift. She		if symptomatic, ensure they			
		he ADON when she realized		immediately tested and			
		e residents and passed along		transmission-based precaution			
	÷ .	to Nurse #3 the residents		if applicable, five times per w			
	who needed to be tes	sted.		weeks, then three times per			
	Nurse #2 the purse y	who took the purging shift		weeks, then weekly for four weekly for four weeks, then as determined by the Q			
		who took the nursing shift lurse #2 on 1/10/2022, was		Assurance Committee The	-		
		2022 at 9:18 AM. Nurse #3		and/or Director of Nursing wi			
		red the conversation with		Quality Assurance Meeting.			
		remember what day the		identified will be addressed in			
		ed. Nurse #3 revealed she		and additional education pro-	•		
		st of residents from Nurse		indicated. Continued complia	nce will be		
		tested for COVID-19 on the		monitored through the facility	r⊡s Quality		
	first shift because no	-		Assurance Program.			
	-	he testing. Nurse #3 did not					
		nation about events that		The Administrator, Director o	•		
		as notified some of the		and other staff members as a	•		
	tested.	oms and needed to be		interview at least 10 direct ca members for new signs and			
	lesieu.			covid of residents and if sym	• •		
	An interview was con	ducted with the ADON on		ensure they are immediately			
		M. The ADON stated she		transmission-based precaution			
		rse #2 on 1/9/2022 or		if applicable, five times per w			
	1/10/2022. The ADOI			weeks, then three times per			
	communicated to her	some of the residents were		weeks, then weekly for four w	veeks, and		
		COVID-19 so that proper		then as determined by the Q	•		
	-	of the residents could be		Assurance Committee The			
	initiated. The ADON r			and/or Director of Nursing wi			
	-	esidents for COVID-19 every		Quality Assurance Meeting.			
	Monday. If the testing			identified will be addressed in			
		tive, they would have been		and additional education pro-			
	put on isolation preca	autions.		indicated. Continued complia	ince will de		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		345389	B. WING			C 02/18/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	RELS OF FOREST GLEN	N		11	101 HARTWELL STREET		
	CELS OF FOREST GLEN			G	ARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page Documentation in a si 1/10/2022 at 5:55 PM tested positive for CC a voice mail was left v notification of the resu Documentation in a si dated 1/11/2022 at 8: member of Resident # positive COVID-19 ra given an additional te second test was posit moved to the COVID- Documentation in an note dated 1/11/2022 family member was n remain in her current was at that time a par An interview was com Administrator on 2/18 facility Administrator e of the residents was in 4:00 PM and was star Resident #3 and her r positive for COVID-19 same time. The Healt contacted, and the fac to put the residents w rapid test under trans The COVID-19 unit w include the room for v roommate resided.	e 9 ocial service note dated revealed Resident #3 VID-19 on a rapid test and with a family member for alts. ocial service progress note 28 AM revealed a family #3 was notified of the pid test, an explanation st would be given, and if the ive Resident #3 would be 19 unit. additional social service at 3:16 PM revealed a otified Resident #3 was to room because her room t of the COVID-19 unit. ducted with the facility /2022 at 9:58 AM. The explained COVID-19 testing nitiated on 1/10/2022 after rted on the 200 Hall area. roommate both tested 0 on the same day at the h Department was cility received confirmation ho tested positive with the mission-based precautions. as expanded at that time to which Resident #3 and her		880			
	Nursing (DON) on 2/1 DON revealed NA #3	8/2022 at 12:08 PM. The was working on the floor as the morning of 1/10/2022					

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY
			A. BUILDING	3		
		345389	B. WING			С
		345389	B. WING			2/18/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
THE LAU	RELS OF FOREST GLEN	IN		1101 HARTWELL STREET		
				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) COMPLETIO DATE
F 880	Continued From page	e 10	F 88	30		
		COVID-19 testing of the er shift ended at 3:00 PM.				
		it was noted on the 24-hour				
	-	g of 1/10/2022, Resident #3				
	had a cough and nee					
	-	l did not know why this was				
		ning meeting so action could				
	be taken with the tes	ting and isolation of the				
	symptomatic residen	ts, but she surmised the				
		over the 24-hour report was				
		the day. The DON stated				
		e called her and notified her				
	if several of the resid					
		-19. DON confirmed she did				
	not receive a call from	m Nurse #2 on 1/10/2022.				
	An interview was cor	nducted with the DON and				
		3/2022 at 2:00 PM. The				
		ned NA #3 was working				
		rom 7:00 AM to 3:00 PM on				
	1/10/2022 and did no	ot start testing residents for				
	COVID-19 until after	3:00 PM. The Administrator				
	stated the facility was	s in the middle of a				
		so any of the residents who				
		10/2022 were tested the				
		/2022, because the facility				
		ot aware of any other				
		er residents at that time. The that some of the residents				
		vere receiving therapy				
	· ·	the therapists documented				
		ns of COVID-19 in the				
		22. On 1/10/2022 some of				
		de Resident #3 were testing				
		9 so the health department				
		Administrator stated the				
	facility was directed b	by the health department to				
		on the COVID-19 unit based				
	I also the allowing the state of the set	COVID-19 and not to wait for				1

Facility ID: 923173

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIE	PLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G	COMPLETED
					с
		345389	B. WING		02/18/202
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•
				1101 HARTWELL STREET	
	RELS OF FOREST GLEN	IN		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 O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE COMPL D THE APPROPRIATE DAT
F 880	Continued From page	o 11	F 88	00	
1 000	15		FOC	80	
		e chain reaction test) results g 6 to 10 days to get results.			
		agnostic test that determines			
		analyzing a sample to see if			
		aterial from the COVID-19			
	virus. The rapid COV	ID-19 test, also called the			
		proteins from the virus which			
		he rapid test is considered			
		se individuals who are			
		ms of COVID-19. The DON			
		ymptoms of COVID-19 were dent #3 on 1/10/2022 or			
		indicated the reason the			
		aced on transmission-based			
		ause of a communication			
	problem. The DON s	tated she and her staff were			
		were symptomatic needed			
	to be tested right awa				
		precautions, but she nor the			
		a phone call from Nurse #2			
	•	sidents were symptomatic			
		f they had been notified,			
		ided for the immediate supplies were in the facility			
		ts who showed positive			
	would have been isol	•			
		precautions. According to the			
		ave called her or the ADON			
	at any time and neith	er of them had a record of			
	any phone calls from	Nurse #2. The Administrator			
	reiterated that all the				
		0/2022 and after the nurse			
	-	esidents who tested positive			
	on 1/10/2022, all wer	e asymptomatic except for			
	2 Documentation in	the vaccine administration			
	contion of the medice	al record revealed, Resident			

Facility ID: 923173

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE	
		345389	B. WING		_		C 18/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	02/	10/2022
				1101 HARTWELL STREET			
THE LAUF	RELS OF FOREST GLEN	N		GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	semi-private room in t roommate. Documentation in the #14 written by Nurses (medication administr administration note da stated, "cough, sore ti (Assistant Director of be tested this AM on [available]." Documentation in the medical record reveal low-grade fever of 99. 1/10/2022 at 10:42 Pf Nurse #2 was intervie PM. Nurse #2 reveale the facility on the 7:00 #2 explained on the e morning of 1/10/2022 respiratory assessme hall. Upon assessmer several of the residen not recall at the time of symptoms of COVID- hall should be tested stated she was not at to a lack of reagent, a were not placed on tra precautions or isolate called and informed th she could not test the in shift change report who needed to be test	Resident #14 resided in a he facility but did not have a medical record of Resident #2 in an electronic MAR ation record) shift level ated 1/10/2022 at 12:28 AM hroat, low fever, ADON Nursing) aware, resident to 1rst shift when supplies vital signs section of the ed Resident #14 had a 3 degrees Fahrenheit on M. wed on 2/17/2022 at 7:17 ed she worked weekends at 0 PM to 7:00 AM shift. Nurse vening of 1/9/2022 into the she was doing her nts of the residents on her nt Nurse #2 discovered ts, whose names she could of the interview, had 19 and concluded the whole for COVID-19. Nurse #2 ble to test the residents due nd therefore the residents ansmission-based d during her shift. She he ADON when she realized residents and passed along to Nurse #3 the residents ted.	F 88				
	who needed to be tes						

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345389	B. WING				C 18/2022
NAME OF P	ROVIDER OR SUPPLIER	•		Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
					1101 HARTWELL STREET		
	RELS OF FOREST GLEN	N			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	change report from N interviewed on 2/18/2 stated she remember Nurse #2 but did not in conversation happend recalled receiving a lia #2 who needed to be first shift because no available to perform the recall any other inform occurred after she was residents had symptot tested. Documentation in a s dated 1/10/2022 at 5: #14 tested positive fot was left for the guardi Documentation in a n note dated 1/11/2022 Resident #14 was see COVID-19 positive te symptoms. Documentation in a n 4:10 PM revealed Re the COVID-19 unit that An interview was con Nursing (DON) on 2/1 DON revealed NA #3 a nursing assistant or and did not start the O residents until after he The DON confirmed i report on the morning had a cough and nee	urse #2 on 1/10/2022, was 022 at 9:18 AM. Nurse #3 ed the conversation with remember what day the ed. Nurse #3 revealed she st of residents from Nurse tested for COVID-19 on the reagent solution was he testing. Nurse #3 did not nation about events that as notified some of the ms and needed to be ocial service progress note 53 PM revealed Resident r COVID-19 and a voicemail ian. urse practitioner progress at 3:03 PM revealed en for an acute visit for st but was not showing any ursing note on 1/11/2022 at sident #14 was moved to at evening. ducted with the Director of 18/2022 at 12:08 PM. The was working on the floor as on the morning of 1/10/2022 COVID-19 testing of the er shift ended at 3:00 PM. t was noted on the 24-hour of 1/10/2022, Resident #3	F	880			

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			TE SURVEY MPLETED
			A. BUILDING	3		
		345389	B. WING	WING		С
		545569	B. WING			2/18/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	DE	
THE LAUF	RELS OF FOREST GLEN	IN		1101 HARTWELL STREET		
	1			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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIOI DATE
F 880	Continued From page	e 14	F 88	30		
1 000			ГОС	50		
		ning meeting so action could ting and isolation of the				
		ts, but she surmised the				
		over the 24-hour report was				
		the day. The DON stated				
		e called her and notified her				
	if several of the resid	ents were showing				
		-19. DON confirmed she did				
	not receive a call fror	n Nurse #2 on 1/10/2022.				
	An interview was cor	ducted with the DON and				
		3/2022 at 2:00 PM. The				
	Administrator confirm	ned NA #3 was working				
	caring for residents fi	rom 7:00 AM to 3:00 PM on				
	1/10/2022 and did no	t start testing residents for				
		3:00 PM. The Administrator				
	stated the facility was					
		so any of the residents who				
		(10/2022 were tested the				
		/2022, because the facility				
		ot aware of any other er residents at that time. The				
		that some of the residents				
		vere receiving therapy				
		the therapists documented				
		ns of COVID-19 in the				
		22. On 1/10/2022 some of				
	the residents to inclu	de Resident #3 were testing				
	positive for COVID-1	9 so the health department				
		Administrator stated the				
	-	by the health department to				
		on the COVID-19 unit based				
	•	COVID-19 and not to wait for				
		e chain reaction test) results				
		g 6 to 10 days to get results.				
		agnostic test that determines				
		analyzing a sample to see if aterial from the COVID-19				
	En contains denenc ma					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345389	B. WING				C / 18/2022
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF FOREST GLEN	N			1101 HARTWELL STREET GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	antigen test detects p causes COVID-19. Th most accurate in thos experiencing symptor noted that no other sy documented for Resid 1/11/2022. The DON residents were not pla precautions was beca problem. The DON st aware residents who to be tested right awa transmission-based p ADON ever received alerting them that resi and needed testing. If they could have provi testing because the s and then the resident: would have been isola transmission-based p DON, nurses could ha at any time and neithe any phone calls from reiterated that all the asymptomatic on 1/10 practitioner saw the re on 1/10/2022, all were one. 3. Documentation in the #15 was up-to-date w COVID-19 vaccination a private room in the #15 written by Nurse	roteins from the virus which he rapid test is considered e individuals who are ns of COVID-19. The DON ymptoms of COVID-19 were dent #3 on 1/10/2022 or indicated the reason the aced on transmission-based base of a communication ated she and her staff were were symptomatic needed y and placed on recautions, but she nor the a phone call from Nurse #2 idents were symptomatic f they had been notified, ded for the immediate upplies were in the facility s who showed positive ated and place on recautions. According to the ave called her or the ADON er of them had a record of Nurse #2. The Administrator residents were D/2022 and after the nurse esidents who tested positive e asymptomatic except for	F	88			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2022 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345389	B. WING		_	(02/ [,]) 18/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			1	101 HARTWELL STREET			
THE LAU	RELS OF FOREST GLEN	N	G	GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	stated, "Cough, sore of Director of Nursing) at this AM on first shift w available." The docum note was to, "show or 24-hour report." Nurse #2 was intervie PM. Nurse #2 revealed the facility on the 7:00 #2 explained on the e morning of 1/10/2022 respiratory assessme hall. Upon assessme several of the residen not recall at the time of symptoms of COVID- hall should be tested stated she was not at to a lack of reagent, a were not placed on tra- precautions or isolate called and informed th she could not test the in shift change report who needed to be test Nurse #3, the nurse w change report from N interviewed on 2/18/2 stated she remember Nurse #2 but did not not conversation happene recalled receiving a li- #2 who needed to be first shift because no available to perform the	ated 1/10/2022 at 12:39 AM throat, ADON (Assistant ware, resident will be tested /hen [COVID-19] supplies mentation also revealed the n shift report" and "show on ewed on 2/17/2022 at 7:17 ed she worked weekends at 0 PM to 7:00 AM shift. Nurse evening of 1/9/2022 into the she was doing her nts of the residents on her nt Nurse #2 discovered tts, whose names she could of the interview, had 19 and concluded the whole for COVID-19. Nurse #2 ole to test the residents due and therefore the residents ansmission-based d during her shift. She he ADON when she realized residents and passed along to Nurse #3 the residents sted. who took the nursing shift urse #2 on 1/10/2022, was 022 at 9:18 AM. Nurse #3 ed the conversation with remember what day the ed. Nurse #3 revealed she st of residents from Nurse tested for COVID-19 on the	F 880				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2022 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345389	B. WING		_		C 18/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			1	101 HARTWELL STREET			
	RELS OF FOREST GLEN	N	G	GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	1/11/2022 at 11:40 AM tested positive for CO Documentation in a N 1/11/2022 at 11:58 AM seeing this patient foll COVID-19 test. Patien [complains of] mild sc symptoms." Documentation in the 1/11/2022 at 6:00 PM transferred to the CO An interview was com Nursing (DON) on 2/1 DON revealed NA #3 a nursing assistant or and did not start the O residents until after he The DON confirmed if report on the morning had a cough and need COVID-19. The DON not discussed in morr be taken with the test symptomatic resident daily meeting going of not held until later in t Nurse #2 should have if several of the reside symptoms of COVID-	s notified some of the ms and needed to be ocial service note dated A revealed Resident #15 VID-19. urse Practitioner note dated A stated in part, "I am lowing her rapid test positive nt is fully vaccinated. She ratchy throat but no other nursing notes dated revealed Resident #15 was VID-19 unit that evening. ducted with the Director of 8/2022 at 12:08 PM. The was working on the floor as the morning of 1/10/2022 COVID-19 testing of the er shift ended at 3:00 PM. t was noted on the 24-hour of 1/10/2022, Resident #3 ded to be tested for did not know why this was hing meeting so action could ing and isolation of the s, but she surmised the ver the 24-hour report was he day. The DON stated e called her and notified her	F 880		DEFICIENCY)		
	symptoms of COVID-	19. DON confirmed she did					

Facility ID: 923173

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			0.00			10. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
			A. BUILDING	3		
		345389	B. WING			С
		545369				2/18/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	'E	
THE LAUF	RELS OF FOREST GLEN	IN		1101 HARTWELL STREET 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 880	Continued From page	e 18	F 88	30		
			1.00			
	An interview was conducted with the DON and Administrator on 2/18/2022 at 2:00 PM. The					
		ned NA #3 was working				
		rom 7:00 AM to 3:00 PM on				
	•	It start testing residents for				
		3:00 PM. The Administrator				
	stated the facility was					
	-	so any of the residents who				
		(10/2022 were tested the				
		/2022, because the facility				
		ot aware of any other				
		er residents at that time. The				
		that some of the residents				
		vere receiving therapy				
		the therapists documented				
		ns of COVID-19 in the				
		22. On 1/10/2022 some of				
		de Resident #3 were testing				
		9 so the health department				
	•	Administrator stated the				
		by the health department to				
	•	on the COVID-19 unit based				
		COVID-19 and not to wait for				
	•	e chain reaction test) results				
		g 6 to 10 days to get results.				
		agnostic test that determines				
		analyzing a sample to see if				
	it contains genetic ma	aterial from the COVID-19				
	•	ID-19 test, also called the				
	-	proteins from the virus which				
	causes COVID-19. T	he rapid test is considered				
		se individuals who are				
	experiencing sympto	ms of COVID-19. The DON				
	noted that no other s	ymptoms of COVID-19 were				
	documented for Resi	dent #3 on 1/10/2022 or				
	1/11/2022. The DON	indicated the reason the				
	residents were not pl	aced on transmission-based				
	precautions was beca	ause of a communication				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345389	B. WING			0 :	C 2/18/2022
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE LAUF	RELS OF FOREST GLEN	N			1101 HARTWELL STREET GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	 aware residents who to be tested right aware transmission-based p ADON ever received alerting them that resident and needed testing. If they could have provises testing because the s and then the resident would have been isolated transmission-based p DON, nurses could have at any time and neither any phone calls from reiterated that all the asymptomatic on 1/10 practitioner saw the resident would not be the medica #12 was up-to-date w COVID-19 vaccination a semiprivate room in Documentation in the #12 written by Nurse (Medication Administration note dastated, "Resident has Director of Nursing) at this AM when supplied documentation also references 	were symptomatic needed by and placed on recautions, but she nor the a phone call from Nurse #2 idents were symptomatic f they had been notified, ded for the immediate upplies were in the facility s who showed positive ated and place on recautions. According to the ave called her or the ADON er of them had a record of Nurse #2. The Administrator residents were D/2022 and after the nurse esidents who tested positive e asymptomatic except for the vaccine administration I record revealed, Resident vith all recommended ns. Resident #12 resided in the facility. medical record of Resident #2 in an electronic MAR ration Record) - shift level ated 1/10/2022 at 12:26 AM a cough, ADON (Assistant ware, resident to be tested	F	880			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
		345389	B. WING				C 18/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
					1101 HARTWELL STREET		
THE LAU	RELS OF FOREST GLEN	N			GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 880	the facility on the 7:00 #2 explained on the e morning of 1/10/2022 respiratory assessme hall. Upon assessme several of the residen not recall at the time of symptoms of COVID- hall should be tested stated she was not at to a lack of reagent, a were not placed on tra- precautions or isolate called and informed th she could not test the in shift change report who needed to be test Nurse #3, the nurse w change report from N interviewed on 2/18/2 stated she remember Nurse #2 but did not n conversation happene recalled receiving a lis #2 who needed to be first shift because no available to perform th recall any other inform occurred after she wa residents had sympto tested. The documentation in testing log dated 1/10 Resident #12 tested p 5:10 PM.	PM to 7:00 AM shift. Nurse vening of 1/9/2022 into the she was doing her nts of the residents on her nt Nurse #2 discovered ts, whose names she could of the interview, had 19 and concluded the whole for COVID-19. Nurse #2 ole to test the residents due and therefore the residents ansmission-based d during her shift. She ne ADON when she realized residents and passed along to Nurse #3 the residents ted. who took the nursing shift urse #2 on 1/10/2022, was 022 at 9:18 AM. Nurse #3 ed the conversation with remember what day the ed. Nurse #3 revealed she st of residents from Nurse tested for COVID-19 on the reagent solution was he testing. Nurse #3 did not nation about events that is notified some of the	F	880			

Facility ID: 923173

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2022 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345389	B. WING		_		C 18/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUF	RELS OF FOREST GLEN	N		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 PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	 #12 was to be moved testing positive for CC An interview was com Administrator on 2/18 facility Administrator e of the residents was in 4:00 PM and was stat Resident #12 and her positive for COVID-19 same time. The Healt contacted, and the fact to put the residents w rapid test under trans The COVID-19 unit w include the room for w roommate resided. An interview was com Nursing (DON) on 2/1 DON revealed NA #3 a nursing assistant or and did not start the C residents until after her The DON confirmed if report on the morning had a cough and nee COVID-19. The DON not discussed in morr be taken with the test symptomatic resident daily meeting going o not held until later in t Nurse #2 should have if several of the resider symptoms of COVID- 	33 PM revealed Resident to the COVID-19 unit after DVID-19. ducted with the facility /2022 at 9:58 AM. The explained COVID-19 testing initiated on 1/10/2022 after ted on the 200 Hall area. Toommate both tested 9 on the same day at the h Department was cility received confirmation ho tested positive with the mission-based precautions. as expanded at that time to which Resident #12 and her ducted with the Director of 8/2022 at 12:08 PM. The was working on the floor as the morning of 1/10/2022 COVID-19 testing of the er shift ended at 3:00 PM. t was noted on the 24-hour of 1/10/2022, Resident #3 ded to be tested for did not know why this was sing meeting so action could ing and isolation of the s, but she surmised the ver the 24-hour report was he day. The DON stated e called her and notified her	F 880				

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	S FOR MEDICARE &					O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDING			
		345389	B. WING	WING		C
	ROVIDER OR SUPPLIER	343303		STREET ADDRESS, CITY, STATE, ZIP COD		2/18/2022
NAME OF PI	ROVIDER OR SUPPLIER			1101 HARTWELL STREET	E	
THE LAUF	RELS OF FOREST GLEN	IN		GARNER, NC 27529		
					DDEOTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIOI DATE
F 880	Continued From pag	e 22	F 88	0		
			1 00			
	An interview was conducted with the DON and Administrator on 2/18/2022 at 2:00 PM. The					
		ned NA #3 was working				
		rom 7:00 AM to 3:00 PM on				
		ot start testing residents for				
		3:00 PM. The Administrator				
	stated the facility was	s in the middle of a				
	COVID-19 outbreak	so any of the residents who				
	were not tested on 1	/10/2022 were tested the				
	following day on 1/11	1/2022, because the facility				
	Administration was n	ot aware of any other				
	symptoms in any oth	er residents at that time. The				
		that some of the residents				
	-	vere receiving therapy				
		f the therapists documented				
		ms of COVID-19 in the				
		22. On 1/10/2022 some of				
		de Resident #3 were testing				
	•	9 so the health department				
		Administrator stated the				
	· ·	by the health department to				
		on the COVID-19 unit based				
		COVID-19 and not to wait for				
		e chain reaction test) results				
		g 6 to 10 days to get results. agnostic test that determines				
		agnostic test that determines				
		aterial from the COVID-19				
		/ID-19 test, also called the				
	-	proteins from the virus which				
		he rapid test is considered				
		se individuals who are				
		ms of COVID-19. The DON				
		symptoms of COVID-19 were				
		ident #3 on 1/10/2022 or				
		indicated the reason the				
		laced on transmission-based				
	precautions was bec	ause of a communication				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	
		345389	B. WING				0 18/2022
	ROVIDER OR SUPPLIER	N			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	1	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	to be tested right awa transmission-based p ADON ever received alerting them that res and needed testing. It they could have provi- testing because the s and then the resident would have been isola- transmission-based p DON, nurses could ha at any time and neither any phone calls from reiterated that all the asymptomatic on 1/10 practitioner saw the re-	were symptomatic needed by and placed on recautions, but she nor the a phone call from Nurse #2 idents were symptomatic f they had been notified, ded for the immediate upplies were in the facility s who showed positive ated and place on recautions. According to the ave called her or the ADON er of them had a record of Nurse #2. The Administrator	F	880	0		
	section of the medica #13 was up-to-date w COVID-19 vaccination a semiprivate room a resident who was fully and was never diagno the facility. Documentation in the #13 written by Nurse (Medication Administr administration note da stated, "cough, fatigue of Nursing) aware, re on 1rst shift when [CC The documentation a	he vaccine administration I record revealed, Resident with all recommended ns. Resident #13 resided in t the facility with another y vaccinated and boosted based with COVID-19 while at medical record of Resident #2 in an electronic MAR ration Record) - shift level ated 1/10/2022 at 12:31 AM e, ADON (Assistant Director sident to be tested this AM DVID-19] supplies available." Iso revealed the note was port" and "show on 24-hour					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/14/2022 MAPPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION			LETED
		345389	B. WING _			_		C 18/2022
NAME OF PF	ROVIDER OR SUPPLIER		- I [ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	<u> </u>	10/2022
	ELS OF FOREST GLEN	N		11	01 HARTWELL STREET			
				G	ARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page report."	24	F٤	380				
	PM. Nurse #2 revealed the facility on the 7:00 #2 explained on the ere morning of 1/10/2022 respiratory assessment hall. Upon assessment several of the resident not recall at the time of symptoms of COVID- hall should be tested stated she was not at to a lack of reagent, at were not placed on tra- precautions or isolate called and informed the she could not test the in shift change report who needed to be test Nurse #3, the nurse we change report from N interviewed on 2/18/2 stated she remember Nurse #2 but did not no conversation happener recalled receiving a lis #2 who needed to be first shift because no available to perform the recall any other inform occurred after she war residents had symptor tested. The documentation in	nts of the residents on her nt Nurse #2 discovered ts, whose names she could of the interview, had 19 and concluded the whole for COVID-19. Nurse #2 ole to test the residents due and therefore the residents ansmission-based d during her shift. She he ADON when she realized residents and passed along to Nurse #3 the residents ted. who took the nursing shift urse #2 on 1/10/2022, was 022 at 9:18 AM. Nurse #3 ed the conversation with remember what day the ed. Nurse #3 revealed she st of residents from Nurse tested for COVID-19 on the reagent solution was he testing. Nurse #3 did not nation about events that is notified some of the ms and needed to be						
		the point of care antigen /2022 at 4:23 PM revealed						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345389	B. WING				C / 18/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1101 HARTWELL STREET		
THE LAUF	RELS OF FOREST GLEN	Ν			GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE	(X5) COMPLETION DATE
F 880	4:43 PM. Documentation in a s 1/10/2022 at 5:50 PM tested positive for CC moved to the COVID- An interview was con Nursing (DON) on 2/1 DON revealed NA #3 a nursing assistant or and did not start the C residents until after he The DON confirmed i report on the morning had a cough and nee COVID-19. The DON not discussed in morr be taken with the test symptomatic resident daily meeting going o not held until later in t Nurse #2 should have if several of the reside symptoms of COVID- not receive a call from An interview was con Administrator on 2/18 Administrator confirm caring for residents fr 1/10/2022 and did no COVID-19 until after 3 stated the facility was COVID-19 outbreak s were not tested on 1/	oositive for COVID-19 at ocial service note dated revealed Resident #13 oVID-19 and was being 19 unit. ducted with the Director of 18/2022 at 12:08 PM. The was working on the floor as in the morning of 1/10/2022 COVID-19 testing of the er shift ended at 3:00 PM. t was noted on the 24-hour of 1/10/2022, Resident #3 ded to be tested for did not know why this was hing meeting so action could ing and isolation of the s, but she surmised the ver the 24-hour report was the day. The DON stated e called her and notified her ents were showing 19. DON confirmed she did in Nurse #2 on 1/10/2022. ducted with the DON and c/2022 at 2:00 PM. The ed NA #3 was working om 7:00 AM to 3:00 PM on t start testing residents for 3:00 PM. The Administrator is in the middle of a so any of the residents who 10/2022 were tested the	F	880			
	following day on 1/11. Administration was no	/2022, because the facility ot aware of any other					

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	S FOR MEDICARE &				OMB NO. 0938-03		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	· · · ·	E SURVEY PLETED	
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING				
						С	
		345389	B. WING		02	/18/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
		IN		1101 HARTWELL STREET			
THE LAUP	RELS OF FOREST GLEN			GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From pag	e 26	F 880				
1 000			F 000				
		er residents at that time. The					
		that some of the residents					
		vere receiving therapy					
		f the therapists documented					
		ns of COVID-19 in the					
		22. On 1/10/2022 some of					
		de Resident #3 were testing					
	positive for COVID-19 so the health department						
		Administrator stated the					
	-	by the health department to					
		on the COVID-19 unit based					
	-	COVID-19 and not to wait for					
		e chain reaction test) results					
		g 6 to 10 days to get results.					
		agnostic test that determines					
		analyzing a sample to see if					
	.	aterial from the COVID-19					
		/ID-19 test, also called the					
		proteins from the virus which					
	causes COVID-19. T	he rapid test is considered					
		se individuals who are					
		ms of COVID-19. The DON					
		ymptoms of COVID-19 were					
		ident #3 on 1/10/2022 or					
	1/11/2022. The DON	indicated the reason the					
	-	laced on transmission-based					
	•	ause of a communication					
		tated she and her staff were					
		were symptomatic needed					
	to be tested right awa						
		precautions, but she nor the					
		a phone call from Nurse #2					
	alerting them that res	sidents were symptomatic					
	and needed testing.	If they had been notified,					
	they could have prov	ided for the immediate					
	testing because the	supplies were in the facility					
						1	
	and then the residen	ts who showed positive					
	would have been iso	-					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMF	
		345389	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF FOREST GLEN	N			1 HARTWELL STREET RNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	DON, nurses could ha at any time and neither any phone calls from reiterated that all the asymptomatic on 1/10 practitioner saw the re on 1/10/2022, all were one.	ave called her or the ADON er of them had a record of Nurse #2. The Administrator residents were 0/2022 and after the nurse esidents who tested positive e asymptomatic except for		380			
F 886 SS=E	CFR(s): 483.80 (h)(1) §483.80 (h) COVID-1 must test residents ar individuals providing s and volunteers, for CO for all residents and fa individuals providing s and volunteers, the L ² §483.80 (h)((1) Condu- parameters set forth b but not limited to: (i) Testing frequency; (ii) The identification of this paragraph diagno COVID-19 in the facili (iii) The identification this paragraph with sy consistent with COVII suspected exposure to (iv) The criteria for co asymptomatic individu paragraph, such as th COVID-19 in a county (v) The response time	-(6) 9 Testing. The LTC facility nd facility staff, including services under arrangement DVID-19. At a minimum, acility staff, including services under arrangement TC facility must: uct testing based on by the Secretary, including of any individual specified in used with ty; of any individual specified in vmptoms D-19 or with known or o COVID-19; nducting testing of uals specified in this ue positivity rate of <i>r</i> ; e for test results; and cified by the Secretary that	F	386			3/17/22

Event ID: L6W311

Facility ID: 923173

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	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ECONSTRUCTION	(X3) DATE	
			A. BUILDI	NG _			C
		345389	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF FOREST GLEN	N					
			ID	GARNER, NC 27529			
(X4) ID PREFIX TAG				х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 886	Continued From page	28		886			
1 000	transmission of COVI			000			
		5 10.					
		uct testing in a manner that rent standards of practice for 9 tests;					
	 (i) Document that test results of each staff te (ii) Document in the re was offered, complete 	esident records that testing					
	individual specified in symptoms	D-19, or who tests positive ctions to prevent the					
	residents and staff, in	procedures for addressing cluding individuals providing gement and volunteers, who unable to be tested.					
	emergencies due to to contact state and local health depa efforts, such as obtain processing test result This REQUIREMENT by: Based on observatio interview, and record provide COVID-19 test	n necessary, such as in esting supply shortages, intments to assist in testing hing testing supplies or is. is not met as evidenced n, staff interview, family review the facility failed to sting upon the appearance esidents #3, #12, #13, #14,			The Laurels of Forest Glenn wishes to have this submitted Plan of Correction stand as allegation of compliance. Our date of compliance is 3/17/2022.	to	

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	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	OMB N	MAPPROVE O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
		345389	B. WING		02	2/18/2022
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF FOREST GLEN	IN		1101 HARTWELL STREET GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 886	Continued From page	e 29	F 886	3		
	for COVID-19 during	a facility COVID-19		Preparation and/or execution of of Correction does not constitut		
	outbreak. This occurred during a coronavirus pandemic. Findings included:			admission to, nor agreement wi the existence of, or the scope a	th, either	
		rus (COVID-19) Testing , dated as last reviewed on		of, any of the cited deficiencies conclusions set forth in the Stat	or	
	2/16/2022, was revie	wed. Documentation in the "Guests/residents who have		Deficiencies. This plan is prepa executed to ensure continued c	red and/or	
	signs and symptoms vaccination status, m	of COVID-19, regardless of nust be tested immediately. nding, guests/residents with		with regulatory requirement.	ompliance	
	signs and symptoms			F886 COVID-19 Testing-Reside Upon discovery of the 5/5 reside		
		must take the appropriate		were already covid recovered, s intervention was needed for the		
	in the policy additiona	results." The documentation ally stated, "A new COVID-19		residents.		
	COVID-19 infection in	or any nursing home-onset n a guest/resident triggers an		All residents have the potential affected. Immediately, upon not	ification of	
		lentification and isolation of		alleged deficiency, The Director Nursing and Assistant Director	of	
	new cases is critical i transmission."	in stopping further viral		Nursing/Infection Control Preve verified that covid testing suppli	es were	
	Documentation in NH data for the week of 2	ISN vaccination summary		immediately available and any r that were symptomatic for covic immediately tested and		
	revealed 85.33% of a	all staff were fully vaccinated, vaccinated, and 7.33 % were		immediately tested and transmission-based precautions if applicable. No other concerns	•	
	unvaccinated. The do	ocumentation in the NHSN dated for the week of		Through our Quality Assurance		
	1/3/2022 to 1/9/2022	also revealed 85.83% of the vaccinated, 2.5% were		Performance Improvement proc potential root cause analysis wa		
	partially vaccinated, a unvaccinated.	-		identified as insufficient staff ed therefore, (re)education was pro	ucation;	
		oded on her admission		all direct care staff by The Direct Nursing and Assistant Director	of	
	-	tively intact with no moods or		Nursing/Infection Preventionist 2/28/2022 regarding signs and	symptoms	
	behaviors. Document	tation in the vaccine		of covid, notification to the licen	sed nurse	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/14/2022 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345389	B. WING			02	C 2/18/2022
NAME OF P	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF FOREST GLEN	Ν			101 HARTWELL STREET ARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 886	administration section revealed Resident #3 recommended COVII Resident #3 had a ph Guaifenesin liquid 10 (milliliters) to be giver every 4 hours as nee 1/9/2022. Guaifenesi congestion. Documer administration record #3 received the medi 1/12/2022 at 6:48 PM Nurse # 4, who obtain Guaifenesin from the was interviewed on 2 #4 revealed she obta #3 because Nurse #2 change of shift on 1/8 physician for cough m #3 had a cough. Nurse know if Resident #3 h only contacted the ph Nurse #2. There was no docum record on 1/8/2022 of Resident #3 was cou Documentation in the #3 written by Nurse # shift level administrat 12:27 AM stated, "Co Director of Nursing) a this AM on [first] shift The documentation a to, "show on shift rep	n of the medical record was up-to-date with all D-19 vaccinations. hysician's order for 0 mg (milligrams) /5 ml n as 10 milliliters by mouth ded for a cough initiated on n is used to relieve chest ntation on the medication (MAR) revealed Resident cation Guaifenesin liquid on 1 and 1/13/2022 at 5:13 PM. hed the order for physician for Resident #3, /18/2022 at 2:37 PM. Nurse ined the order for Resident 2, requested in report at 0/2022 she contacted the nedicine because Resident as #4 stated she did not nad a cough on 1/9/2022 and nysician at the request of entation in the medical r 1/9/2022 indicating ghing or had congestion. medical record of Resident t2 in an electronic MAR - ion note dated 1/10/2022 at ough, ADON (Assistant aware, resident will be tested when supplies [available]." Iso revealed the note was	F	886	on duty, how to test utilizing current testing supplies, immediate testing of resident and initiating transmission-ba- precautions when applicable, location testing supplies and notification if non available. Additionally, new hirers providing direc care will be educated upon hire and a least annually regarding signs and symptoms of covid, notification to the licensed nurse on duty, how to test utilizing current testing supplies, immediate testing of resident and initi transmission-based precautions wher applicable, location of testing supplies notification if none available. The Administrator, Director of Nursing and other staff members as assigned interview and/or observe 10% of resid for new signs and symptoms of covid if symptomatic, ensure they re immediately tested and transmission-based precautions in pla if applicable, five times per week for t weeks, then three times per week for t weeks, then weekly for four weeks, at then as determined by the Quality Assurance Committee The administr and/or Director of Nursing will take to Quality Assurance Meeting. Any varia identified will be addressed immediate and additional education provided wh indicated. Continued compliance will monitored through the facility s Qual Assurance Program.	ased of e ct t ating s and g, will lents and ace, wo two nd rator the inces ely en be ity	
	 physician for cough medicine because Resident #3 had a cough. Nurse #4 stated she did not know if Resident #3 had a cough on 1/9/2022 and only contacted the physician at the request of Nurse #2. There was no documentation in the medical record on 1/8/2022 or 1/9/2022 indicating Resident #3 was coughing or had congestion. Documentation in the medical record of Resident #3 written by Nurse #2 in an electronic MAR - shift level administration note dated 1/10/2022 at 12:27 AM stated, "Cough, ADON (Assistant Director of Nursing) aware, resident will be tested this AM on [first] shift when supplies [available]." The documentation also revealed the note was to, "show on shift report" and "show on 24-hour report." 				for new signs and symptoms of covid if symptomatic, ensure they re immediately tested and transmission-based precautions in pla if applicable, five times per week for to weeks, then three times per week for weeks, then weekly for four weeks, and then as determined by the Quality Assurance Committee The administra and/or Director of Nursing will take to Quality Assurance Meeting. Any varia- identified will be addressed immediate and additional education provided wh indicated. Continued compliance will monitored through the facility s Qual	and ace, wo two nd rator the inces ely en be ity	

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		O. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3		IPLETED		
						С		
		345389	B. WING		— 02	2/18/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
THE LAUF	RELS OF FOREST GLEN	N		1101 HARTWELL STREET				
	I			GARNER, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION COTIVE ACTION SHOULD BE INCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE		
F 886	Continued From page	e 31	F 88	6				
					mbers as assigned will			
		ewed on 2/17/2022 at 7:17		interview at least 1				
		ed she worked weekends at 0 PM to 7:00 AM shift. Nurse			signs and symptoms of and if symptomatic,			
		evening of 1/9/2022 into the			mediately tested and			
	morning of 1/10/2022			-	d precautions in place,			
	respiratory assessments of the residents on her			if applicable, five t	imes per week for two			
hall. Upon assessr		nt Nurse #2 discovered			times per week for two			
		nts, whose names she could			ly for four weeks, and			
	not recall at the time			then as determine	d by the Quality ittee⊡The administrator			
		-19 and concluded the whole for COVID-19. Nurse #2		-	Nursing will take to the			
		p to the front of the building			Meeting. Any variances			
		o get the testing supplies to			ddressed immediately			
	test the residents she	-			cation provided when			
	•••	s. Nurse #2 explained at the			ed compliance will be			
	-	he found testing swabs and		•	the facility⊡s Quality			
		solution to conduct the ted she called the ADON and		Assurance Progra	m.			
		d the DON (Director of						
		ome to the building. Nurse #2						
	_ ,	ected by the ADON to tell						
	Nurse #3 when she c	ame in at 7:00 AM to have						
		mptoms of COVID-19 to be						
	-	ent solution was obtained.						
	Nurse #2 confirmed s	D-19 symptoms to Nurse #3						
	in report at 7:00 AM a	• •						
	· ·	be tested for COVID-19						
		ution was available in the						
	morning.							
	Nurse #3 was intervio	ewed on 2/18/2022 at 9:18						
		she remembered the						
		rse #2 but did not remember						
	what day the convers	sation happened. Nurse #3						
	revealed she recalled	receiving a list of residents						
	from Nurse #2 who n	eeded to be tested for		1				
		t shift because no reagent						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE	E SURVEY PLETED
		345389	B. WING				C / 18/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
					1101 HARTWELL STREET		
THE LAU	RELS OF FOREST GLEN	N			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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 886	Nurse #2 stated she of COVID-19 testing was testing on that day. N the COVID-19 testing her job to test all the r An interview was com 2/17/2022 at 12:50 Pf facility kept a COVID- documented the time each resident in the fa the testing log for Res located. The ADON s Nurse #2 on 1/9/2022 Documentation in a s 1/10/2022 at 5:55 PM tested positive for CC a family member was An interview was com- member of Resident # AM. The family member Resident #3 on 1/8/20 The family member st her and the other visit get too close to her be and congestion and n family member stated had informed the facil symptoms. Documentation in a n 1/13/2022 at 2:11 PM assessment and plan x-ray revealed Resider	e to perform the testing. did not recall if the s done or who did the urse #2 surmised NA #3 did on that day because it was residents every Monday. ducted with the ADON on M. The ADON revealed the 19 testing log which and date and result for acility. The ADON revealed sident #3 could not be tated she was not called by or 1/10/2022. ocial service note dated revealed Resident #3 VID-19 on a rapid test and notified. ducted with a family #3 on 2/18/2022 at 10:21 ber stated she visited 022 along with other visitors. tated Resident #3 said to tors during the visit to not ecause she had a cough night have COVID-19. The Resident #3 indicated she ity nursing staff of her	F	886	6		

Facility ID: 923173

If continuation sheet Page 33 of 58

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		345389	B. WING				C / 18/2022	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	_ ·		
	RELS OF FOREST GLEN	N		.	1101 HARTWELL STREET			
	TELS OF FOREST GLEN			•	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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 886	Dexamethasone 1 mg is prescribed to treat I Dexamethasone was recovering COVID-19 An observation was n AM in the front of the of the COVID-19 testi- nurses. Seventeen bo supplies were stacked Documentation on the testing boxes stated, qualitative detection of swab specimens." Th box revealed each bo Name] COVID-19 Ag positive control swab, insert, and 1 procedur made of each COVID each box contained a supplies that were list the boxes contained a Documentation on the the reagent bottle was process. An interview was con- 2/18/2022 at 11:49 AI performed COVID-19 the facility every othe she was working on N stated there were only where to obtain COVI facility, in the coffee s with the receptionist. An interview was con- Receptionist/Administ	g daily for 10 days. Levaquin bacterial infections and found to have benefits for patients. ande on 2/18/2022 at 11:30 building in the coffee shop ng supplies available to the oxes of COVID-19 testing d on top of each other. e outside of the COVID-19 "Rapid test for the of COVID-19 antigen in nasal ne Documentation on the ox was to contain, "40 [Brand cards, 40 nasal swabs, 1 , 1 reagent bottle, 1 product re card." Observations were -19 testing supply box and varying amount of the ted to be in the box. None of a reagent bottle. e procedure card revealed is required for the testing ducted with NA #3 on M. NA #3 confirmed she testing of the residents in r Monday, NA #3 confirmed Monday, 1/10/2022. NA #3 y two places she knew ID-19 testing supplies in the shop and at the front desk	F	886				

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If continuation sheet Page 34 of 58

	MENT OF HEALTH AN					FORM): 03/14/2022 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345389	B. WING		_		C 18/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				1101 HARTWELL STREET			
THE LAU	RELS OF FOREST GLEN	N		GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 886	COVID-19 testing sup solution bottle was ob interview in the office Receptionist/Administ box of COVID-19 test office should anyone in need to be tested for for COVID-19. The Re Assistant stated testin coffee shop and the fir the speech therapy of An interview was come Nursing (DON) on 2/1 DON confirmed the C Resident #3 could not revealed NA #3 was w nursing assistant on t and did not start the C residents until after he The DON confirmed if report on the morning had a cough and need COVID-19. The DON not discussed in morr be taken but she sum going over the 24-hou later in the day. The D supplies in the coffee reagent were kept so wasted, and additional ordered so the supplie explained the facility r testing supplies with r but it was removed up team. The DON further staff also had access supplies at the recept	pplies including a reagent served at the time of the of the receptionist. The trative Assistant revealed a ing supplies are kept in her arrive at the front door and COVID-19 after screening eceptionist/Administrative g supplies are kept in the ont desk area as well as fice. ducted with the Director of 8/2022 at 12:08 PM. The OVID-19 testing log for to be found. The DON vorking on the floor as a he morning of 1/10/2022 COVID-19 testing of the er shift ended at 3:00 PM. t was noted on the 24-hour of 1/10/2022, Resident #3 ded to be tested for did not know why this was ing meeting so action could nised the daily meeting ur report was not held until DON explained the testing shop in the boxes without that supplies were not al reagent solution was es could be used. The DON outinely kept a box of eagent in the coffee shop, yoon the arrival of the survey er explained the nursing	F 886				

Facility ID: 923173

If continuation sheet Page 35 of 58

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES					FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345389	B. WING					C 18/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
					1101 HARTWELL STREET			
THE LAU	RELS OF FOREST GLEN	N			GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
F 886	stated if the testing su the receptionist desk reagent solution, she directly so the testing made available to her facility had more reag stated that she had st have come to the buil the reagent solution for could have been imm #2 had called her. An the time of the intervie testing supplies that w speech therapy room nursing staff do not ha testing supplies in the they are stored there An interview was com- the Administrator on 2 Administrator confirm caring for residents fm 1/10/2022 and did noi COVID-19 until after 3 stated the facility was COVID-19 outbreak s were not tested on 1/ following day on 1/11/ was not aware of any other residents at that added that some of the positive were receiving of the therapists docu symptoms of COVID- 1/10/2022. On 1/10/20 include Resident #3 w COVID-19 so the heat contacted. The Admir	upplies were locked up at and Nurse #2 could not find should have called her supplies could have been immediately, because the ent available. The DON aff members who could ding immediately, retrieved or Nurse #2, and the testing ediately completed if Nurse observation was made at ew of additional COVID-19 vere kept locked in the . The DON confirmed the ave access to the COVID-19 e speech therapy room, but if needed. ducted with the DON and 2/18/2022 at 2:00 PM. The ed NA #3 was working om 7:00 AM to 3:00 PM on t start testing residents for 3:00 PM. The Administrator in the middle of a to any of the residents who 10/2022 were tested the /2022, because the facility other symptoms in any t time. The Administrator he residents who tested g therapy services and none mented any signs or 19 in the residents on 022 some of the residents to vere testing positive for	F	88				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345389	B. WING				_ 18/2022
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE LAUF	RELS OF FOREST GLEN	N			1101 HARTWELL STREET GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 886	the residents on the C rapid test for COVID- PCR (polymerase cha because it was taking The PCR test is a dia if you are infected by it contains genetic ma virus. The rapid COVI antigen test detects p causes COVID-19. Th most accurate in thos experiencing symptor noted that no other sy documented for Resid 1/11/2022. The Admir the residents were as and after the nurse pr who tested positive of asymptomatic except 2. Documentation in the #14 was up-to-date w COVID-19 vaccination Documentation in the #14 written by Nurse 4 (medication administr administration note da stated, "cough, sore t (Assistant Director of be tested this AM on [available]."	COVID-19 unit based on the 19 and not to wait for the ain reaction test) results 6 to 10 days to get results. gnostic test that determines analyzing a sample to see if aterial from the COVID-19 ID-19 test, also called the roteins from the virus which he rapid test is considered e individuals who are ns of COVID-19. The DON withow and the covid of the dent #3 on 1/10/2022 or histrator reiterated that all ymptomatic on 1/10/2022 ractitioner saw the residents in 1/10/2022, all were for one. he vaccine administration I record revealed, Resident ith all recommended ns. medical record of Resident #2 in an electronic MAR ation record) shift level ated 1/10/2022 at 12:28 AM hroat, low fever, ADON Nursing) aware, resident to 1rst shift when supplies	F	886			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>			(X3) DATE	
		345389	B. WING				C 18/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
					1101 HARTWELL STREET		
THE LAU	RELS OF FOREST GLEN	N			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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 886	Nurse #2 was intervie PM. Nurse #2 revealed the facility on the 7:00 #2 explained on the e morning of 1/10/2022 respiratory assessme hall. Upon assessme several of the residen not recall at the time of symptoms of COVID- hall should be tested indicated she went up to the "coffee shop" to test the residents she COVID-19 symptoms front of the building sh cards but no reagent testing. Nurse #2 stat was told both she and (DON) could not com- revealed she was dire Nurse #3 when she ca the residents with sym tested when the reagen Nurse #2 confirmed s residents with COVID in report at 7:00 AM a residents needed to b when the reagent solu- morning. Nurse #3 was intervie AM. Nurse #3 stated a conversation with Nur- what day the convers revealed she recalled from Nurse #2 who ne COVID-19 on the first	wed on 2/17/2022 at 7:17 ed she worked weekends at 0 PM to 7:00 AM shift. Nurse evening of 1/9/2022 into the she was doing her ints of the residents on her int Nurse #2 discovered its, whose names she could of the interview, had 19 and concluded the whole for COVID-19. Nurse #2 to the front of the building or get the testing supplies to identified as having . Nurse #2 explained at the ne found testing swabs and solution to conduct the ed she called the ADON and d the Director of Nursing e to the building. Nurse #2 excted by the ADON to tell ame in at 7:00 AM to have inptoms of COVID-19 to be ent solution was obtained. he gave a list of the 19 symptoms to Nurse #3 and told Nurse #3 the be tested for COVID-19 ution was available in the exwed on 2/18/2022 at 9:18 she remembered the rse #2 but did not remember ation happened. Nurse #3 receiving a list of residents	F	886	6		

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/14/2022 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345389	B. WING _					C 18/2022
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
THE LAUF	ELS OF FOREST GLEN	N			01 HARTWELL STREET ARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PI (EACH CORRECTI CROSS-REFERENC	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 886	the COVID-19 testing her job to test all the r Documentation in a se dated 1/10/2022 at 5: #14 tested positive for Documentation in a n note dated 1/11/2022 Resident #14 was see COVID-19 positive tes symptoms. An observation was n AM in the front of the of the COVID-19 testi nurses. Seventeen bo supplies were stacked Documentation on the testing boxes stated, ' qualitative detection of swab specimens." Th box revealed each bo Name] COVID-19 Ag positive control swab, insert, and 1 procedur made of each COVID each box contained a supplies that were list the boxes contained a Documentation on the the reagent bottle was process. An interview was contained	did not recall if the s done or who did the urse #2 surmised NA #3 did on that day because it was residents every Monday. ocial service progress note 53 PM revealed Resident r COVID-19. urse practitioner progress at 3:03 PM revealed en for an acute visit for st but was not showing any hade on 2/18/2022 at 11:30 building in the coffee shop ng supplies available to the bxes of COVID-19 testing d on top of each other. e outside of the COVID-19 "Rapid test for the of COVID-19 antigen in nasal ne Documentation on the x was to contain, "40 [Brand cards, 40 nasal swabs, 1 1 reagent bottle, 1 product re card." Observations were -19 testing supply box and varying amount of the ted to be in the box. None of a reagent bottle. e procedure card revealed is required for the testing	F	.86				
	2/18/2022 at 11:49 AM	M. NA #3 confirmed she						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345389	B. WING		_		C 18/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUF	RELS OF FOREST GLEN	Ν		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 PREFIX TAG	(EACH CORREC CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 886	the facility every other she was working on M stated there were only where to obtain COVI facility, in the coffee s with the receptionist. An interview was come Receptionist/Administ 2/18/2022 at 12:02 PI COVID-19 testing sup solution bottle was ob- interview in the office Receptionist/Administ box of COVID-19 test office should anyone a need to be tested for for COVID-19. The Ref Assistant stated testir coffee shop and the fit the speech therapy of An interview was come Nursing (DON) on 2/1 DON confirmed the C Resident #3 could not revealed NA #3 was w nursing assistant on t and did not start the C residents until after he The DON confirmed if report on the morning had a cough and need COVID-19. The DON not discussed in morr be taken but she sum going over the 24-hou	testing of the residents in r Monday. NA #3 confirmed Aonday, 1/10/2022. NA #3 y two places she knew D-19 testing supplies in the hop and at the front desk ducted with the trative Assistant on M in her office. One box of oplies including a reagent isserved at the time of the of the receptionist. The trative Assistant revealed a ing supplies are kept in her arrive at the front door and COVID-19 after screening eceptionist/Administrative ng supplies are kept in the ront desk area as well as ffice. ducted with the Director of 8/2022 at 12:08 PM. The OVID-19 testing log for t be found. The DON working on the floor as a he morning of 1/10/2022 COVID-19 testing of the er shift ended at 3:00 PM. t was noted on the 24-hour of 1/10/2022, Resident #3	F 886				

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 03/14/2022 ORM APPROVED NO. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) [DATE SURVEY COMPLETED	
		345389	B. WING			C 02/18/2022		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
THE LAU	RELS OF FOREST GLEN	N		11	01 HARTWELL STREET			
				G	ARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 886	reagent were kept so wasted, and additional ordered so the suppli- explained the facility in testing supplies with ri- but it was removed up team. The DON further staff also had access supplies at the recept when the screener lead stated if the testing su the receptionist desk reagent solution, she directly so the testing made available to her facility had more reag stated that she had so have come to the buil the reagent solution for could have been imm #2 had called her. And the time of the intervise testing supplies that will speech therapy room nursing staff do not have testing supplies in the they are stored there An interview was con Administrator on 2/18 Administrator confirm caring for residents fr 1/10/2022 and did no COVID-19 until after 3 stated the facility was	shop in the boxes without that supplies were not al reagent solution was es could be used. The DON routinely kept a box of reagent in the coffee shop, bon the arrival of the survey er explained the nursing to the box of testing to the box of the day. The DON taff members who could ding immediately, retrieved or Nurse #2, and the testing tediately completed if Nurse observation was made at the of additional COVID-19 were kept locked in the . The DON confirmed the ave access to the COVID-19 e speech therapy room, but if needed. ducted with the t/2022 at 2:00 PM. The ed NA #3 was working om 7:00 AM to 3:00 PM on t start testing residents for 3:00 PM. The Administrator	F	886				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345389	B. WING					C 18/2022
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
THE LAU	RELS OF FOREST GLEN	Ν			1101 HARTWELL STREET GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
F 886	following day on 1/11, was not aware of any other residents at that added that some of the positive were receiving of the therapists docu symptoms of COVID- 1/10/2022. On 1/10/2 were testing positive to department was conta- stated the facility was department to isolate COVID-19 unit based COVID-19 unit based COVID-19 and not to (polymerase chain re- it was taking 6 to 10 of test is a diagnostic test infected by analyzing contains genetic mate- virus. The rapid COV/ antigen test detects p causes COVID-19. The most accurate in those experiencing symptor Administrator reiterate asymptomatic on 1/10 practitioner saw the re- on 1/10/2022, all were- one. 3. Documentation in the #15 was up-to-date w COVID-19 vaccination	/2022, because the facility other symptoms in any t time. The Administrator he residents who tested in the residents who tested in the residents on 022 some of the residents for COVID-19 so the health acted. The Administrator of directed by the health the residents on the on the rapid test for wait for the PCR action test) results because days to get results. The PCR st that determines if you are a sample to see if it erial from the COVID-19 ID-19 test, also called the roteins from the virus which he rapid test is considered e individuals who are ms of COVID-19. The ed that all the residents were D/2022 and after the nurse esidents who tested positive e asymptomatic except for	F	88	16			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/14/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í				(X3) DATE COMP	SURVEY LETED
		345389	B. WING _			_		C 18/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				11	101 HARTWELL STREET			
THE LAUP	RELS OF FOREST GLEN	N		G	ARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 886	Director of Nursing) a this AM on first shift w available." The docur note was to, "show or 24-hour report." Nurse #2 was intervie PM. Nurse #2 revealed the facility on the 7:00 #2 explained on the e morning of 1/10/2022 respiratory assessme hall. Upon assessme hall. Upon assessme hall. Upon assessme hall. Upon assessme hall should be tested indicated she went up to the "coffee shop" to test the residents she COVID-19 symptoms front of the building sh cards but no reagent testing. Nurse #2 stat was told both she and (DON) could not come revealed she was dire Nurse #3 when she ca the residents with syn tested when the reagen Nurse #2 confirmed s residents meded to b when the reagent solu-	throat, ADON (Assistant ware, resident will be tested then [COVID-19] supplies mentation also revealed the a shift report" and "show on weed on 2/17/2022 at 7:17 ed she worked weekends at 0 PM to 7:00 AM shift. Nurse vening of 1/9/2022 into the she was doing her nts of the residents on her at Nurse #2 discovered ts, whose names she could of the interview, had 19 and concluded the whole for COVID-19. Nurse #2 to the front of the building o get the testing supplies to identified as having . Nurse #2 explained at the ne found testing swabs and solution to conduct the ed she called the ADON and the Director of Nursing to the building. Nurse #2 excted by the ADON to tell ame in at 7:00 AM to have approms of COVID-19 to be ent solution was obtained. he gave a list of the -19 symptoms to Nurse #3 and told Nurse #3 the te tested for COVID-19 ution was available in the	F	386				
	Nurse #3 was intervie	wed on 2/18/2022 at 9:18						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE	E SURVEY PLETED
		345389	B. WING				C / 18/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	101 HARTWELL STREET		
THE LAU	RELS OF FOREST GLEN	Ν			GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)					(X5) COMPLETION DATE
F 886	AM. Nurse #3 stated a conversation with Nur what day the convers revealed she recalled from Nurse #2 who ne COVID-19 on the first solution was available Nurse #2 stated she of COVID-19 testing was testing on that day. N the COVID-19 testing her job to test all the n Documentation in a st 1/11/2022 at 11:40 AN tested positive for CO Documentation in a N 1/11/2022 at 11:58 AN seeing this patient foll COVID-19 test. Patien [complains of] mild so symptoms." An observation was n AM in the front of the of the COVID-19 test nurses. Seventeen bo supplies were stacked Documentation on the testing boxes stated, qualitative detection of swab specimens." Th box revealed each bo Name] COVID-19 Ag positive control swab, insert, and 1 procedur	she remembered the rese #2 but did not remember ation happened. Nurse #3 receiving a list of residents eeded to be tested for shift because no reagent to perform the testing. did not recall if the s done or who did the urse #2 surmised NA #3 did on that day because it was residents every Monday. bocial service note dated A revealed Resident #15 VID-19. urse Practitioner note dated A stated in part, "I am lowing her rapid test positive nt is fully vaccinated. She ratchy throat but no other hade on 2/18/2022 at 11:30 building in the coffee shop ng supplies available to the boxes of COVID-19 testing d on top of each other. e outside of the COVID-19	F	886			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2022 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345389	B. WING		_		C 18/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAUF	RELS OF FOREST GLEN	Ν		101 HARTWELL STREET ARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 886	the boxes contained a Documentation on the the reagent bottle was process. An interview was com 2/18/2022 at 11:49 Al performed COVID-19 the facility every othe she was working on M stated there were only where to obtain COVI facility, in the coffee s with the receptionist. An interview was com Receptionist/Administ 2/18/2022 at 12:02 Pl COVID-19 testing sup solution bottle was ob interview in the office Receptionist/Administ box of COVID-19 test office should anyone need to be tested for for COVID-19. The Re Assistant stated testin	ted to be in the box. None of a reagent bottle. e procedure card revealed s required for the testing ducted with NA #3 on M. NA #3 confirmed she testing of the residents in r Monday. NA #3 confirmed Monday, 1/10/2022. NA #3 y two places she knew ID-19 testing supplies in the shop and at the front desk ducted with the trative Assistant on M in her office. One box of oplies including a reagent served at the time of the of the receptionist. The trative Assistant revealed a ing supplies are kept in her arrive at the front door and COVID-19 after screening eceptionist/Administrative ng supplies are kept in the ront desk area as well as	F 886		DEFICIENCY)		
	Nursing (DON) on 2/1 DON confirmed the C Resident #3 could no revealed NA #3 was w nursing assistant on t and did not start the C	ducted with the Director of 18/2022 at 12:08 PM. The OVID-19 testing log for t be found. The DON working on the floor as a he morning of 1/10/2022 COVID-19 testing of the er shift ended at 3:00 PM.					

Facility ID: 923173

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345389	B. WING				C / 18/2022
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1101 HARTWELL STREET		
	RELS OF FOREST GLEN	N			GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 886	report on the morning had a cough and neer COVID-19. The DON not discussed in morr be taken but she sum going over the 24-hou later in the day. The D supplies in the coffee reagent were kept so wasted, and additional ordered so the supplie explained the facility of testing supplies with or but it was removed up team. The DON further staff also had access supplies at the recept when the screener leas stated if the testing su the receptionist desk reagent solution, she directly so the testing made available to her facility had more reag stated that she had st have come to the buil the reagent solution for could have been imm #2 had called her. An the time of the intervie testing supplies in the they are stored there An interview was com-	t was noted on the 24-hour of 1/10/2022, Resident #3 ded to be tested for did not know why this was ning meeting so action could nised the daily meeting ur report was not held until DON explained the testing shop in the boxes without that supplies were not al reagent solution was es could be used. The DON routinely kept a box of reagent in the coffee shop, bon the arrival of the survey er explained the nursing to the box of testing ionist area until 11:30 PM, aves for the day. The DON upplies were locked up at and Nurse #2 could not find should have called her supplies could have been rimmediately, because the tent available. The DON taff members who could ding immediately, retrieved or Nurse #2, and the testing ediately completed if Nurse observation was made at ew of additional COVID-19 vere kept locked in the . The DON confirmed the ave access to the COVID-19 e speech therapy room, but	F	886			

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE S COMPL	
	CONTECTION			i	C	
		345389	B. WING			8/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
THE LAUF	RELS OF FOREST GLEN	N		1101 HARTWELL STREET 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 886	Continued From page	e 46	F 88	6		
	caring for residents fr	ed NA #3 was working om 7:00 AM to 3:00 PM on t start testing residents for				
	COVID-19 until after stated the facility was	3:00 PM. The Administrator in the middle of a				
	were not tested on 1/	so any of the residents who 10/2022 were tested the /2022, because the facility				
	other residents at tha	other symptoms in any t time. The Administrator ne residents who tested				
	positive were receivir of the therapists docu	ng therapy services and none Imented any signs or				
	1/10/2022. On 1/10/2	19 in the residents on 022 some of the residents for COVID-19 so the health				
	department was contained the facility was	acted. The Administrator directed by the health				
	department to isolate COVID-19 unit based COVID-19 and not to	l on the rapid test for				
	(polymerase chain re it was taking 6 to 10 c	action test) results because days to get results. The PCR				
	infected by analyzing	st that determines if you are a sample to see if it erial from the COVID-19				
	antigen test detects p	ID-19 test, also called the proteins from the virus which he rapid test is considered				
	most accurate in thos experiencing symptor	e individuals who are ms of COVID-19. The				
	asymptomatic on 1/1	ed that all the residents were 0/2022 and after the nurse esidents who tested positive				
	on 1/10/2022, all wer	o asymptomatic avcont for				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	03/14/2022 APPROVED
STATEMENT O	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345389	B. WING		_	(02/	C 18/2022
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•=	10/2022
			1	101 HARTWELL STREET			
THE LAUF	RELS OF FOREST GLENI	N		GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 886	Continued From page		F 886				
	#12 was up-to-date w COVID-19 vaccination						
	#12 written by Nurse a (Medication Administr administration note da stated, "Resident has Director of Nursing) a this AM when supplies documentation also re "show on shift report" report." Nurse #2 was intervie PM. Nurse #2 revealed the facility on the 7:00	evealed the note was to, and "show on 24-hour wed on 2/17/2022 at 7:17 ed she worked weekends at 0 PM to 7:00 AM shift. Nurse					
	morning of 1/10/2022 respiratory assessme hall. Upon assessmer several of the residen	nts of the residents on her ht Nurse #2 discovered ts, whose names she could					
	hall should be tested t indicated she went up to the "coffee shop" to test the residents she	19 and concluded the whole for COVID-19. Nurse #2 o to the front of the building o get the testing supplies to					
	front of the building sh cards but no reagent s testing. Nurse #2 state was told both she and (DON) could not come revealed she was dire Nurse #3 when she ca the residents with syn	ne found testing swabs and solution to conduct the ed she called the ADON and I the Director of Nursing e to the building. Nurse #2 ected by the ADON to tell ame in at 7:00 AM to have nptoms of COVID-19 to be ent solution was obtained.					

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	-	ID HUMAN SERVICES				FORM): 03/14/2022 MAPPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	LETED
		345389	B. WING		_		C 18/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
-				101 HARTWELL STREET			
THE LAUF	RELS OF FOREST GLEN	N		GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 886	Continued From page residents with COVID in report at 7:00 AM a residents needed to b when the reagent solu- morning. Nurse #3 was intervie AM. Nurse #3 stated conversation with Nur what day the convers revealed she recalled from Nurse #2 who ne COVID-19 on the first solution was available Nurse #2 stated she of COVID-19 testing was testing on that day. N the COVID-19 testing her job to test all the ner The documentation in testing log dated 1/10 Resident #12 tested p 5:10 PM. An observation was no AM in the front of the	e 48 -19 symptoms to Nurse #3 and told Nurse #3 the be tested for COVID-19 ution was available in the ewed on 2/18/2022 at 9:18 she remembered the rse #2 but did not remember ation happened. Nurse #3 receiving a list of residents eeded to be tested for a shift because no reagent e to perform the testing. did not recall if the s done or who did the urse #2 surmised NA #3 did on that day because it was residents every Monday. a the point of care antigen 1/2022 at 4:55 PM revealed bositive for COVID-19 at made on 2/18/2022 at 11:30 building in the coffee shop	F 886				
	nurses. Seventeen bo supplies were stacked	ng supplies available to the oxes of COVID-19 testing d on top of each other. e outside of the COVID-19					
	testing boxes stated, qualitative detection of swab specimens." Th box revealed each bo Name] COVID-19 Ag positive control swab,	"Rapid test for the of COVID-19 antigen in nasal ne Documentation on the ox was to contain, "40 [Brand cards, 40 nasal swabs, 1 , 1 reagent bottle, 1 product					
	· · ·	re card." Observations were -19 testing supply box and					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345389	B. WING				C 18/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE LAURELS OF FOREST GLENN					1101 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 886	each box contained a supplies that were list the boxes contained a Documentation on the the reagent bottle was process. An interview was con 2/18/2022 at 11:49 AI performed COVID-19 the facility every othe she was working on N stated there were only where to obtain COVI facility, in the coffee s with the receptionist. An interview was con Receptionist/Adminis 2/18/2022 at 12:02 PI COVID-19 testing sup solution bottle was ob interview in the office Receptionist/Adminis box of COVID-19 test office should anyone need to be tested for for COVID-19. The Re Assistant stated testin coffee shop and the fi the speech therapy of An interview was con Nursing (DON) on 2/1 DON confirmed the C Resident #3 could no revealed NA #3 was y nursing assistant on the	varying amount of the ted to be in the box. None of a reagent bottle. e procedure card revealed s required for the testing ducted with NA #3 on M. NA #3 confirmed she testing of the residents in r Monday. NA #3 confirmed Aonday, 1/10/2022. NA #3 y two places she knew ID-19 testing supplies in the shop and at the front desk ducted with the trative Assistant on M in her office. One box of oplies including a reagent oserved at the time of the of the receptionist. The trative Assistant revealed a ing supplies are kept in her arrive at the front door and COVID-19 after screening eceptionist/Administrative ng supplies are kept in the ront desk area as well as ffice.	F	886	3		

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STATEMENT OF DERICENCES AND PLAN OF CORRECTION (M) PROVIDERSUPFLIERCLA IDENTIFICATION NUMBER (M) DENTIFICATION NUMBER (M) DE		-	D HUMAN SERVICES					FORM): 03/14/2022 MAPPROVED). 0938-0391
345399 B: WHG 02/18/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE THE LAURELS OF FOREST GLENN STREET ADDRESS, CITY, STATE, 2P CODE VALID VALID </td <td>STATEMENT (</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td>` '</td> <td></td> <td></td> <td></td> <td>(X3) DATE COMP</td> <td>SURVEY LETED</td>	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '				(X3) DATE COMP	SURVEY LETED
IMAGE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STREE, ZP CODE THE LAURELS OF FOREST GLENN STREET ADDRESS, CITY, STREE, ZP CODE ION ISUMMARY STATEMENT OF DEFICIENCIES IPACE IPACING IPACIN REGULATORY OR LSD DEMTIFYING INFORMATION; PREEX CONTINUED CORRECTION UST BET PRECEDED BY FULL REGULATORY OR LSD DEMTIFYING INFORMATION; F 886 Continued From page 50 residents until after her shift ended at 3:00 PM. The DON confirmed it was noted on the 24-hour report on the morning of 11/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did not know why this was not discussed in morning meeting so action could be taken but she summised the daily meeting going over the 24-hour report was not held until later in the day. The DON with the boxes without reagent were kept so that supplies were not wasted, and additional reagent solution was ordered so the supplies could be used. The DON explained the facility routinely kept a box of testing supplies in the coffee shop, but it was removed upon the arrival of the survey team. The DON further explained the noting supplies at the receptionist area until 11:30 PM, when the screene leaves for the day. The DON stated if the testing supplies were locked up at the receptionist desk and Nurse #2 could have called her dicctly so the tubiling immediately, retrieved the reagent solution, for Nurse #2, and the testing could have been immediately, certieved the reagent solution for Nurse #2, and the testing could have been immediately, certieved the tragent solution, for Nurse #2, and the testing could have been immediately, contrieved the speech therapy room. The DON contirmed the speech therapy room. The DON			345389	B. WING _			-		
GARNER, NC 27529 CARTERLARGE OF FOREST GLEIN TAG CARNER, NC 27529 PROVIDERS PLAN OF CONRECTION (EACH EDFICIENCY MUST BE RECEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF CONRECTION (EACH EDFICIENCY MUST BE REFERENCED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDERS PLAN OF CONRECTION (EACH EDFICIENCY MUST BE REFERENCED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDERS PLAN OF CONRECTION (EACH EDFICIENCY MUST BE REFERENCED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDERS PLAN OF CONRECTION (EACH EDFICIENCY MUST BE REFERENCED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDERS PLAN OF CONRECTION (EACH EDFICIENCY MUST BE REFERENCED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDERS PLAN OF CONRECTION (EACH EDFICIENCY MUST BE REFERENCED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 886 Continued From page 50 residents unit after her shift ended at 3:00 PM. The DON Nord in the now as not held unit! Later in the day. The DON explained the facility routinely kept a box of testing supplies with reagent in the oxfore shop, but it was removed upon the arrival of the survey team. The DON Inther explained the survey team. The DON Nuther explained the survey team. The DON subt area culi 11:30 PM. When the screener leaves for the day. The DON stated that she had staff members who could have come to the building immediately, creates the fach and aled her. An observation was made at the time of the interi	NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
CANID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIENCE BY FULL (EACH DEFICIENCY MUST BE PRECIENCE BY FULL PRECIL/LITORY OR LSC IDENTIFYING INFORMATION) ID PRECIL/LITORY OF LSC IDENTIFYING INFORMATION) ID PRECIL/LITORY OF LSC IDENTIFYING INFORMATION INFORMATION ID PRECIL/LITORY INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INF					11	01 HARTWELL STREET			
Precipy TXG (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREINT TAG CEACH CORRECTIVE ACTION BOILD BE CROSS-BERESENCED TO THE APPROPRIATE DOMINITIES DEFICIENCY) F 886 Continued From page 50 residents until after her shift ended at 3:00 PM. The DON confirmed it was noted on the 24-hour report on the morning of 1/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did netwow why this was not discussed in morning meeting so action could be taken but she surmised the daily meeting going over the 24-hour report was not held until later in the day. The DON explained the testing supplies in the coffee shop, in the boxes without reagent were kept so that supplies could be used. The DON explained the facility routinely kept a box of testing supplies with reagent in the offee shop, but It was removed upon the arrival of the survey team. The DON turther explained the nursing staff also had access to the box of testing supplies at the receptionist area until 11:30 PM, when the screener leaves for the day. The DON stated if the testing supplies cuuld have called her directly so the testing supplies cuuld have access to the box of stated that she had staff members who could have come to the building immediately, retrieved the reagent solution for Nurse #2, and the testing could have been immediately, completed if Nurse #2 could have been immediately, retrieved the reagent solution for Nurse #2, and the testing could have been immediately, completed if Nurse #2 #2 Ad called her A. no bservation was made at the time of the interview of additional COVID-19 testing supplies in the speech therapy room. The DON stated that she had staff members who could have access to the COVID-19 testing supplies in the speech therapy room. The DON confirmed the nursing staff do not have access to the COVID-19 testing supplies there access	THE LAUF	RELS OF FOREST GLEN	N		G	ARNER, NC 27529			
residents until after her shift ended at 3:00 PM. The DON confirmed it was noted on the 24-hour report on the morning of 1/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did not know why this was not discussed in morning meeting so action could be taken but she surmised the daily meeting going over the 24-hour report was not held until later in the day. The DON explained the testing supplies in the coffee shop in the boxes without reagent were kept so that supplies were not wasted, and additional reagent solution was ordered so the supplies could be used. The DON explained the facility routinely kept a box of testing supplies with reagent in the coffee shop, but it was removed upon the arrive of the survey team. The DON further explained the nursing staff also had access to the box of testing supplies at the receptionist area until 11:30 PM, when the screener leaves for the day. The DON stated if the testing supplies were locked up at the receptionist desk and Nurse #2 could not find reagent solution, she should have called her direcity so the testing supplies where called her direcity to the testing supplies where alled her direcity to the testing supplies where could have been made available to her immediately, cretieved the reagent solution for Nurse #2, and the testing could have been immediately completed if Nurse #2 had called her. An observation was made at the time reagent solution for Nurse #2, and the testing could have been immediately completed if Nurse #2 had called her. An observation was made at the time of the interview of additional COVID-19 testing supplies in the speech therapy room, but	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BI		COMPLETION
An interview was conducted with the	F 886	residents until after he The DON confirmed in report on the morning had a cough and neer COVID-19. The DON not discussed in morr be taken but she surn going over the 24-hou later in the day. The D supplies in the coffee reagent were kept so wasted, and additional ordered so the supplie explained the facility r testing supplies with r but it was removed up team. The DON further staff also had access supplies at the recept when the screener leas stated if the testing su the receptionist desk reagent solution, she directly so the testing made available to her facility had more reag stated that she had st have come to the buil the reagent solution for could have been imm #2 had called her. An the time of the intervie testing supplies that w speech therapy room. nursing staff do not ha testing supplies in the they are stored there	er shift ended at 3:00 PM. t was noted on the 24-hour of 1/10/2022, Resident #3 ded to be tested for did not know why this was ning meeting so action could nised the daily meeting ar report was not held until DON explained the testing shop in the boxes without that supplies were not al reagent solution was es could be used. The DON routinely kept a box of eagent in the coffee shop, bon the arrival of the survey er explained the nursing to the box of testing ionist area until 11:30 PM, aves for the day. The DON upplies were locked up at and Nurse #2 could not find should have called her supplies could have been immediately, because the ent available. The DON aff members who could ding immediately, retrieved or Nurse #2, and the testing ediately completed if Nurse observation was made at ew of additional COVID-19 vere kept locked in the . The DON confirmed the ave access to the COVID-19 e speech therapy room, but if needed.	F	86				

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(V2)	IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY IPLETED
			A. BOILDING			С
		345389	B. WING			2/18/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/10/2022
				1101 HARTWELL STREET	-	
THE LAUP	RELS OF FOREST GLEN	IN		GARNER, NC 27529		
	STIWWARA S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	PRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X3) COMPLETIO DATE
F 886	Continued From pag	e 51	F 886	3		
		8/2022 at 2:00 PM. The	1 000			
		ned NA #3 was working				
		rom 7:00 AM to 3:00 PM on				
		ot start testing residents for				
		3:00 PM. The Administrator				
	stated the facility was					
		so any of the residents who				
		/10/2022 were tested the				
	following day on 1/11	/2022, because the facility				
		y other symptoms in any				
		at time. The Administrator				
	added that some of t	he residents who tested				
	positive were receivi	ng therapy services and none				
	of the therapists doc	umented any signs or				
		-19 in the residents on				
		2022 some of the residents				
		for COVID-19 so the health				
		tacted. The Administrator				
		s directed by the health				
		e the residents on the				
		d on the rapid test for				
	COVID-19 and not to					
		eaction test) results because				
		days to get results. The PCR est that determines if you are				
	-	-				
		g a sample to see if it erial from the COVID-19				
	•	/ID-19 test, also called the				
	-	proteins from the virus which				
		he rapid test is considered				
		se individuals who are				
		ms of COVID-19. The DON				
		the facility policy to notify an				
		pre sending a resident who				
	has tested positive for					
		ecision could be made to				
		lent should be seen by the				
	outside provider for t	-				
	outside provider for t	ne appointment. The				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345389	B. WING				_ 18/2022
NAME OF PI	ROVIDER OR SUPPLIER		-	;	STREET ADDRESS, CITY, STATE, ZIP CODE	, <u> </u>	
THE LAUF	RELS OF FOREST GLEN	N			1101 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	D PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE CC			
F 886	asymptomatic on 1/10 practitioner saw the re- on 1/10/2022, all were one. 5. Documentation in t section of the medica #13 was up-to-date w COVID-19 vaccination Documentation in the #13 written by Nurse (Medication Administr administration note da stated, "cough, fatigue of Nursing) aware, re- on 1rst shift when [CC The documentation at to, "show on shift repor- report." Nurse #2 was intervie PM. Nurse #2 revealed the facility on the 7:00 #2 explained on the e morning of 1/10/2022 respiratory assessme hall. Upon assessme not recall at the time of symptoms of COVID- hall should be tested indicated she went up	0/2022 and after the nurse esidents who tested positive e asymptomatic except for he vaccine administration I record revealed, Resident ith all recommended ns. medical record of Resident #2 in an electronic MAR ration Record) - shift level ated 1/10/2022 at 12:31 AM e, ADON (Assistant Director sident to be tested this AM DVID-19] supplies available." Iso revealed the note was ort" and "show on 24-hour ewed on 2/17/2022 at 7:17 ed she worked weekends at 0 PM to 7:00 AM shift. Nurse vening of 1/9/2022 into the she was doing her nts of the residents on her nt Nurse #2 discovered ts, whose names she could of the interview, had 19 and concluded the whole for COVID-19. Nurse #2 o to the front of the building o get the testing supplies to	F	886	,		
	front of the building sl cards but no reagent	. Nurse #2 explained at the ne found testing swabs and solution to conduct the ed she called the ADON and					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345389	B. WING			0	C 2/18/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	RELS OF FOREST GLEN	N			1101 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 886	 was told both she and (DON) could not com- revealed she was dire Nurse #3 when she ca the residents with synt tested when the reage Nurse #2 confirmed s residents with COVID in report at 7:00 AM a residents needed to b when the reagent solut morning. Nurse #3 was intervie AM. Nurse #3 stated s conversation with Nur what day the convers revealed she recalled from Nurse #2 who ne COVID-19 on the first solution was available Nurse #2 stated she co COVID-19 testing was testing on that day. N the COVID-19 testing her job to test all the ne The documentation in testing log dated 1/10 Resident #13 tested p 4:43 PM. Documentation in a se 1/10/2022 at 5:50 PM tested positive for CC moved to the COVID- 	d the Director of Nursing e to the building. Nurse #2 ected by the ADON to tell ame in at 7:00 AM to have inptoms of COVID-19 to be ent solution was obtained. the gave a list of the 0-19 symptoms to Nurse #3 and told Nurse #3 the be tested for COVID-19 ution was available in the ewed on 2/18/2022 at 9:18 she remembered the rse #2 but did not remember ation happened. Nurse #3 receiving a list of residents eeded to be tested for t shift because no reagent e to perform the testing. did not recall if the s done or who did the urse #2 surmised NA #3 did on that day because it was residents every Monday. The point of care antigen 1/2022 at 4:23 PM revealed positive for COVID-19 at cocial service note dated i revealed Resident #13 pVID-19 and was being	F	886	6		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345389	B. WING				C / 18/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·	
THE LAU	RELS OF FOREST GLEN	Ν			1101 HARTWELL STREET GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE C TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 886	of the COVID-19 testi nurses. Seventeen bo supplies were stacked Documentation on the testing boxes stated, qualitative detection of swab specimens." Th box revealed each bo Name] COVID-19 Ag positive control swab, insert, and 1 procedu made of each COVID each box contained a supplies that were list the boxes contained a Documentation on the the reagent bottle was process. An interview was con 2/18/2022 at 11:49 Af performed COVID-19 the facility every othe she was working on N stated there were only where to obtain COVI facility, in the coffee s with the receptionist. An interview was con Receptionist/Adminis 2/18/2022 at 12:02 Pf COVID-19 testing sup solution bottle was ob interview in the office Receptionist/Adminis box of COVID-19 test office should anyone	ing supplies available to the boxes of COVID-19 testing d on top of each other. e outside of the COVID-19 "Rapid test for the of COVID-19 antigen in nasal ne Documentation on the box was to contain, "40 [Brand cards, 40 nasal swabs, 1 , 1 reagent bottle, 1 product re card." Observations were -19 testing supply box and a varying amount of the ted to be in the box. None of a reagent bottle. e procedure card revealed s required for the testing ducted with NA #3 on M. NA #3 confirmed she testing of the residents in r Monday. NA #3 confirmed Monday, 1/10/2022. NA #3 y two places she knew ID-19 testing supplies in the shop and at the front desk	F	88	6		

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	-	ID HUMAN SERVICES				FORM): 03/14/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345389	B. WING		_		C 18/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				1101 HARTWELL STREET			
THE LAUF	RELS OF FOREST GLEN	N		GARNER, NC 27529			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDERS	S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRE	CTIVE ACTION SHOULD BI		COMPLETION DATE
IAG					DEFICIENCY)		
F 886	Continued From page	e 55	F 886	;			
	for COVID-19. The Re	eceptionist/Administrative					
	Assistant stated testir	ng supplies are kept in the					
	coffee shop and the fi	ront desk area as well as					
	the speech therapy of	ffice.					
	An interview was con	ducted with the Director of					
		8/2022 at 12:08 PM. The					
		OVID-19 testing log for					
	Resident #3 could not	00					
		working on the floor as a					
		he morning of 1/10/2022					
		COVID-19 testing of the					
		er shift ended at 3:00 PM.					
		t was noted on the 24-hour					
		of 1/10/2022, Resident #3					
	had a cough and nee						
		did not know why this was					
		ning meeting so action could					
		nised the daily meeting					
		ur report was not held until					
		OON explained the testing					
	-	shop in the boxes without					
		that supplies were not					
		al reagent solution was					
	ordered so the suppli	es could be used. The DON					
	explained the facility r	routinely kept a box of					
	testing supplies with r	eagent in the coffee shop,					
	but it was removed up	oon the arrival of the survey					
	team. The DON furthe	er explained the nursing					
	staff also had access	to the box of testing					
		ionist area until 11:30 PM,					
	when the screener lea	aves for the day. The DON					
		upplies were locked up at					
	-	and Nurse #2 could not find					
		should have called her					
	directly so the testing	supplies could have been					
		immediately, because the					
	facility had more reag	ent available. The DON					
	stated that she had st	aff members who could					

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME					FORM	: 03/14/2022 APPROVED . 0938-0391
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345389	B. WING		_	02/ [,]	; 18/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE LAURELS OF FOREST GLENN			1101 HARTWELL STREET			
THE LAURELS OF FOREST GLENN			GARNER, NC 27529			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES /UST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
the reagent solution for could have been immed #2 had called her. An of the time of the interview testing supplies that we speech therapy room. T nursing staff do not have testing supplies in the si they are stored there if n An interview was condu Administrator on 2/18/20 Administrator confirmed caring for residents from 1/10/2022 and did not si COVID-19 until after 3:0 stated the facility was in COVID-19 outbreak so were not tested on 1/10 following day on 1/11/20 was not aware of any of other residents at that til added that some of the positive were receiving of the therapists docum symptoms of COVID-19 1/10/2022. On 1/10/202 were testing positive for department was contact stated the facility was did department to isolate th COVID-19 unit based of COVID-19 and not to wa (polymerase chain react it was taking 6 to 10 day	ng immediately, retrieved Nurse #2, and the testing diately completed if Nurse bservation was made at v of additional COVID-19 re kept locked in the The DON confirmed the e access to the COVID-19 peech therapy room, but needed. ucted with the 022 at 2:00 PM. The d NA #3 was working n 7:00 AM to 3:00 PM on start testing residents for 00 PM. The Administrator n the middle of a any of the residents who //2022 were tested the 022, because the facility ther symptoms in any ime. The Administrator residents who tested therapy services and none ented any signs or 0 in the residents on 22 some of the residents r COVID-19 so the health ted. The Administrator irected by the health ted residents on the n the rapid test for ait for the PCR tion test) results because ys to get results. The PCR that determines if you are	F 886				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/14/2022 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345389	B. WING			_		C 18/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		10,2022
THE LAU	RELS OF FOREST GLEN	Ν			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 PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 886	contains genetic mate virus. The rapid COVI antigen test detects p causes COVID-19. Th most accurate in thos experiencing symptor Administrator reiterate asymptomatic on 1/10 practitioner saw the re	erial from the COVID-19 ID-19 test, also called the roteins from the virus which ne rapid test is considered se individuals who are	F	886				

Event ID: L6W311

Facility ID: 923173

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