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 08/11/2021

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
F 000	INITIAL COMMENTS A complaint investigation was conducted 8/9/21 through 8/11/21. Event ID# C68P11. 7 of the 19 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, Rehabilitation Service Director, and staff, the facility failed to refer Resident #5 to home healthcare as ordered by the physician, as care planned, and as recommended by Occupational Therapy and Physical Therapy when discharged from the facility. This was for 1 of 3 residents (Resident #5) reviewed for discharge. The findings included: Resident #5 was admitted to the facility on 6/4/21 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), respiratory failure, and Diabetes Mellitus (DM). The admission Minimum Data Set (MDS) assessment dated 6/9/21 indicated Resident #5's	F 624	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 09/01/2021. 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. F624 Preparation for Safe/Orderly Transfer/Discharge Upon discovery that the home health agency had not received a referral for Resident #5, a referral was sent as noted.	9/1/21

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

Electronically Signed | 08/24/2021

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F 624	Continued From page 1 cognition was fully intact. He had no behaviors and no rejection of care. He required the extensive assistance of 2 or more for bed mobility, toileting, and personal hygiene and the extensive assistance of 1 for dressing. Resident #5 required the limited assistance of 2 or more for transfers. He utilized a wheelchair and walker and had no functional impairment with range of motion. Resident #5 was receiving Occupational Therapy (OT) and Physical Therapy (PT). Resident #5's care plan included the focus area of his wish to return to the community upon the completion of rehabilitation and skilled nursing services. This area was initiated on 6/9/21 and the goal was for Resident #5 to be prepared for discharge within 90 days. The interventions, all initiated on 6/9/21, included: - Obtain discharge orders from physician as needed - Set up home health service prior to discharge A physician's order for Resident #5 dated 7/16/21 indicated a referral for home healthcare nursing, Nursing Assistant (NA), PT, and OT. The OT discharge summary for services from 6/5/21 through 7/19/21 indicated Resident #5 gained functional improvements throughout services. The discharge recommendations included home healthcare services. The PT discharge summary for services from 6/7/21 through 7/19/21 indicated Resident #5 reached maximum potential with skilled services, had consistent progress throughout services, and made substantial gains in response to skilled interventions. The discharge recommendations included home healthcare services.	F 624	Home health services began for Resident #5 on 7/23/2021. Residents with pending discharge dates have the potential to be affected. All upcoming scheduled discharges were reviewed to ensure that home health referrals were completed by the Social Services Director on 8/12/2021. No additional concerns were identified. Education was provided to the Social Services Director by The Administrator on 8/11/2021 regarding safe and orderly transfer and discharge, including specifically about home health referrals to be sent prior to a guest's planned discharge. Education will be provided to the Social Services Assistant by the Social Services Director upon her planned return on 9/1/2021 regarding safe and orderly transfer and discharges; however, phone education was provided by Social Services Director and Administrator on 8/12/2021. The Administrator, Social Services Director, or Designee will audit all pending discharges to ensure home health referrals are sent prior to guest's actual discharge. Any variances identified will be sent and followed up on immediately, if applicable, and additional education provided when indicated. Audits will occur five times weekly for two weeks, three times weekly for two weeks, then weekly for four weeks, and then as determined by the Quality Assurance Committee—The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Continued compliance will be monitored	

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F 624	Continued From page 2 A Social Service note dated 7/21/21 completed by the Social Worker (SW) indicated Resident #5 was discharged home on 7/20/21 with home healthcare ordered. During a phone interview with Resident #5 on 8/9/21 at 2:05 PM he stated that he was discharged from the facility on 7/20/21. He indicated he required some assistance with Activities of Daily Living (ADLs) and home healthcare was supposed to have been ordered for him upon discharge. He revealed that on 7/23/21 he had yet to hear from the home healthcare provider so he contacted the facility's SW to ask about services. He indicated that the home healthcare provider contacted him for the first time later that day (7/23/21) to schedule a visit. An interview was conducted with the SW on 8/10/21 at 11:28 AM. She stated that Resident #5 was discharged from the facility on 7/20/21 and that the Assistant SW was assigned to complete his home healthcare referral. She reported that on 7/23/21 Resident #5 contacted her by phone and indicated that he had not heard from the home healthcare provider. She revealed that she reached out to the home healthcare provider and they stated that they had not received a referral for Resident #5. The SW stated that she completed the referral that day and that the provider contacted Resident #5 on the same day (7/23/21). She indicated that she thought the Assistant SW completed the referral, but there was no evidence of the referral being sent to the provider. The SW added that when she learned of the delay in home healthcare services for Resident #5 she was not in fear of any harm or	F 624	through the facility's Quality Assurance Program.	

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F 624	Continued From page 3	F 624		

negative consequences due to his ability to complete most of his ADL care independently.

A phone interview was conducted with the Assistant SW on 8/10/21 at 12:19 PM. She revealed that she had no recollection of completing the home healthcare referral for Resident #5. She stated that this was her error.

During a follow up interview with the SW on 8/10/21 at 3:45 PM the interview with the Assistant SW in which she shared that she had no recollection of completing the home healthcare referral for Resident #5 was reviewed. She stated that she was unaware of this information. She indicated that she thought the referral was made and that the error was on the part of the home healthcare provider.

An interview was conducted with the Rehabilitation Service Director on 8/10/21 at 11:45 AM. She stated that she was familiar with Resident #5 and she spoke about his ability to complete his ADL tasks. She stated that he was able to transfer in and out of bed and onto the toilet independently. He was able to walk 75 feet and he had a walker at his home. She indicated that Resident #5 was a large man so it would have been a little bit difficult for him to complete excellent personal hygiene care to his buttock's region due to the reach it required. She stated that a personal hygiene/toileting aide utilized to assist with reaching was offered to Resident #5 prior to discharge, but he declined reporting that he was able to complete his care without it. The Rehabilitation Service Director stated that home healthcare was recommended for Resident #5 at discharge by both OT and PT and that ideally the service would have been initiated the day

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F 624	Continued From page 4 following discharge. She indicated that the delayed start of home healthcare services for Resident #5 would not have caused any negative consequences. During an interview with the Marketing Director on 8/10/21 at 12:00 PM she stated that she spoke with Resident #5 on 7/22/21 during a routine phone call made to discharged residents approximately 48 hours after discharge. She stated that Resident #5 reported no concerns or complaints during the phone call. The Marketing Director indicated that there was no mention of home healthcare services or care needs that were not able to be met during this call with Resident #5 on 7/22/21. During an interview with the Administrator on 8/10/21 at 2:30 PM she stated that she expected referrals for home healthcare services and/or other referrals related to discharge to be completed prior to the resident discharging from the facility.	F 624		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, family interview, and staff interview, the facility failed to change soiled geri-sleeves (sleeves used to protect the integrity of sensitive skin areas) on a resident's arms during bathing and personal hygiene care for a resident who was dependent	F 677	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 09/01/2021. Preparation and/or execution of this Plan of Correction does not constitute	9/1/21

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F 677	Continued From page 5 on staff's assistance. This was for 1 of 3 residents (Resident #3) reviewed for Activities of Daily Living care. The findings included: Resident #3 was initially admitted to the facility on 6/28/13 and most recently readmitted on 2/4/16 with diagnoses that included dementia, history of cerebral infarction with hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body). The significant change Minimum Data Set (MDS) assessment dated 6/17/21 indicated Resident #3's cognition was severely impaired. She had physical behaviors on 4 to 6 days, verbal behaviors on 1 to 3 days, and rejection of care on 1 to 3 days. Resident #3 was dependent on 2 or more for transfers and dependent on 1 for toileting and bathing. She required the extensive assistance of 1 for bed mobility and personal hygiene and the limited assistance of 1 for dressing. Resident #3 had functional impairment with range of motion on 1 side of her upper extremities and both sides of her lower extremities. Resident #3's active care plan included the focus area of Activities of Daily Living (ADLs) assistance related to generalized weakness, cognitive impairment, decreased mobility, visual impairment, history of cerebrovascular accident with left hemiparesis, left arm contracture at elbow, and behaviors. The interventions included, in part, provide assistance with more difficult dressing tasks like buttons, tying shoes etc. as needed; provide assistance to comb hair,	F 677	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. F677 ADL Care Provided for Dependent Residents Upon notification to staff of soiled geri-sleeves on Resident #3 at time of family visit on 7/03/2021, direct-care staff changed the guest's sleeves and provided any other Activities of Daily Living (ADL) services needed. Current residents that have geri-sleeves have the potential to be affected. All residents with geri-sleeves were observed to ensure that geri-sleeves were clean when applied by the Director of Nursing on 8/11/2021 and 8/12/2021. No additional concerns were identified. Education was provided to all Management staff by The Administrator on 8/11/2021 regarding ensuring that residents with geri-sleeves only have clean geri-sleeves applied. Education was provided to all active direct care staff by The Director of Nursing and/or Designee regarding ensuring that residents with geri-sleeves only have clean geri-sleeves applied by 8/24/2021. The Administrator, Director of Nursing, and other staff members as assigned will observe guests to include any guests who wear geri-sleeves to ensure that they are clean when applied. Observations will include at least ten residents five times	

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F 677	Continued From page 6 brush/clean teeth, apply makeup, shave; allow adequate time for completion of tasks. Resident #3's active care plan also included the focus area of the potential for impaired skin integrity related to: impaired bed mobility, incontinence of bowel and/or bladder, impaired nutritional status, impaired cognition, and impaired vision. Resident #3 was noted with very fragile skin and frequent skin tears along with bruising. The interventions included, in part, geri-sleeves to her bilateral arms as allowed by the resident. An observation was conducted of Resident #3 on 8/9/21 at 12:08 PM. She was in bed, alert, and was wearing clean geri-sleeves. A family interview was conducted by phone on 8/9/21 at 12:17 PM. Resident #3's family member stated that she visited the resident at the facility on 7/3/21 during the first shift. She revealed that Resident #3 was wearing soiled geri-sleeves during the time of the visit. She had not known what the soiled substance was. She reported that Resident #3 was dependent on staff's assistance with changing her geri-sleeves. The family member stated that she informed Nurse #8 about this concern after her visit on 7/3/21 as she had not understood why the NA had not changed her geri-sleeves when morning ADL care was provided. Based on the schedule with assignments, Nursing Assistant (NA) #1 was assigned to Resident #3 during the first shift on 7/3/21. An interview was conducted with NA #1 on 8/10/21 at 1:36 PM. She stated that Resident #3	F 677	per week for two weeks, then three times per week for two weeks, then weekly for four weeks, and then as determined by the Quality Assurance Committee—The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances identified will be addressed immediately, as residents will allow, and additional education provided when indicated. Continued compliance will be monitored through the facility's Quality Assurance Program.	

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F 677	Continued From page 7	F 677		

required assistance with most ADLs to include personal hygiene, baths/showers, and dressing. She indicated that Resident #3 had very fragile skin and she wore geri-sleeves on her arms to protect her from skin tears. She stated that Resident #3 required staff's assistance to take the geri-sleeves on and off. NA #1 verified she was assigned to Resident #3 on 7/3/21 during the first shift and that she provided her with ADL care prior to the visit with her family. She stated that she gave Resident #3 a bed bath, personal hygiene care, and she changed her clothing. NA #1 revealed during care she noticed the resident's geri-sleeves were soiled with what she thought was most likely dried blood as the resident sometimes picked at her arms. NA #1 verified that she had not replaced the soiled geri-sleeves with clean ones. When asked why she had not changed the geri-sleeves she stated that they were underneath the sleeves to her top so they were not visible unless the sleeves to the top were pulled up. NA #1 stated that she realized now that this was a mistake and that later that day (7/3/21) she was inserviced by Nurse #8 on the need to change soiled geri-sleeves to clean geri-sleeves at the time they were identified. She added that Resident #3 had behaviors and refusals of care at times, but that this was not why she had not changed the soiled geri-sleeves on 7/3/21.

During an interview with Nurse #8 on 8/10/21 at 12:15 PM she confirmed she spoke with Resident #3's family member following her visit with the resident on 7/3/21. She stated that the family member expressed her concern with Resident #3 wearing soiled geri-sleeves. Nurse #8 reported that she spoke with the assigned NA, NA #1, and

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F 677	Continued From page 8 she admitted she noticed the geri-sleeves were soiled when she was providing Resident #3 with a bed bath and personal hygiene care prior to the family visit on 7/3/21 and that she had not changed them to clean sleeves. She indicated that NA #1 was instructed that the soiled geri-sleeves should have been replaced with clean sleeves. During an interview with the Administrator on 8/10/21 at 5:06 PM she stated that she expected residents to be provided with the ADL care necessary to meet their required needs.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff, facility nurse practitioner, wound physician and resident interviews, the facility failed to clarify physician orders for the treatment of non-pressure related wounds on readmission and nursing staff provided the treatments without a physician's order. This affected 1 of 5 residents reviewed for well-being (Resident #9). The findings included:	F 684	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 09/01/2021. 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	9/1/21

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F 684	Continued From page 9 Resident #9 was originally admitted to the facility on 9/28/09 with multiple diagnoses that included diabetes type 2, reduced mobility, and coronary artery disease (CAD). A review of Resident #9's active care plan, dated 3/17/21, revealed the following areas of need: - Potential for further impaired skin integrity related to impaired bed mobility, catheter tubing and paraplegia. - Risk for impaired skin integrity/pressure injury related to diabetes, CAD, anemia, chronic kidney disease and reduced mobility. The annual Minimum Data Set (MDS) assessment dated 6/8/21 indicated Resident #9 was cognitively intact and displayed physical and verbal behavioral symptoms towards others as well as rejection of care 1 to 3 days during the 7 day look back period. He required extensive to total assistance for bed mobility and transfers. Resident #9 was coded with 1 stage 4 pressure ulcer and a pressure reducing device to the bed. Review of the nursing progress notes from 7/1/21 to 8/9/21 did not reveal any rejection of wound care by Resident #9. Review of Resident #9's physician orders revealed an order dated 7/10/21 to cleanse the left outer thigh wound with normal saline, apply Xeroform (a sterile, non-adhering protective dressing) and a dry dressing every 3 days and as needed. A wound physician progress note dated 7/15/21 indicated Resident #9 had the following non-pressure related wounds:	F 684	Deficiencies. This plan is prepared and/or executed to ensure continued compliance with regulatory requirement. F684 Quality of Care Upon discovery, Resident #9 was assessed by the physician and order placed for wound treatment for non-pressure related areas on 8/10/2021. Current residents with non-pressure related areas have the potential to be affected. Head to toe skin assessments were conducted on current residents to ensure that all non-pressure related areas were identified and had wound treatments ordered by a Licensed Nurse by 8/23/2021. No additional concerns were identified. Education was provided to the Nurse Managers by The Administrator on 8/11/2021 regarding expectations for identifying non-pressure related areas and obtaining physician's orders for wound treatment to these areas. Subsequently, education was provided to all Licensed Nurses and Certified Nurse Aide lls (CNA lls) by The Director of Nursing and/or Designee by 8/24/2021. Nurse Managers and/or designated facility wound care nurse will audit resident weekly skin assessments to ensure that non-pressure related areas have been identified and have physician's orders for wound treatments in place. The audits will include all current residents with non-pressure related areas five times per week for two weeks, then three times per week for two weeks, then weekly for four weeks, then as determined by the Quality	

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F 684	Continued From page 10 - A wound to the left outer thigh that measured 8.5 centimeters (cm) in length, 5.5 cm in width and 0.1 cm in depth. - A new wound to the right posterior (back side) thigh with a 1-day duration, measured 15 cm in length, 3 cm in width and 0.1 cm in depth. It was classified as a skin tear likely from the use of tape. The order was to apply a sterile, non-adhering protective dressing and a dry dressing every day and as needed. Resident #9 was transferred to the hospital on 7/20/21 and returned to the facility on 7/24/21. The After Visit and Discharge summaries from the hospital, dated 7/24/21, included no orders for the non-pressure related wounds to Resident #9's left or right thigh. A wound physician progress note dated 7/29/21 revealed Resident #9 had the following non-pressure related wounds: - A wound to the left outer thigh measured 10 cm in length, 5 cm in width and 0.1 cm in depth. - A wound to the right posterior thigh measured 14 cm in length, 9.5 cm in width and 0.1 cm in depth. A review of Resident #9's Treatment Administration Records (TARs) for July 2021 and August 2021 revealed there was no order for wound care to the non-pressure related wounds to the right and left thigh from 7/24/21 to 8/5/21. A wound physician progress note dated 8/5/21 indicated Resident #9 was seen for the following non-pressure related wounds: - A wound to the left outer thigh measured 8.5 cm in length, 6 cm in width and 0.1 cm in depth.	F 684	Assurance Committee—The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances will be corrected at the time of audit and additional education provided when indicated. The Director of Nursing or designee will additionally audit all new admission/readmission medical records to ensure that non-pressure related areas have been identified and have physician's orders for wound treatments in place. The audits will be completed five time per week for two weeks, then three times per week for two weeks, then weekly for four weeks, then as determined by the Quality Assurance Committee—The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances will be corrected at the time of audit and additional education provided when indicated. Continued compliance will be monitored through the facility's Quality Assurance Program.	

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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 684	Continued From page 11	F 684		

- A wound to the right posterior thigh measured 16 cm in length, 9 cm in width and 0.1 cm in depth.

Resident #9 was transferred to the hospital on 8/6/21 and returned to the facility on 8/8/21.

The After Visit and Discharge summaries from the hospital, dated 8/8/21, included no orders for the non-pressure related wounds to Resident #9's left or right thigh.

The Comprehensive Admission Assessment completed by Nurse #7 on 8/8/21 indicated Resident #9 had wounds to his left upper thigh and right rear thigh.

Review of the August 2021 TAR revealed from 8/8/21 to 8/9/21, there was no order present to provide wound care to the left outer thigh or the right posterior thigh.

Review Resident #9's medical record revealed orders dated 8/10/21 for the following wound care:
- Cleanse the left thigh wound with normal saline, apply Xeroform, cover with dry dressing and change every 48 hours and as needed.
- Cleanse the open area to the right posterior thigh with normal saline, apply Xeroform, cover with a dry dressing and change every evening shift and as needed.

On 8/9/21 at 12:15 PM, an interview was completed with Resident #9 who stated his wound care was completed daily since his readmission from the hospital in July 2021 and August 2021.

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Nurse #6 was interviewed via phone on 8/11/21 at 11:47 AM and was the nurse who had completed the Admission Assessment on 7/24/21. Nurse #6 stated she was familiar with Resident #9 but could not recall completing the Admission Assessment on 7/24/21 or if wound orders were present on the discharge summary for his right and left leg wound. Nurse #6 further stated she had not completed any wound care on Resident #9 as it was scheduled for the 7:00 PM to 7:00 AM shift. Nurse #6 added she should have made sure treatment orders were in place at the time of the admission assessment.

On 8/10/21 at 10:55 AM, an interview occurred with Nurse #8, who explained the facility did not have a treatment nurse, and the floor nurses were responsible for wound care. The facility also utilized Nurse Aide II's (NAIIs) to assist with wound care to non-pressure related wounds such as abrasions and skin tears. Nurse #8 was aware Resident #9 had non-pressure related wounds to his right and left thigh prior to his hospitalization in July 2021.

Another interview was completed with Nurse #8 on 8/10/21 at 4:20 PM. She recalled providing wound care to Resident #9 on 7/28/21 but stated she didn't look at the TAR for Resident #9's treatment orders because she "just knew" what treatment supplies were used and provided the treatment to the right and left thigh wounds using Xeroform and a dry dressing. Nurse #8 stated if she had reviewed the TAR at that time, she would have caught the treatment orders were not present for the bilateral thigh wounds and should have documented the treatments as completed.

A phone interview was conducted with Nurse Aide

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F 684	Continued From page 13	F 684		

II #1 (NAII) on 8/11/21 at 11:09 AM and explained she had been assisting with wound care for about a year and NAII's provided dressing changes to the skin tear and abrasion wounds if the nurse was not able to. The NAII stated she knew Resident #9 had non-pressure areas to his thighs as she had been working with him prior to each hospitalization in July 2021 and August 2021. She recalled providing wound care to Resident #9 on 8/5/21 but stated she didn't look at the TAR because she "just knew" what treatment supplies were used and provided the treatment to the right and left thigh wounds using Xeroform and a dry dressing. NAII #1 stated if she had reviewed the TAR at that time, she would have caught the treatment orders were not present for the bilateral thigh wounds and should have documented the treatments as completed.

On 8/11/21 at 11:32 AM, a phone interview was completed with Nurse #9. She explained she was familiar with Resident #9 and was working from 7:00 AM to 7:00 PM on 8/8/21 when Resident #9 returned from the hospital. She explained Resident #9 returned to the facility around 6:40 PM, she got his vital signs and a dinner tray. Nurse #9 stated she did not complete the admission assessment, assess his skin nor did she notice the wound care to his left and right thigh was not present on the orders.

A phone interview was conducted with Nurse #7 on 8/11/21 at 7:00 PM, who was familiar with Resident #9 and completed the readmission process and reviewed the readmission orders on 8/8/21. She recalled doing the assessment and stated he had dressings in place to the right and left thigh from the hospital and provided wound care to the areas during the assessment. Nurse

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#7 stated she should have reviewed the hospital discharge forms for wound care and if none were present she should have called the physician, nurse practitioner (NP), or wound care provider for clarification on the treatment orders. In addition, Nurse #7 was assigned to Resident #9 for the evening shifts of 7/24/21, 7/25/21, 7/29/21, 8/2/21 and 8/5/21. Nurse #7 stated she had completed wound care with the Xeroform and dry dressing to his bilateral thigh wound and "just knew what was used on the area" since she had cared for him for a while. She acknowledged she had not reviewed the orders or TAR and if she had, she would have noticed there was no order in place and would have initiated one at that time and that she should have documented the treatment as completed.

The Unit Manager (UM) was interviewed on 8/10/21 at 2:49 PM and confirmed the wound care order for Resident #9's left outer thigh and right posterior thigh were not present on readmission from the hospital on 7/24/21 or 8/8/21, nor was the wound care to the non-pressure related areas present on the July 2021 and August 2021 TAR's. The UM further stated at the time of readmission from the hospital, on 7/24/21 and 8/8/21, when the nurse completed the readmission assessment and skin review, they should have looked for any wound care orders on the discharge paperwork and if none were present they should have either resumed the prior wound care order or notified the physician or Nurse Practitioner for an order. The UM was unable to state what systems were in place to prevent wound care orders not being clarified or in place at the time of readmission from the hospital.

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F 684	Continued From page 15	F 684		

On 8/10/21 at 3:30 PM, an interview occurred with the facility Nurse Practitioner who was familiar with Resident #9. She was aware he had non-pressure related wounds to his right and left thighs prior to discharge to the hospital in July 2021 and was under the care of the wound care physician that came to the facility weekly. The NP stated she would have expected the wound care orders to be resumed if there were no orders present on the discharge or After Visit summaries from the hospital. She also stated the staff could have called either herself or the physician if they were unsure of what treatment orders to use.

On 8/11/21 at 12:01 PM, a phone interview occurred with the wound care physician who sees Resident #9 weekly and was familiar with him. He explained Resident #9 had a history of frequent skin tears to the right posterior leg from tape used on his sacral pressure ulcer and had an area on his left lateral leg where a blister had once been. The physician stated he last assessed Resident #9 on 8/5/21 with no deterioration in his wounds. He stated he would have expected the previous treatment orders to resume upon readmission from the hospital in July 2021 and August 2021 if there were no new orders from the hospital. The wound care physician added staff could have reached out to the facility physician, NP, or himself if they were not sure what treatment orders to use at the time of readmissions.

The Administrator was interviewed on 8/10/21 at 5:02 PM and stated she would have expected Resident #9's wound care to his right and left thighs be present as ordered and upon readmission from the hospital.

The Director of Nursing was not available for

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F 684	Continued From page 16 interview during the investigation.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff, facility nurse practitioner, wound physician and resident interviews, the facility failed to clarify physician orders for the treatment of a stage 4 pressure ulcer on readmission and nursing staff provided the treatment without a physician's order. This affected 1 of 3 residents reviewed for pressure ulcers (Resident #9). The findings included: Resident #9 was originally admitted to the facility on 9/28/09 with diagnoses that included diabetes type 2, a stage 4 pressure ulcer of the sacral region, reduced mobility, and coronary artery disease (CAD). A review of Resident #9's active care plan, dated	F 686	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 09/01/2021. 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. F686 Treatment/Services to Prevent/Heal Pressure Ulcer Upon discovery, Resident #9 was assessed by the physician and verified	9/1/21

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F 686	Continued From page 17 3/17/21, revealed an area of need for a stage 4 pressure area to the sacral/buttocks area. The interventions included wound physician as ordered and treatments as ordered. The annual Minimum Data Set (MDS) assessment dated 6/8/21 indicated Resident #9 was cognitively intact and displayed physical and verbal behavioral symptoms towards others as well as rejection of care 1 to 3 days during the 7 day look back period. He required extensive to total assistance for bed mobility and transfers. Resident #9 was coded with 1 stage 4 pressure ulcer and a pressure reducing device to the bed. Review of the nursing progress notes from 7/1/21 to 8/6/21 did not reveal any rejection of wound care by Resident #9. Review of Resident #9's physician orders revealed an order dated 7/1/21 to cleanse the sacral wound with normal saline, gently pack with Calcium Alginate (a dressing that helps to promote wound healing) and cover with a dry dressing every day and as needed. A wound physician progress note dated 7/15/21 indicated Resident #9 had a Stage 4 pressure ulcer of the sacral area that measured 3.5 centimeters (cm) in length, 1 cm in width and 2.5 cm in depth. No changes to the treatment order. Resident #9 was transferred to the hospital on 7/20/21 and returned to the facility on 7/24/21. The After Visit and discharge summaries from the hospital, dated 7/24/21, included no treatment orders for the sacral pressure ulcer for Resident #9.	F 686	orders in place for wound treatment for pressure related areas on 8/10/2021. Current residents with pressure related areas have the potential to be affected. Head to toe skin assessments were conducted on current residents to ensure that all pressure related areas were identified and had wound treatments ordered by a Licensed Nurse by 8/23/2021. No additional concerns were identified. Education was provided to the Nurse Managers by The Administrator on 8/11/2021 regarding expectations for identifying pressure related areas and obtaining physician's orders for wound treatment to these areas. Subsequently, education was provided to all Licensed Nurses and Certified Nurse Aide lls (CNA lls) by The Director of Nursing and/or Designee by 8/24/2021. Nurse Managers and/or designated facility wound care nurse will audit resident weekly skin assessments to ensure that pressure related areas have been identified and have physician's orders for wound treatments in place. The audits will include all current residents with pressure related areas five times per week for two weeks, then three times per week for two weeks, then weekly for four weeks, then as determined by the Quality Assurance Committee—The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances will be corrected at the time of audit and additional education provided when indicated. The Director of Nursing or designee will	

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F 686	Continued From page 18 The Comprehensive Admission Assessment completed by Nurse #6 and dated 7/24/21 noted a stage 4 pressure ulcer to the sacral area. Nurse #6 was interviewed via phone on 8/11/21 at 11:47 AM and was the nurse who had completed the Admission Assessment on 7/24/21. Nurse #6 stated she was familiar with Resident #9 but could not recall completing the Admission Assessment on 7/24/21 or if wound orders were present on the discharge summary for the sacral pressure ulcer. Nurse #6 further stated she had not completed any wound care on Resident #9 as it was scheduled for the evening shift. A review of Resident #9's Treatment Administration Records (TARs) for July 2021 and August 2021 revealed there was no order for wound care to the stage 4 pressure ulcer from 7/24/21 through 8/6/21. A wound physician progress note dated 7/29/21 revealed Resident #9 had a stage 4 sacral pressure ulcer that measured 3.7 cm in length, 1 cm in width and 2 cm in depth. There was no change to the treatment order. A wound physician progress note dated 8/5/21 indicated Resident #9 had a stage 4 pressure ulcer to the sacral area that measured 4 cm in length, 1.7 cm in width and 2.5 cm in depth. There was no change to the wound progress or treatment orders. Resident #9 was discharged to the hospital on 8/6/21 and was readmitted to the facility on 8/8/21.	F 686	additionally audit all new admission/readmission medical records to ensure that pressure related areas have been identified and have physician's orders for wound treatments in place. The audits will be completed five times per week for two weeks, then three times per week for two weeks, then weekly for four weeks, then as determined by the Quality Assurance Committee—The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances will be corrected at the time of audit and additional education provided when indicated. Continued compliance will be monitored through the facility's Quality Assurance Program.	

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F 686	Continued From page 19	F 686		

On 8/9/21 at 12:15 PM, an interview occurred with Resident #9 who stated his wound care was completed daily after his readmission from the hospital in July 2021.

An observation of Resident #9's wound care was completed with Nurse #11 and Nurse Aide II (NAII) #2 on 8/9/21 at 12:20 PM. Resident #9 with multiple scarred areas light pink in color to sacral and buttocks area from previous wounds. The stage 4 pressure ulcer to the sacrum was 4cm in length, 1 cm in width and 2 cm in depth, with no drainage or odor present. The treatment was completed as ordered.

Nurse #1 was interviewed on 8/10/21 at 2:08 PM and was assigned to Resident #9 on 8/4/21. She stated she provided the pressure ulcer treatment to Resident #9 but that she didn't look at the TAR as she knew he required Calcium Alginate for the area and a dry dressing. Nurse #1 acknowledged if she had looked at the TAR, she would have caught the treatment order was not present for the sacral wound and should have documented the treatment as completed.

Another interview was completed with Nurse #8 on 8/10/21 at 4:20 PM. She recalled providing wound care to Resident #9 on 7/28/21 but stated she didn't look at the TAR for Resident #9's treatment orders because she "just knew" what treatment supplies were used and provided the treatment to the sacral wound with Calcium Alginate and a dry dressing. Nurse #8 stated if she had reviewed the TAR at that time, she would have caught the treatment order was not present for the sacral wound and should have documented the treatment as completed.

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A phone interview was conducted with Nurse #7 on 8/11/21 at 7:00 PM, who was familiar with Resident #9 and was assigned to Resident #9 for the evening shifts of 7/24/21, 7/25/21, 7/29/21, 8/2/21 and 8/5/21. Nurse #7 stated she had completed wound care with the Calcium Alginate and dry dressing since she had cared for him for a while and "just knew what was used on the area". She acknowledged she had not reviewed the orders or TAR and if she had, she would have noticed there was no order in place and would have initiated one at that time and that she should have documented the treatment as completed.

The Unit Manager (UM) was interviewed on 8/10/21 at 2:49 PM and confirmed the wound care order for Resident #9's sacral pressure ulcer was not present on readmission from the hospital on 7/24/21 nor was the wound care to sacral area present on the July 2021 and August 2021 TAR's. The UM further stated on 7/24/21, when the nurse completed the readmission assessment and skin review, they should have then looked for any wound care orders on the discharge paperwork and if none were present they should have either resumed the prior wound care order or contacted the physician or Nurse Practitioner (NP) for an order. The UM was unable to state what systems were in place to prevent wound care orders not being clarified or in place at the time of readmission from the hospital.

On 8/10/21 at 3:30 PM, an interview occurred with the facility Nurse Practitioner who was familiar with Resident #9. She was aware he had a chronic stage 4 sacral pressure ulcer prior to the hospital discharge in July 2021 and was under the care of the wound care physician that came to the facility weekly. The NP stated she

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F 686	Continued From page 21 would have expected the wound care order to be resumed if there were no orders present on the discharge or After Visit summaries from the hospital. She also stated the staff could have called either herself or the physician if they were unsure of what treatment order to use. On 8/11/21 at 12:01 PM, a phone interview occurred with the wound care physician who sees Resident #9 weekly and was familiar with Resident #9. He explained Resident #9 had a chronic stage 4 pressure ulcer to the sacral area and last assessed the area on 8/5/21 with no deterioration to the wound. He stated he would have expected the previous treatment order to resume upon readmission from the hospital in July 2021 if there were no new orders from the hospital. The wound care physician added staff could have reached out to the facility physician, NP, or himself if they were not sure what treatment order to use at the time of the readmission. The Administrator was interviewed on 8/10/21 at 5:02 PM and stated she would have expected Resident #9's wound care to his sacral pressure ulcer be renewed upon his readmission from the hospital in July 2021. The Director of Nursing was not available for interview during the investigation.	F 686		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		9/1/21

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resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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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
F 842	Continued From page 23 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate medical records for 3 of 4 residents reviewed for wound care (Residents #2, #9 and #5). The findings included: 1) Resident #2 was originally admitted to the facility on 6/4/21 with multiple diagnoses that included morbid obesity, erythema intertrigo (inflammation of the skin folds) and chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS) assessment dated 6/10/21 indicated Resident #2 was cognitively intact and displayed rejection of	F 842	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 09/01/2021. 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. F842 Resident Records - Identifiable Information	

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	345389	A. BUILDING _____ B. WING _____	C 08/11/2021

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F 842	Continued From page 24 care 1 to 3 days during the 7 day look back period. She required extensive to total assistance for bed mobility, transfers, dressing, toileting, and bathing. Limited range of motion was present to her bilateral lower extremities. Resident #2 was not coded for any pressure ulcers or other skin impairments but did have a pressure reducing device to the bed. Resident #2's physician orders revealed the following: - An order dated 6/19/21 to cleanse the abrasion wound to the right thigh with normal saline. Apply Xeroform (a sterile, medicated, non-adhering protective dressing) and a dry dressing every 3 days and as needed. - An order dated 7/26/21 to apply Xeroform to skin tears on the right and left buttock as well as the left inner thigh every 48 hours and as needed. The July 2021 Treatment Administration Record (TAR) was reviewed and revealed the right thigh, left inner thigh, right and left buttock wound care had not been documented as completed or refused by the resident for the day shift on 7/7/21, 7/19/21 and 7/26/21. Review of the nursing progress notes from 6/21/21 to 7/29/21 revealed Resident #2 would often delay personal care assistance but normally accepted wound care. Resident #2 was transferred to the hospital on 7/29/21 and had not returned to the facility. On 8/10/21 at 2:08 PM, an interview occurred with Nurse #1, who was scheduled for the 7:00 AM to 7:00 PM shift on 7/26/21. She explained wound care was completed after the medication	F 842	Current residents with orders for wound care have the potential to be affected. All treatment records for current residents with orders for wound care were audited by the Director of Nursing and designated Nurse Managers on 8/11/2021. No additional concerns were identified at that time. Education was provided to the Nurse Managers by The Administrator on 8/11/2021 regarding the facility expectation of timely and complete documentation of the Treatment Administration Record (TAR). Subsequently, all Licensed Nurses were educated by The Director of Nursing and/or Designee by 8/24/2021. The Director of Nursing and/or Designee will audit for completion of the TAR on all residents with orders for wound care daily for one week, then five times weekly for three weeks, then three times weekly for two weeks, then weekly for two weeks, and then as determined by the Quality Assurance Committee—The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances will be corrected at the time of audit and additional education provided when indicated. Continued compliance will be monitored through the facility's Quality Assurance Program.	

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F 842	Continued From page 25	F 842		

pass and Resident #2 accepted. Nurse #1 stated she had forgotten to document the wound care as completed on the TAR.

A phone interview was completed with Nurse #2 on 8/10/21 at 3:56 PM, who was familiar with Resident #2. She was scheduled for the 7:00 AM to 7:00 PM shift on 7/7/21 and could not recall Resident #2 refusing wound care to her abrasion areas. She verified the date in question and stated she completed the wound care as ordered but had forgotten to sign them as completed.

On 8/10/21 at 4:15 PM, an interview occurred with Nurse #3 who was scheduled to work on the 7:00 AM to 7:00 PM shift on 7/19/21. She was able to recall Resident #2 had wound care to abrasion areas on her thighs and buttocks and could not remember the resident refusing wound care. She verified the date in question and stated she forgot to sign the wound care as completed on the TAR.

The Administrator was interviewed on 8/10/21 at 5:02 PM and indicated she expected the nursing staff to complete wound care as ordered as well as to document it was completed or refused by the resident.

2) Resident #9 was originally admitted to the facility on 9/28/09 with multiple diagnoses that included diabetes type 2, stage 4 pressure ulcer of the sacrum, and chronic pain syndrome.

The annual Minimum Data Set (MDS) assessment dated 6/8/21 indicated Resident #9 was cognitively intact and displayed physical and verbal behavioral towards others and rejection of

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care 1 to 3 days during the 7 day look back period. Resident #9 was coded with an indwelling catheter, ostomy and 1 stage 4 pressure ulcer.

Resident #9's physician order revealed the following order dated 7/1/21 to cleanse the sacral wound with normal saline, gently pack with Calcium Alginate (a highly absorbent dressing that promotes healing) and cover with a dry dressing. Change every day and as needed.

The July 2021 Treatment Administration Record (TAR) was reviewed and revealed the sacral wound care had not been documented as completed or refused by the resident for the evening shift on 7/1/21 and 7/11/21.

Resident #9 was transferred to the hospital on 7/20/21 and was readmitted to the facility on 7/24/21.

Review of the nursing progress notes from 7/1/21 to present revealed Resident #9 had no verbal or physical behaviors towards others nor refusal of care.

A phone interview was completed with Nurse #5 on 8/10/21 at 2:30 PM, who was familiar with Resident #9. She was scheduled for the 7:00 PM to 7:00 AM shift on 7/1/21 and could not recall Resident #9 refusing wound care to his sacral area. She verified the date in question and stated she completed the wound care as ordered but had forgotten to sign it as completed.

On 8/11/21 at 2:45 PM, a phone interview occurred with Nurse #4 who was familiar with Resident #9. She was scheduled for the 7:00 PM to 7:00 AM shift on 7/11/21. She verified the

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evening shift date in question, that she completed the wound care as ordered but forgot to the sign it has completed.

The Administrator was interviewed on 8/10/21 at 5:02 PM and indicated she expected the nursing staff to complete wound care as ordered as well as to document it was completed or refused by the resident.

3. Resident #5 was admitted to the facility on 6/4/21 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), respiratory failure, and Diabetes Mellitus (DM).

The admission Minimum Data Set (MDS) assessment dated 6/9/21 indicated Resident #5's cognition was fully intact.

A review of Resident #5's physician's orders for June 2021 and July 2021 included Nystatin-Triamcinolone Cream (antifungal medication) apply topically two times a day (once in the morning and once in the evening).

A review of Resident #5's Treatment Administration Record (TAR) for June 2021 revealed no documentation of the Nystatin-Triamcinolone Cream being applied for the evening administration time on 6/23/21, 6/28/21, or 6/29/21.

A review of Resident #5's TAR for July 2021 revealed no documentation of the Nystatin-Triamcinolone Cream being applied for the morning administration time on 7/1/21, 7/6/21, 7/12/21, 7/13/21, and 7/15/21 or for the evening administration time on 7/5/21, 7/6/21, 7/9/21 and 7/15/21.

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A phone interview was attempted with Nurse #10 on 8/10/21 at 12:09 PM. She was unable to be reached. According to the schedule with assignments Nurse #10 was assigned to Resident #5 on 5 dates that the Nystatin-Triamcinolone Cream was not documented on his TAR as applied (6/28/21, 6/29/21, 7/1/21, 7/6/21, and 7/15/21).

An interview was conducted with Nurse #8 on 8/10/21 at 12:15 PM. According to the scheduled with assignments, Nurse #8 was assigned to Resident #5 on 1 date that the Nystatin-Triamcinolone Cream was not documented on his TAR as applied (7/9/21). Nurse #8 stated that she had not recalled working with Resident #5 that day, but that she always completed her treatments as ordered and she may have forgotten to document it on the TAR.

An interview was conducted with Nurse #11 on 8/10/21 at 1:34 PM. According to the schedule with assignments, Nurse #11 was assigned to Resident #5 on 3 dates that the Nystatin-Triamcinolone Cream was not documented on his TAR as applied (6/23/21, 7/12/21, and 7/13/21). Nurse #11 stated that she completed these applications, but must have forgotten to document them on the TAR.

During an interview with the Administrator on 8/10/21 at 5:06 PM she stated that she expected the TARs to be complete and accurate and for all administered treatments to be documented.