STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING _____ B. WING _____	C 04/04/2024

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THE LAURELS OF FOREST GLENN	1101 HARTWELL STREET GARNER, NC 27529

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E 000	Initial Comments An unannounced complaint investigation and recertification survey was conducted on 4/1/24 through 4/4/24. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID # TKV411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/1/24 to 4/4/24 event ID#TKV411. The following intakes were investigated: NC00215206, NC00206609, and NC00215864. 6 of the 6 complaint allegations did not resut in deficiency.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		4/22/24

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

Electronically Signed | 04/29/2024

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F 761	Continued From page 1 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to ensure medications were not left unattended on top of the medication cart (100 Hall medication cart) and failed to dispose or discard out of date medications stored in 2 of 5 medication carts (100 Hall middle A/B medication cart). The findings included: 1a. On 4/03/24 a continuous observation from 9:50 AM through 9:55 AM was conducted during a medication pass. Nurse #2 was observed to have left 2 medicine cups of prepared medication unattended on top of the 100-hall medication cart. Nurse #2 was observed to have covered each medication cup with a plastic cup. Nurse #2 was then observed to have left the medication cart and proceeded down the 100 hallway toward the 100-hall nursing desk looking for a vital signs monitor to take a resident's blood pressure. Nurse #2 went to a resident's room, donned on personal protective equipment, then entered a resident room to check a resident's blood pressure. At 9:55 AM Nurse #2 returned to the medication cart. Two residents, one from room 128 and another from room 131, (semi-private rooms) were in the hall near the medication cart during the period when the nurse left the medication cups unattended. The two residents had cognitive loss and were up in their wheelchairs self-mobilizing around the hall.	F 761	F761 The facility will continue to store medications in accordance with State and Federal laws. The undated and unpackaged medications were discarded at the time of discovery. No negative outcome was identified as a result of this observation. Nurse #2 that did not secure all medications in the medication cart received a one-to-one education on 4/3/24, by the Director of Nursing, on proper medication storage. No negative outcome was identified as a result of this observation. Current residents have the potential to be affected. All medication carts and medication rooms were audited by the Director of Nursing, Assistant Director of Nurse and or Unit Managers on 4/10/24 to ensure that medications were stored in accordance with State and Federal laws. No negative outcome was identified as a result of these observations. 100% of licensed nurses and medication aides will be inserviced by the Director of Nursing, Assistant Director of Nursing and or Unit Managers as of 4/19/24 on the facility policy for storing medications in	

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F 761	Continued From page 2 1b. On 4/03/24 a continuous observation from 1:44 PM through 1:49 PM during a medication pass, Nurse #2 was observed to have left a medicine cup of prepared medication unattended on top of the 100-hall medication cart. Nurse #2 was observed to have covered the medication cup with a plastic cup. Nurse #2 went to the medication room and returned at 1:49 PM to the medication cart. Two residents, room 128 and room 131 were observed to have been in the hallway near the medication cart. The two residents had cognitive loss and were in their wheelchairs self-mobilizing around the hall. An interview with Nurse #2 on 4/3/24 at 1:56 PM revealed the nurse acknowledged she left the medications cups unattended on top of 100 hall medication cart during both observations. Nurse #2 stated she normally doesn't go that far away from the medications cart but explained she was in a rush. 2a. An observation was conducted on 4/4/24 at 2:43 PM of middle A/B medication cart with Nurse #3. A vial of multidose lidocaine hydrochloride injection 1% (used as a local injectable anesthetic) was found open in the medication cart and was not dated when opened. 2b. The manufacturer's recommendations for Ipratropium-albuterol stated to keep the medication in the container it came in, and to keep the packaging tightly closed. Keep the unused vials of nebulizer solution in the foil pouch until they were used. Once removed from the foil pouch, the individual vials should be used within one week. An observation was conducted on 4/4/24 at 2:43	F 761	accordance with State and Federal laws. A QA monitoring tool will be utilized to ensure ongoing compliance by the Director of Nursing, Assistant Director of Nursing and or Unit Managers beginning on 4/22/24. The Director of Nursing, Assistant Director of Nursing and or Unit Managers will audit each medication cart and medication room 5x/week x 2 weeks, then 3x/week x 2 weeks, then weekly x 1 month, then bi-weekly x 1 month to ensure that medications are stored in accordance with State and Federal laws. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 4/22/24 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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F 761	Continued From page 3 PM of middle A/B medication cart. Ipratropium-albuterol 0.5-3 milligrams (mg)/3 (used for chronic obstructive pulmonary disease) vials were observed in the medication cart. The individual vials were found outside of the foil in two different boxes in the medication cart with no date. An interview with Nurse #3 on 4/4/24 at 2:45PM revealed nursing staff should be checking the medication cart and remove all non-dated medications. Nurse #3 also stated that the vial of multidose lidocaine hydrochloride and vials of Ipratropium-albuterol 0.5-3mg/3 should have been removed and returned to the pharmacy. An interview with the Nurse Supervisor on 4/4/24 at 2:48 PM revealed the vial of multidose lidocaine hydrochloride should have been dated and the vials of Ipratropium-albuterol 0.5-3mg/3 should have been inside of the foil packaging. An interview with the Director of Nursing (DON) on 4/4/24 at 3:20 PM revealed that all medication when pulled from the medication cart should be secured, and not left unattended. Nursing staff should check all medication rooms and medication carts for any expired medications on a weekly basis and remove multidose vials with no dates and remove Ipratropium-albuterol 0.5-3mg/3 when out of the foil packaging. Medication rooms and medication carts were inspected for proper medication storage monthly by the pharmacy staff.	F 761		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and	F 867		4/9/24

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F 867	Continued From page 4	F 867		

monitoring.
A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and

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F 867	Continued From page 5	F 867		

systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

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F 867	Continued From page 6 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 6/21/21 recertification and complaint investigation. This was for 1 recited deficiency on	F 867	F867 The facility will continue to ensure that the quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance	

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F 867	Continued From page 7 the current recertification and complaint survey of 2/23/24 in the area of label/store drugs and biologicals (F761). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F671- Label/store drugs and biologicals: Based on record review, observation and staff interviews, the facility failed to ensure that medication were securely stored in a locked medication cart and not left unattended that was inaccessible by residents and failed to dispose or discard out of date medications in 2 of 5 medication carts. During the 6/21/21 recertification and complaint investigation survey the facility failed to discard insulin medications in accordance with the manufacturer's instruction for 1 medication cart (100 hall) out of 4 medication carts observed for medication storage.	F 867	activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. All Residents have the potential to be affected by the same deficient practice. The facility's quality assurance committee was in serviced by Regional Clinical Coordinator on 4/9/24. Material presented was a repeat of our QAPI training completed by our Regional Quality Coordinator on 3/29/24. The facility□s quality assurance committee was monitored for compliance with F867 citation by our Regional Clinical Coordinator on 4/17/24. The facility□s QAPI Team will complete education for QAPI related activities as recommended by Alliant Health QIO. Education session with the Alliant QIO completed on 4/23/24 Titled QAPI Talk. Additional education may be scheduled as needed per Alliant QIO Health recommendations. Education has included determining the root cause of the identified concerns, and identifying, implementing, and monitoring the corrective action plan and recognizing when an action plan may need to be revised. The facility□s QAPI Team will complete education for QAPI related activities as recommended by Alliant Health QIO. Additional education session with the Alliant QIO completed on 4/23/24 Titled QAPI Talk. Additional education will be	

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F 867	Continued From page 8	F 867	scheduled as needed per Alliant QIO Health recommendations. QA monitoring will be completed at least quarterly, with results shared with Regional Clinical Services Coordinator to ensure quality assessment and assurance committee is identifying issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies and monitoring of the corrective action plans and revising the corrective action plan as needed. Audit results will be reported to the QAPI Committee for 2 quarters beginning on 4/29/24. Our Regional Clinical Services Coordinator will attend either in person or remotely for input and changes as indicated. Continued compliance will be monitored through the facilitys Quality Assurance Performance Improvement Committee. Compliance will be monitored by the QA Committee and the Regional Clinical Coordinator for 2 quarters and deficient practice is resolved. Additional education/training/actions will be provided for any issues	