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 _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF FOREST GLENN	1101 HARTWELL STREET GARNER, NC 27529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to ensure that medication was locked in secure storage for 1 out of 2 residents (Resident #131), found with medication in room. The findings included: Resident #131 was admitted to the facility on 6/7/12 with the following cumulative diagnoses, macular degeneration, anxiety and hypertension. On the quarterly Minimum Data Set (MDS) assessment, dated 9/2/13, she was assessed as being cognitively intact with moderate vision impairment. On 12/2/13 at 11:12 am, during an initial tour, Resident #131's room was observed. It was located next to the nurse's station. Resident #131 was not in her room, yet the door remained open. Several residents with cognitive impairments were seated in wheelchairs next to the nurse's station; none were noted to wander into rooms. In the corner of her room, next to the window, a small nightstand stood, covered with personal	F 323	The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is January 2, 2014. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F323 The bottle of store brand eye drops and stool softener for resident #131 has been removed. The family has been educated not to bring in medications to the facility without notifying the charge nurse and Unit Manager done by Unit Manager on 12/04/2013.	1/2/14

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

Electronically Signed | 12/23/2013

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F 323	Continued From page 1 grooming supplies. Within the contents, a box of store brand eye drops were viewed as well as a bottle of store brand stool softener. It was not determined if the containers holding the medication, were previously opened. On 12/3/13 at 11:00 am, a second visit was made to Resident #131's unoccupied room. The door remained open and the stool softener and eye drops were viewed on the night stand again. A chart review was conducted and revealed that Resident #131 did not have an assessment to self-administer medication, nor did she have orders to use eye drops or a stool softener. Her care plan, last reviewed on 9/2/13, did not reflect any instructions for her to use these medications independently. Administrative Staff #1 was interviewed on 12/4/13 at 8:38 am. She stated that Resident #131 was legally blind with intermittent confusion. She shared that she was able to recognize staff visually but probably needed large print to read. She shared that a relative that visited her often, purchased her supplies, but she was unaware that she had medication, unattended in her room. Nurses were responsible for giving residents stool softeners, she added and she would have to investigate why the medications were left with the resident in her room. On 12/4/13 at 9:34 am, the Administrative Staffs #1 and #2 stated that they spoke to Resident #131 and she explained that a family member brought in medication for her to use but she hadn't used any of it. Administrative Staff #2 commented that she explained to Resident #131 that they would need to confiscate the medication	F 323	Current residents have the potential to be affected. The Unit Managers will audit all rooms for medications located at the bedside by 12/30/2013. Medications will be removed or an order obtained for the medication and a self administration assessment completed for those residents who wish to self administer. Residents who wish to self administer medications will be provided with a means to secure the medications when they are not in their rooms. All nursing staff to be re-educated by the Staff Development Coordinator (SDC) relating to residents keeping medications at the bedside on 12/27/2013. Staff that were not able to attend will be re-educated before working their next shift. Education will include but not limited to the assessment for self-administration of medications, obtaining physician orders for medications at bedside, updating resident care plans, and making sure that residents□ medications are locked at the bedside when unattended. Nursing Administrative Staff to conduct alternating halls 100/200 observations of resident rooms and audits (3) three times weekly for (4) four weeks. All variances will be corrected at the time of observation. Monitoring results will be reported to the Director of Nursing and to the Quality Assurance committee during	

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F 323	Continued From page 2 and could look into getting a medical order for her, if it was warranted. She shared that she planned to address with the family member, not to bring in medications when they visited later today. On 12/5/13 at 11:38 am, Resident #131 was interviewed. She was sitting in her doorway, wearing her eye glasses. Her vision appeared to be functional and she was alert and oriented. When asked about the stool softener and eye drops in her room, she commented that she believed that a family member brought them in for her about six months ago, but she never used them. She mentioned that she had macular degeneration and didn't notice the items.	F 323	the monthly meeting. Continued compliance will be monitored through routine round observations and record reviews by the charge nurses and Unit Managers and through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329		1/2/14

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F 329	Continued From page 3 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain a valproic acid level (used to check medications used for seizures) and HgbA1c level (used to test blood sugars) for the 2013 calendar year for 1 out of 5 (Resident #77) sampled residents for unnecessary medications. The findings included: Resident #77 was admitted to the facility in 2006 and then re-admitted on 9/21/12. His diagnoses included peripheral neuropathy, seizure disorder, psychosis and advanced dementia. Review of the physician's orders for 12/1/13 to 12/31/13 revealed that Resident #77 was started on Depakote Sprinkles (anti-seizure medication) 1000 mg (milligrams) at bedtime since 3/22/10. Labs for the Depakote level were to be drawn every six months in June and December. Likewise, Risperdal (anti-psychotic medication) 0.5 mg for a diagnosis of psychosis, was administered at bedtime, since 7/12/13, when the dosage was decreased. Labs for HgbA1c were to be drawn every six months in March and September. The Medication Regimen Review recorded on 4/23/13 the pharmacy consultant recommended	F 329	F329 Resident #77 had an HgbA1c and valproic acid level drawn on 12/5/2013. No negative outcome resulted from the delay in lab testing. Current residents with lab orders and/or pharmacy recommendations have the potential to be affected. Nursing Administrative Staff will conduct record audits to ensure that all labs have been completed as ordered by the physician by 12/31/2013. Corrections will be made promptly upon identification. Licensed staff will be reeducated by the SDC relating to the facilities lab tracking process by 12/27/2013. Nursing Administrative Staff will conduct audits of the lab tracking logs (2) twice weekly for (4) four weeks to ensure labs have been completed as ordered. Variances will be corrected as identified. Additionally the Unit Managers will review the pharmacy recommendations for the past 60 days to ensure the attending physician has responded. Variances will be re-addressed with the physician.	

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F 329	Continued From page 4 checking the valproic level. On 5/29/13, she mentioned that a gradual dose reduction for Risperdal would be planned in the future. A Physician's Progress Note, 5/16/13, did not respond to any recommendations by the pharmacist to obtain laboratory results for anti-seizure and anti-psychotic medications. On 6/29/13, a new pharmacy consultant reviewed the chart but did not make any recommendations for obtaining the valproic and HgbA1c levels. On 7/24/13, a new pharmacy consultant reviewed the chart but did not make any recommendations for obtaining the valproic and HgbA1c levels. On 8/20/13 and 9/23/13, a new pharmacy consultant reviewed the chart but did not make any recommendations for obtaining the valproic and HgbA1c levels. The Medical History and Physical Examination performed on 9/18/13 did not respond to any recommendation by the pharmacist and noted no pertinent laboratory findings. On 10/23/13, a new pharmacy consultant reviewed the chart but did not make any recommendations for obtaining the valproic and HgbA1c levels. The pharmacy consultant was interviewed on 12/4/13 at 3:00 PM. She stated that the pharmacy group representing the facility had not had stable representation of consultants, since the previously pharmacist was promoted and re-assigned last spring. She mentioned that she had only performed the medication regimen	F 329	Monitoring results will be reported to the Director of Nursing weekly and to the Quality Assurance committee during the monthly meeting. Continued compliance will be maintained through the facility□s monthly changeover process which includes review of current lab orders, routine review of the lab tracking logs, review of pharmacy recommendations monthly and through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 329	Continued From page 5	F 329		

review at the facility once this summer, otherwise, several pharmacists have been used to perform the task. She shared that their agency had recently acquired a string of nursing homes and were waiting to determine who would be assigned to this territory.

On 12/5/13 at 9:55 am, Resident #77's chart was reviewed. There were no laboratory results in the chart for valproic acid and HgbA1c levels. The record did indicate that labs had been drawn for other unrelated testing on 6/3/13, 8/5/13, 8/21/13, 9/5/13 and 11/4/13.

The Administrative Staff #1 was interviewed on 12/5/13 at 10:00 am. She was asked to assist with locating the valproic acids and HgbA1c testing in the file, but was unsuccessful. At 10:25 am, she returned to state that they recently ordered labs and she was waiting for the results to come back. She then phoned the laboratory who shared with her that they had no record of the labs being collected or the resident in their data base.

On 12/5/13 at 10:47 am, Administrative Staff #1 stated that she performed daily reviews of the lab books to make sure that they were recorded, drawn and sent out, and then received by the facility. She continued by stating the night nurse on her unit, double checked the information. She shared a new lab scheduling tool and tracking form that they started using in November and stated that she had good compliance overall getting the nurses to complete the information.

When asked upon discovering their lab problems months ago, what was the reason for delaying drawing labs for Resident #77's until December,

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F 329	Continued From page 6 2013; Administrative Staff #1 responded that she didn't look back (audits) at missed labs, only looked forward in correcting the problem. Next she commented that she recognized that they still had a problem with labs and that there was still work to be done. She shared that Resident #77 had a history of seizure disorder but did not have activity for years. He was kept on Depakote to prevent a re-occurrence of seizure activity. She was able to produce the Lab Scheduling And Tracking Log for 12/4/13, which contained the name of Resident #77 with orders for HgbA1c and valproic acid. There were undated staff initials that the labs were drawn however, no staff initials that the results were received. Administrative Staff #2 was interviewed on 12/5/13 at 12:05 PM and shared that Administrative Staff #1 had brought to her attention a few months ago that she had a problem with missing labs on her unit. She wasn't sure if this information was brought forth in their quality assurance committee but stated that an action plan was developed. The Action Plan for Lab Services revealed a final goal date of 11/1/13. Actions to be completed included in-servicing staff on the appropriate use of the lab log, which must be checked each shift to ensure all labs were correct, results obtained, and are followed up with the physician. Lab books would be brought to the morning clinical meetings daily and reviewed by the administrative nurse for completion and accuracy. Results would be tracked monthly by the Administrator and Administrative Staff #2.	F 329		

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F 329	Continued From page 7 Administrative Staff #2 also shared during her interview, that she was unsuccessful in locating communications between the pharmacist and physician based on the medication regimen reviews. She commented that the facility had used about 4 different pharmacists since the original consultant relocated to a different territory, last spring. Laboratory log sheets, pertaining to Resident #77, from earlier in the year could not be found.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that the medication error rate was 5% or below by not flushing the gastostomy (G) tube with water between medications and by not giving the medication on a scheduled time. There were 2 errors of 25 opportunities for error, resulting to an 8 % error rate. The findings include: 1. Resident #110 was admitted to the facility on 9/3/10 with multiple diagnoses including Hypertension and Seizures Disorder. The facility's policy on medication administration via enteral feeding tube dated 11/02 was reviewed. The policy read in part " Each medication is administered separately. If the	F 332	F332 Resident #110 is receiving medications via G-tube per policy. No negative outcome resulted from the observation. Nurse #4 has received additional education on 12/9/2013 by the Director of Nursing, (DON) relating to flushing the G-tube between medications. Resident #186 is receiving his/her medication as ordered by the physician. No negative outcome resulted from the observation. Nurse #1 has received additional education on 12/11/2013 by the DON	1/2/14

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F 332	Continued From page 8 guest is to receive more than one medication at the same time, the enteral tubing is flushed with at least 5-10 milliliter (ml) of water between each medication to ensure tube patency and avoid possible physical interaction of the medications." Review of the physician's orders for December, 2013 revealed that Resident #110 was due for Coreg (antihypertensive drug) 25 milligrams (mgs) and Keppra (anti epileptic drug) 500 mgs /5 milliliter (ml) daily at 9:00 AM. On 12/4/13 at 8:33 AM, Nurse #4 was observed during the medication pass. She was observed to prepare the Keppra 5 ml and Coreg 25 mgs tablet. She crushed the Coreg and dissolved it in 30 ml of water. She administered the Keppra 5 ml via the G tube and followed it with the Coreg dissolved in water. Nurse #4 was not observed to flush the tube with water between the medications. At 2:45 PM, Nurse #4 was interviewed. She stated that she thought she flushed the tube between medications but she was nervous and might have missed to flush the tube. 2. Resident #186 was admitted to the facility on 11/6/13. Diagnoses included stage 4 decubitus ulcer and protein calorie malnutrition. Review of December 2013 Physician Orders included Vitamin C 500 milligrams daily at 4:00 PM. On 12/4/13 at 8:10 AM Nurse #1 was observed to administer Vitamin C 500 milligrams to Resident #186. During an interview on 12/4/13 at 1:37 PM, Nurse #1 indicated she did not notice that the Vitamin C	F 332	relating to the proper procedures for administering medications via G tube and as ordered by the physician. Current residents with G-tubes and/ or receiving medications have the potential to be affected. The SDC has in-serviced all licensed nurses on the proper procedures for G-tube medication administration and administering medications as ordered by the physician on 12/27/2013. The Administrative Nursing Staff will complete (2) medication pass observations per week x (4) weeks. Variances will be corrected at the time of observation. Results from the medication pass observations will be reviewed by the DON weekly for the next (4) weeks and concerns will be reported to the QA committee during the monthly meeting. Continued compliance will be monitored through routine med pass observations and through the facility□s Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns.	

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F 332	Continued From page 9 was scheduled to be given at 4:00 PM.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interviews the facility failed to implement their policy for storage of potentially hazardous food by not discarding expired food, not labeling and dating perishable food items in walk-in and reach-in coolers; failed to contain hair in net, during food preparation; failed to tightly cover meat stored in cooler; failed to ensure that dome lids were completely dry before using and failed to replaced 6 out of 17 stained divided meal plates. The findings included: The facility's policy on Storage of Potentially Hazardous Foods, dated April, 2010, stated that "Foods shall be stored in a manner that prevents cross-contamination and food borne illnesses. Food shall be dated, labeled, and properly covered or wrapped tightly. Refrigerated items shall bear label indicating product name and date	F 371	F Tag 371 The undated and unlabeled food items were discarded. The identified stained sectioned plates have been replaced. The Certified Dietary Manager, (CDM) will receive additional education on 12/19/2013 by the Administrator relating to the use of hairnets and the requirement for securing her hair. Dietary staff will ensure the dome lids are completely dry prior to utilization. Current residents who receive food from the kitchen have the potential to be affected.	1/2/14

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F 371	Continued From page 10 (month, day and year) product was received, used, or first opened." An initial tour of the kitchen was conducted on 12/2/13 at 9:30 am. The dietary manager was present and relayed that she had been in her current position since April, 2013. In the reach-in cooler, undated sandwiches and undated poured drinks were observed. The dietary manager explained that she does not have full compliance of her staff to follow policies and procedures. A second visit was made to the kitchen on 12/4/13 at 4:05 PM. Inside of the reach-in cooler was a half full container of sour cream with the date 11/4/13; two large 5 lb. containers of cottage cheese, opened, with no dates; 7 cups of milk, not labeled or dated; 3 racks of orange juice and 3 racks of gelatin with no visible dates or labels; five bowls of tossed salads with no labels or dates and eight slices of wheat bread in plastic wrap with no label or date. The walk-in cooler contained a bowl of au gratin potatoes with the date 11/28/13 written on the plastic cover. The dietary manager was present during the discovery and threw the potatoes out, once brought to her attention. She stated that perishable foods had to be discarded by the third day. At the steam table, the cook placed a rack of dishes to be used for dinner, that contained 5 stained sectioned plates and 1 sectioned plate with mild stains and deep knife markings. The dietary manager was interviewed and mentioned that she was advised to replace her worn dome lids, which she did, but did not relay that she had new inventory of sectioned plates.	F 371	The Dietary Staff have been re-educated on the facility□s policy for storage, preparation, distribution, and serving food under sanitary conditions by the CDM on 12/20/2013. A QA monitoring tool will be utilized (5) times a week by the Cooks times (1) month, then weekly times (2) months to ensure ongoing compliance with the facility□s food sanitation policies. Items will be discarded at the time of observation if out of compliance monitoring results will be reported to the Administrator weekly x 2 months and to the Quality Assurance Committee during the monthly meeting. Additional education and monitoring will be initiated for any identified concerns.	

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F 371	Continued From page 11 On 12/4/13 from 4:45 to 5:00 PM, the dietary manager was noted to be wearing a hairnet, which had slid away from her forehead and nape, leaving her bangs outside of the net and some hair, cascading around her neck. She stood at the sink, removing boiled sweet potatoes from a pot, peeling and cutting them and then mashing them for dinner. By the time, she completed the dish; the net had slid further off her head, only containing her pony tail. Immediately the dietary manager was interviewed about her hairnet. She commented that she frequently had problems keeping the net to stay on her head; so she'll ask her staff to tell her if it was sliding off. Then she stated that she used to wear a chef hat, that contained her hair better, but it became too hot to wear. She readjusted the hairnet so that it contained her hair, went to the sink to wash her hands, and then returned to food preparation. On 12/4/13 at 5:17 PM, the tray line began. An aide stood at the end of the line, using a suction device to remove warmed plates and then placed them in the insulated dome lids. During the process, four dome lids were observed with condensation in them, after being removed from the dry rack. A final tour of the kitchen was conducted on 12/5/13 at 9:30 am. Inside of the reach-in cooler was an undated, unlabeled plastic storage bag containing ham. Also, in unlabeled and undated plastic storage bag was a dry food item that the dietary aide stated was granola. Three pitchers of juice were observed undated, with no labels and there were also 2 pimiento cheese sandwiches	F 371		

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	345389	A. BUILDING _____ B. WING _____	12/05/2013

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F 371	Continued From page 12 without dates. The dietary aide relayed that these foods should have been labeled and dated. Next the contents in the walk-in cooler were observed. A bag of opened sausage, left exposed was on the shelf, undated. The dietary aide commented that the sausage should have been sealed inside of plastic storage bag, with the date written on the outside. Also a cheese sandwich was wrapped loosely in aluminum foil, still exposed. On 12/5/13 at 11:40 am, the corporate nurse was interviewed. She recorded the findings from the kitchen tours and relayed that they would ensure that staff were trained on the proper policies and procedures for food handling and sanitary conditions.	F 371		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, pharmacy and staff interviews, the facility failed to act upon a pharmacy recommendation regarding physician	F 428	F Tag 428 Resident #77 had an HgbA1c and valproic	1/2/14

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F 428	Continued From page 13 ordered laboratory tests for anti-seizure and anti-psychotic medications as well as the pharmacists failed to report irregularities to the attending physician and the director of nursing, for 1 of 5 residents (Resident #77) reviewed for unnecessary medications. The findings included: Resident #77 was admitted to the facility in 2006 and then re-admitted on 9/21/12. His diagnoses included peripheral neuropathy, seizure disorder, anxiety, psychosis and advanced dementia. Review of the physician's orders for 12/1/13 to 12/31/13 revealed that Resident #77 was started on Depakote Sprinkles (anti-seizure medication) 1000 mg (milligrams) at bedtime since 3/22/10. Labs for the Depakote level were to be drawn every six months in June and December. Likewise, Risperdal (anti-psychotic medication) 0.5 mg for a diagnosis of psychosis, was administered at bedtime, since 7/12/13, when the dosage was decreased. Labs for HgbA1c were to be drawn every six months in March and September. There were no laboratory results for valproic acid and HgbA1c for the 2013 calendar year in Resident #77's chart. The Medication Regimen Review recorded on 4/23/13 the pharmacy consultant recommended checking the valproic level. The following medication regimen reviews were performed by four separate pharmacy consultants on 6/29/13, 7/24/13, 8/20/13, 9/23/13	F 428	acid level drawn on 12/5/2013. Current residents with pharmacy recommendations have the potential to be affected. The Licensed Nursing staff will receive additional education by the SDC relating to follow up on pharmacy recommendations and the facility□s lab tracking process by 12/27/2013. Upon receipt of the pharmacy consultant□s monthly recommendations, the DON will review and forward the recommendations to the appropriate Unit Manager. The Unit Manager will ensure that recommendations are reviewed timely by the physician and any labs are scheduled and completed as ordered. The Unit Managers will forward the completed recommendations to the DON. The DON will review completion of the recommendations and report concerns to the Quality Assurance Committee during the monthly meeting. The Administrative Nursing Staff will conduct audits of the lab tracking logs weekly to ensure labs are completed as ordered. Variances will be corrected when indicated. Monitoring results will be reported to the DON weekly and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be maintained through the facility□s monthly changeover process, review of the monthly pharmacy	

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F 428	Continued From page 14 and 10/23/13, without mentioning (irregularities) missing labs for valproic acid and HgbA1c levels, for the entire year. The pharmacy consultant was interviewed on 12/4/13 at 3:00 PM. She stated that the pharmacy group representing the facility had not had stable representation of consultants, since the previously pharmacist was promoted and re-assigned last spring. She mentioned that she had only performed the medication regimen review at the facility once this summer, otherwise, several pharmacists have been used to perform the task. She shared that their agency had recently acquired a string of nursing homes and were waiting to determine who would be assigned to this territory. The Administrative Staff #1 was interviewed on 12/5/13 at 10:00 am. She was asked to assist with locating the valproic acids and HgbA1c testing in the file, but was unsuccessful. Administrative Staff #2 was interviewed on 12/5/13 at 12:05 PM and shared that Administrative Staff #1 had brought to her attention a few months ago that she had a problem with missing labs on her unit. She also shared that she was unsuccessful in locating communications between the pharmacist and physician based on the medication regimen reviews. She commented that the facility had used about 4 different pharmacists since the original consultant relocated to a different territory, last spring.	F 428	recommendations, review of the lab tracking logs and through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		1/2/14

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F 431	Continued From page 15 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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 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 facility policy, manufacturer specifications, observation and staff interview, the facility failed to date Advair and liquid protein	F 431	F431 The potentially expired protein	

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F 431	Continued From page 16 supplement when opened on 4 of 5 medication carts (Carts A, B, C, D and E) and failed to discard expired Lantus in 1 of 2 medication refrigerators (Unit 2 refrigerator). The findings included: The facility policy entitled " Storage and Expiration of Medications, Biologicals, Syringes and Needles " dated 12/1/07 and last revised 1/1/13 read in part, " Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. " " Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications of biologicals in accordance with Pharmacy return/destruction guidelines and other Applicable Law. " 1. Manufacturer specifications for Advair Diskus include, " Safely discard Advair Diskus 1 month after you remove it from the foil pouch, or after the dose indicator reads ' 0 ', whichever comes first. " Observation of the medication cart C on 12/4/13 at 1:36 PM with Nurse #1 in attendance revealed one Advair Diskus opened and undated. Nurse #1 stated that Advair should be dated when opened and usually lasted one month. 2. Observation of medication cart D on 12/4/13 at 1:45 PM with Nurse #2 in attendance revealed 2 opened undated bottles of liquid protein supplement. The label on the bottle read, " Discard 90 days after opening " . Nurse #2	F 431	supplements, insulin and Advair diskus were discarded. All medication carts, med rooms and medication refrigerators were checked by Nursing Administrative Staff by 12/31/2013. Any undated and/or expired medications were discarded and the medications replaced. All Licensed nursing staff will receive additional education by the SDC by 12/27/2013 relating to dating medications and supplements upon opening and the need to check medications for expiration dates. Staff that were not re-educated by 12/27/2013 will be educated before they work their next shift. The Administrative Nursing Staff will conduct med cart and med room audits weekly to ensure all required medications and supplements are dated, and expired medications are discarded. Corrections will be made upon identification. Monitoring results will be reported to the Director of Nursing weekly for the next (4) four weeks and concerns will be reported to the Quality Assurance committee during the monthly meeting. Continued compliance will be monitored through weekly review of medication carts and med rooms and through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 431	Continued From page 17 indicated she was not aware that the protein should be discarded after 90 days. 3. Observation of medication cart E on 12/4/13 at 2:17 PM with Nurse #3 in attendance revealed 2 opened undated bottles of liquid protein supplement. The label on the bottle read, " Discard 90 days after opening " . Nurse #3 indicated she was not aware that the protein should be discarded after 90 days. 4. Manufacturer specifications for Lantus insulin include " Lantus vials can be either refrigerated or kept at room temperature for 28 days after first use. " Observation of Unit 2 medication refrigerator on 12/4/13 at 2:04 PM with Nurse #1 in attendance revealed 1 vial of Lantus Insulin, designated as stock, opened 10/10/13. Nurse #1 stated the insulin was expired and should have been discarded. 5. On 12/4/13 at 1:45 PM, medication cart A (station 1) was observed. An opened bottle of Provide, sugar free (protein supplement) was observed with no date of opening. The direction on the bottle read " discard 3 months after opening, record date opened on bottom of container. " On 12/4/13 at 2:10 PM, Nurse #5 was interviewed. She stated that the nurse who first opened the bottle should have written the date. Nurse #5 also indicated that Provide and Prostat were good for 90 days after opening. 6. On 12/4/13 at 2:00 PM, medication cart B (station 1) was observed. There were opened	F 431		

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F 431	Continued From page 18 bottle of Provide, sugar fee and an opened bottle of Prostat (protein supplement) with no date of opening written on the bottle. The direction on the bottle read " discard 3 months after opening, record date opened on bottom of container. " On 12/4/13 at 2:10 PM, Nurse #5 was interviewed. She stated that the nurse who first opened the bottle should have written the date. Nurse #5 also indicated that Provide and Prostat were good for 90 days after opening.	F 431		

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K 000	INITIAL COMMENTS This Life safety Code(LSC) survey was conducted as per The Federal Register, using the Existing Health Care section of the LSC and its referenced publications. This building is type V(111) construction , one story with a complete automatic sprinkler system.	K 000	The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is February 13, 2014. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.	JAN 17 2014
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 12/30/2013 the doors to the laundry (soiled and clean linen) and the door to Central Supply were propped open.	K 029	K 029 The wedges propping open the doors leading to the laundry (soiled and clean) and the door to the Central Supply Room have been removed. The Department Managers, central supply and laundry employees will receive re-education on not propping open doors in the facility. The Director of Maintenance will conduct facility door observations to ensure there are no propped open doors in the facility. The Director of Maintenance will conduct these observations (1) once weekly for (4) four weeks. All	2-13-14
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administratee — (X6) DATE: 1/17/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 038	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation o 12/30/2013 the delayed egress exit at the laundry failed to release on pressure and the delayed egress locked exit door near room 134 some times failed to release on pressure. 42 CFR 483.70 (a)	K 038	variances will be corrected at the time of observation. Observation results will be reported to the Administrator and to the Quality Assurance committee during the monthly meeting. Continued compliance will be monitored through daily round observations and through the facility's quality assurance committee. Additional education and monitoring will be initiated for any identified concerns.	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050	K 038 The delayed egress exit door near the laundry room and the delayed egress exit door near room 134 were corrected on 12/30/2013 by the Maintenance Director who adjusted the pressure release switch for both doors.	2-13-14
K 072 SS=D	This STANDARD is not met as evidenced by: A. Based on observation and staff interview on 12/30/2013 the staff did not know the fire drill procedure. NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	The Maintenance Director will check all delayed egress exit doors weekly to ensure they release properly. Repairs will be made as needed and concerns will be reported to the Administrator and to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through the facility's preventative maintenance and quality assurance programs.	

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K 072	Continued From page 2 This STANDARD is not met as evidenced by: A. Based on observation on 12/30/2013 there were lifts, furniture and other items stored in the corridors.	K 072	K 050 All staff will be re-educated on the facility's fire drill procedures. The fire drill procedures are included in new employee orientation and re-in-serviced through the facility in-service calendar. The Director of Maintenance will conduct random staff interviews weekly for the next (4) four weeks to ensure staff is educated on the facility's fire drill procedures. Additional education will be provided as needed and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through random staff interviews and through the facility's quality assurance program.	2-13-14
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation on 12/30/2013 there were full and empty 02 cylinders mixed in the 02 storage at the 200 hall nuses station.42 CFR 483.70 (a)	K 076	K 072 All staff will be re-educated on keeping the corridors free of equipment i.e. furniture and lifts when not in use. The Administrative Nursing Staff will conduct audits to ensure corridors are free of equipment.	2-13-14

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K 072	Continued From page 2 This STANDARD is not met as evidenced by: A. Based on observation on 12/30/2013 there were lifts, furniture and other items stored in the corridors.	K 072	The Administrative Nursing Staff will conduct these audits (2) two times a week for (4) four weeks. All variances will be corrected at the time of observation. Monitoring results will be reported to the Administrator and to the Quality Assurance committee during the monthly meeting. Continued compliance will be monitored through routine facility round observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu ft are enclosed by a one-hour separation (b) Locations for supply systems of greater than 3,000 cu ft are vented to the outside. NFPA 99 4 3 1 1 2. 19 3 2 4 This STANDARD is not met as evidenced by: A Based on observation on 12/30/2013 there were full and empty 02 cylinders mixed in the 02 storage at the 200 hall nuses station.42 CFR 483 70 (a)	K 076	K 076 The Oxygen Storage Closet was organized to ensure that full and empty oxygen canisters are not mixed on 12/30/2013. All Licensed Staff will be re-educated on keeping the Oxygen Storage Closet organized to ensure that full and empty oxygen canisters are not mixed. The Administrative Nursing Staff and Maintenance Director will conduct audits of the Oxygen Storage Closet to ensure that full and empty oxygen canisters are not mixed.	2-13-14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 2 This STANDARD is not met as evidenced by: A. Based on observation on 12/30/2013 there were lifts, furniture and other items stored in the corridors	K 072	The Administrative Nursing Staff and Maintenance Director will conduct these audits (1) once weekly for (4) four weeks. All variances will be corrected at the time of observation. Monitoring results will be reported to the Administrator and to the Quality Assurance committee during the monthly meeting. Continued compliance will be monitored through the facility's preventative maintenance and quality assurance programs.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu ft are enclosed by a one-hour separation (b) Locations for supply systems of greater than 3,000 cu ft are vented to the outside. NFPA 99 4 3 1 1 2. 1 9 3 2 4 This STANDARD is not met as evidenced by. A Based on observation on 12/30/2013 there were full and empty 02 cylinders mixed in the 02 storage at the 200 hall nuses station.42 CFR 483 70 (a)	K 076		