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 11/10/2015

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 329 SS=D	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 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain a physician's order prior to administering a medication to a resident for 1 (Resident #3) of 3 sampled residents reviewed. Finding included: Resident #3 was admitted to the facility on 10/23/15 with multiple diagnoses including left femoral neck fracture and status post open	F 329	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 12/4/15. 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	12/4/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/18/2015

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

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F 329 Continued From page 1

reduction and internal fixation (ORIF) of the left hip. The admission Minimum Data Set (MDS) assessment dated 10/30/15 indicated that Resident #3's cognition was intact.

The admission and telephone orders for Resident #3 were reviewed. Resident #3 was admitted (10/23/15) with an order for oxycodone (use to treat moderate to severe pain) 5/325 milligrams (mgs) every 6 hours as needed for pain. On 10/26/15, there was an order for Ultram (use to treat moderate to severe pain) 50 mgs by mouth every 8 hours for left hip pain. On 11/2/15, there was an order for Naprosyn (non-steroidal anti-inflammatory drug (NSAID) use to treat pain) 500 mgs two times a day for pain and Naprosyn was discontinued the same day. On 11/2/15, there was also an order for colchicine (use to treat gout) 0.6 mgs by mouth every 8 hours for 7 days for gout.

The Medication Administration records were reviewed. Resident #3 had received oxycodone 4 times in October, 2015 (Oct 23, 24, 26 & 27) and 4 times in November, 2015 (Nov 2, 4, 5 & 9). Resident #3 also had received Ultram 3 times a day from October 26 through November 9, 2015. Resident #3 did not receive Naprosyn in October and November, 2015.

On 11/10/15 at 9:30 AM, administrative staff #2 provided information regarding Resident #3. The information included a disciplinary action for Nurse #1. Nurse #1 had received a disciplinary action for not following policy and procedure of administering medication correctly with doctor's order. Nurse #1 administered allopurinol (use to treat gout) to Resident #3 without a doctor's order on 10/31/15.

On 11/10/15 at 9:40 AM, interview with

F 329

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.

F Tag 329:

Resident #3 discharged from the facility 11/09/15. Resident received no harm related to this deficiency.

All current residents have the potential to be affected. The Administrative nurse team will complete a 100% audit of all current residents and licensed nursing staff to ensure medications are given per physician orders by 12/4/15.

The DON (Director of Nursing) and ADON (Assistant Director of Nursing) will in service all licensed staff on professional standards of quality care related to obtaining a physician order prior to administering medications by 12/4/15.

Nurse #1 has completed continued education on Disciplinary Actions during the period of 11/11/15-11/13/15 per certificate and given to the DON. Nurse #1 has also complete Legal scope of practice for nursing 11/19/15 and certificate given to the DON. This education was suggested for Nurse #1 after consulting with the North Carolina Board of Nursing after knowledge of the incident.

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F 329	Continued From page 2 administrative staff # 1 & #2 was conducted. Administrative staff #1 indicated that Resident #3 went to the surgeon on 10/30/15 for follow up. On 10/31/15, Resident #3 and a family member informed Nurse #1 that the surgeon had prescribed a medication for gout on the resident's left foot. The prescription was called to the pharmacy by the family member and they were waiting for it to be filled. Nurse #1 borrowed Allopurinol 1 tablet from another resident and administered it to Resident #3. Nurse #1 failed to call the doctor and obtain an order for the allopurinol. Administrative staff #2 stated that Nurse #1 admitted to her mistake, she should not borrow a medication from another resident and should not administer a medication without a doctor 's order. Administrative staff #2 indicated that she had called the board of nursing and Nurse #1 had to complete an on line continuing education on legal scope of practice. Administrative staff #2 also had in-serviced the nursing staff regarding not administering medication without a doctor's order from November 3-5, 2015. Administrative staff #1 & #2 did not provide information of any audit or monitoring that had been planned/conducted. On 11/10/15 at 11:28 AM, Nurse #1 was interviewed. She indicated that she was the 3-11 shift nurse for Resident #3 on October, 31, 2015. She revealed that on 10/31/15, the resident and a family member had informed her that the resident's foot was swollen and red and the resident had been seen by the surgeon on 10/30/15 and diagnosed her foot with gout. A prescription was written for the gout and the medication was called in to the pharmacy and they were waiting for it to be filled. She borrowed allopurinol from another resident and	F 329	The Administrative nurse team will review all current physician orders 5x/week to ensure accuracy and completeness of orders. All new admission orders will also be reviewed 5x/week to ensure accuracy. Concerns will be reported to the DON weekly for the next (4) four weeks. The DON will report results to the quality assurance committee monthly. On-going compliance will be monitored by the Administrative nurse team through routine med pass observations and random interviews with current residents and licensed staff to ensure physician orders are accurately followed. Any variances will be corrected and continued education provided. The DON will report results to the facility's quality assurance program.	

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F 329	Continued From page 3 administered it to Resident #3. Nurse #1 admitted that she was not supposed to borrow a medication from another resident and she was not supposed to administer a medication without a doctor's order. Nurse #1 admitted that she was wrong.	F 329		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to document the administration of a medication in the resident's clinical records for 1 (Resident #3) of 3 sampled residents reviewed. Finding included: Resident #3 was admitted to the facility on 10/23/15 with multiple diagnoses including left femoral neck fracture and status post open reduction and internal fixation (ORIF) of the left hip. The admission Minimum Data Set (MDS) assessment dated 10/30/15 indicated that	F 514	Resident #3 discharged from the facility 11/09/15. Resident received no harm related to this deficiency. All current residents have the potential to be affected. The Administrative nurse team will complete a 100% audit of all medication administration records to ensure signage for administration of medications per physician orders. The DON and ADON will in service all	12/4/15

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F 514	Continued From page 4 Resident #3's cognition was intact. The admission and telephone orders for Resident #3 were reviewed. Resident #3 did not have an order for allopurinol (use to treat gout). The Medication Administration records for Resident #3 were reviewed. There were no documentation in the records that Resident #3 had received allopurinol. The nurse's notes were reviewed. There were no documentation in the notes that Resident #3 had received allopurinol. On 11/10/15 at 9:30 AM, administrative staff #2 provided information regarding Resident #3. The information included a disciplinary action for Nurse #1. Nurse #1 had received a disciplinary action for not following policy and procedure of administering medication correctly with doctor's order. Nurse #1 administered allopurinol to Resident #3 without a doctor's order on 10/31/15. On 11/10/15 at 9:40 AM, interview with administrative staff # 1 & #2 was conducted. Administrative staff #1 indicated that Nurse #1 borrowed Allopurinol 1 tablet from another resident and administered it to Resident #3. Nurse #1 failed to document in the MAR or nurse's notes that she administered allopurinol to Resident #3. Administrative staff #2 had in-serviced the nursing staff regarding not administering medication without a doctor's order from November 3-5, 2015. The in-service did not address complete documentation. On 11/10/15 at 11:28 AM, Nurse #1 was interviewed. She indicated that she was the 3-11 shift nurse for Resident #3 on October, 31, 2015. Nurse #1 revealed that she borrowed allopurinol from another resident and administered it to Resident #3. Nurse #1 admitted that she was not	F 514	licensed staff on maintaining clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized with a focus on documenting the administration of a medication in the resident's clinical record by 12/4/15 The Unit Managers will audit the medication administration records for omissions and accuracy related to physician orders 3x/week for 4 weeks and then 2x/week for 4 weeks. Any variances will be corrected and ongoing education will be provided. The results of these audits will be reported weekly to the DON. The DON will report results to the quality assurance committee monthly. Ongoing monitoring will occur 5x/week during clinical meeting to ensure compliance. Any variances will be reported to the DON. The DON will report results to the quality assurance program monthly. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 514	Continued From page 5 supposed to borrow a medication from another resident and she was not supposed to administer a medication without a doctor's order. Nurse #1 admitted that she was wrong and she did not document it on then MAR or the nurse's notes.	F 514		