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 06/21/2021

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
E 000	Initial Comments The survey team entered the facility on 6/14/21 to conduct a Recertification survey. The survey team was onsite 6/14/21 through 6/17/21. Additional information was obtained offsite 6/18/21 through 6/21/21. Therefore, the exit date was 6/21/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 9BWI11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 6/14/21 to conduct a recertification survey and complaint investigation. The survey team was onsite 6/14/21 through 6/17/21. Additional information was obtained offsite 6/18/21 through 6/21/21. Therefore, the exit date was 6/21/21. 4 of the 49 complaint allegations were substantiated. Event ID: 9BWI11	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		7/19/21

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

Electronically Signed | 07/09/2021

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F 584	Continued From page 1 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to (1) maintain walls, ceilings, wall vents and resident furniture in good repair for 6 of 14 resident rooms (Rooms 121, 122, 123, 124, 127 and 130) and the facility failed to (2) maintain a clean living environment for 4 of 14 resident rooms (Rooms 122, 123, 125 and 133) observed for environment. Findings included: 1.Observation of hall 100 revealed failed to maintain walls, ceilings, wall vents and resident furniture in good repair for the following resident	F 584	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 7/19/2021. 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 continued compliance with regulatory requirement.	

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F 584	Continued From page 2 rooms: a. Observation of rooms 121, 123 and 130 occurred on 6-14-21 at 11:20am. The observations revealed exposed dry wall and/or sheetrock on the residents' walls behind the beds. A second observation was conducted on 6-17-21 at 10:30am with the Maintenance Director and Environmental Director revealing exposed dry wall and/or sheetrock on the residents' walls behind the beds. An interview with the Maintenance Director occurred on 6-17-21 at 10:40am. The Maintenance Director discussed patching the walls behind the residents' beds frequently because the walls are damaged each time staff moves the bed. b. Rooms 122 and 124 were observed on 6-14-21 at 11:25am revealing the base boards in the resident rooms were peeled away from the wall. Second observations were made with the Maintenance Director and Environmental Director on 6-17-21 at 10:35am. The observation revealed base boards in the resident rooms were peeled away from the wall. During an interview with the Maintenance Director on 6-17-21 at 10:40am, the Maintenance Director stated he was not aware of the base boards becoming loose from the wall but that he would have the problem corrected. c. Room 123 was observed on 6-14-21 at 11:30am. The observation revealed the popcorn	F 584	F584 Safe/Clean/Comfortable/Homelike Environment Upon discovery of the 6/14 rooms noted with maintenance-related areas and 4/14 rooms noted with housekeeping-related areas, the Maintenance Director and Environmental Services Director immediately began addressing these areas. All items were repaired and/or cleaned by 6/25/2021. Education was provided to the Maintenance Director and the Environmental Services Director by The Administrator on 6/17/2021 regarding maintaining of a safe, clean, comfortable and homelike environment, which included the physical environment policy, repair requisition process, housekeeping policies and cleaning schedules. Education was provided to all managers by The Administrator on 6/21/2021 regarding physical environment policy and repair requisition process. Subsequently, each department was educated by their respective managers regarding the physical environment policy and repair requisition process by 6/25/2021. Areas of importance, which include, but are not limited to: walls, ceilings, wall vents/PTACs and furniture within all resident rooms will be audited and initial repairs completed beginning immediately and finished by 7/19/2021.	

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F 584	Continued From page 3 ceiling was cracked and loose from the ceiling. During a second observation of room 123 on 6-17-21 at 10:43am with the Maintenance Director and Environmental Director, the popcorn ceiling was noted to be cracked and loose from the ceiling. The Maintenance Director was interviewed on 6-17-21 at 10:44am. He stated he was unaware of the popcorn ceiling being cracked and loose from the ceiling. d. Room 127 was observed on 6-14-21 at 11:33am. The observation revealed the front of the resident's PTAC unit (wall heat and air unit) was coming off the unit. A second observation was completed on 6-17-21 at 10:45am with the Maintenance Director and Environmental Director. The observation revealed the front of the resident's PTAC unit (wall heat and air unit) was coming off the unit. During an interview with the Maintenance Director on 6-17-21 at 10:46am, the Maintenance Director stated he was not aware of the issue but that he would have the problem corrected. e. Observation of room 121 occurred on 6-14-21 at 11:20am. The observation revealed the resident's nightstand had the front of the second drawer missing. A second observation was conducted on 6-17-21 at 10:30am with the Maintenance Director and Environmental Director revealing the resident's nightstand had the front of the second drawer missing.	F 584	Administrator and/or Maintenance Director/Designee will audit residential areas for needed repairs of furniture, walls, baseboards, door frames, and ceilings at least three times for one week, weekly time four weeks, monthly times two months, and as needed as determined by the Quality Assurance Committee thereafter and repairs completed as applicable. Ongoing repairs will be completed as needed. Continued compliance will be monitored through the facility's Quality Assurance Program.	

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F 584	Continued From page 4	F 584		

The Maintenance Director was interviewed on 6-17-21 at 10:40am. The Maintenance Director stated he had a work order for the resident's nightstand but had not been able to complete the request.

f. Room 124 was observed on 6-14-21 at 11:25am. The observation revealed the laminate on the residents over the bed table had peeled off around the edges exposing the particle board and leaving sharp laminate edges.

Second observations were made with the Maintenance Director and Environmental Director on 6-17-21 at 10:35am. The observation revealed the residents over the bed table had peeled off around the edges exposing the particle board and leaving sharp laminate edges.

During an interview with the Maintenance Director on 6-17-21 at 10:40am, the Maintenance Director stated he was in the process of ordering new over the bed tables and would have the resident's table replaced when the new one was delivered.

2. Observation of hall 100 revealed failed to maintain a clean-living environment for the following resident rooms:

a. Observation of rooms 122, 123, 125 and 133 occurred on 6-14-21 between 11:20am and 11:30am. The observation revealed the vents of the PTAC units in the resident rooms contained in part blue paper, black flecks, moths and crumbs.

A second observation was conducted with the Maintenance Director and Environmental Director on 6-17-21 between 10:30am and 10:45am. The

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F 584	Continued From page 5 second observation revealed the PTAC units in the resident rooms contained in part blue paper, black flecks, moths and crumbs. The Environmental Director was interviewed on 6-17-21 at 10:50am. The Environmental Director stated housekeeping was to check the PTAC unit vents daily for any dirt or debris and discussed having a PTAC cleaning schedule in place that would include the filters as well as the vents. The Administrator was interviewed on 6-17-21 at 11:00am. The Administrator discussed during their COVID19 outbreak; the environment was not attended to as frequently allowing for issues to surface. She discussed having a good maintenance person and felt the issues would be resolved and the facility would educate staff on reporting issues.	F 584		
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.	F 761		7/19/21

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F 761	Continued From page 6 §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 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 observations and staff interviews the facility failed to discard insulin medications in accordance with the manufacturer's instruction for 1 medication cart (100 hall) out of 4 medication cart observed for medication storage. The findings included: The medication cart of 100 hall was observed on 6/17/21 at 11:23 AM in the presence of Nurse#2 who was assigned to the medication cart. The observation revealed a Victoza (liraglutide) 18mg injection pen (insulin) was opened on 5/15/21. The manufacturer's storage instruction for Victoza (liraglutide) 18mg/3ml injection pen was to discard 30 days after first use. Additional observation revealed a Novolog Mix 70/30 (insulin aspart protamine and insulin aspart) flexpen was opened on 5/10/21. The Novolog Mix 70/30 (insulin aspart protamine and insulin aspart) flexpen manufacturer's storage instruction was to dispose after 14 days from opening. Both insulin pens were outdated and were not discarded from the medication cart. An interview with Nurse #2 on 6/17/21 at 11:39 AM stated that all nurses who worked were responsible for checking and removing any out of	F 761	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 7/19/2021. 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 continued compliance with regulatory requirement. F761 Label/Store Drugs & Biologicals Upon discovery, the Victoza 18mg injection pen and Novolog Mix 70/30 insulin flexpen were immediately both discarded properly. Additionally, all other medication storage areas were checked by the Nurse Managers, which included the Director of Nursing, Assistant Director of Nursing and RN Unit Manager resulting in discovery of no additional expired medications.	

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F 761	Continued From page 7 date medication. Nurse #2 stated that the insulin pens were out of date and should have been discarded. The Director of Nursing (DON) was interviewed on 6/17/21 at 12:06 PM and she stated nurses on the medication cart and unit managers should spot check the medication carts for out of date medications. The DON stated that the staff should discard out of date medication to adhere to the manufacturer's storage instruction.	F 761	Education was provided to the Director of Nursing by the RN Regional Clinical Coordinator regarding proper medication storage on 6/17/2021. Subsequently, the Director of Nursing educated all Nurse Managers regarding proper medication storage by 6/25/2021. Additionally, all Licensed Nurses were educated on proper medication storage by 7/2/2021. The Director of Nursing and/or Designee will monitor all medication storage areas daily for at least one week, then at least three times weekly for three weeks, then weekly for four weeks, and then as needed as determined by the QA Committee. Continued compliance will be monitored through the facility's Quality Assurance Program.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		7/19/21

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F 812	Continued From page 8 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure 15 of 55 dishware were dry before stacked and ready for use. The facility additionally failed to ensure 4 of 50 dishware were clean before stacked and ready for use. These practices had the potential to effect food served to residents. Findings included: The initial tour of the kitchen was conducted on 6-14-21 at 10:15am with the Dietary Manager. The tour revealed the following: a.14 plate lids on the tray line ready for use were stacked wet. b. 1 divided plate on the tray line ready for use was stacked wet. c. 2 desert bowls on the tray line ready for use contained a brown and yellow substance. d. 1 divided plate on the tray line ready for use contained a dried brown substance e. 1 dinner plate on the tray line ready for use contained a dried yellow substance. The Dietary Manager was interviewed on 6-14-21 at 10:25am. The Dietary Manager explained the drying rack for the plate lids was missing a shelf	F 812	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 7/19/2021. 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 continued compliance with regulatory requirement. F812 Food Procurement, Store/Prepare/Serve-Sanitary Upon discovery, 15/55 dishware item and 4/50 dishware items in observance were rewashed and sanitized, as well as, dried properly before storing again by The Dietary Manager. Immediately following, The Dietary Manager inspected the Kitchen to ensure all other dishware items and dietary equipment was cleaned, sanitized and stored appropriately. The Dietary Manager was educated by The Administrator on requirements of	

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F 812	Continued From page 9 causing a lack of space to dry all the plate lids. He also explained staff were responsible for making sure the plates and bowls were clean and dry prior to placing them on the tray line. The Administrator was interviewed on 6-17-21 at 11:00am. The Administrator stated the Dietary Manager performed his job duties well and she would discuss with him educating the staff further on making sure dishware was clean and dry prior to serving meals.	F 812	proper cleaning, sanitation and storage of dishware on 6/21/2021. Subsequently, all dietary staff were educated by the Dietary Manager regarding proper cleaning, sanitation and storage of dishware beginning on 6/21/2021 and completed by 6/25/2021. The Dietary Manager/Designee will complete audits to assure proper cleaning, sanitation and storage of dishware daily for one week during various times of day, then weekly times four weeks during various times of day, and then as needed as determined by the QA Committee. Continued compliance will be monitored through the facility's Quality Assurance Program.	