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 12/09/2021

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

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F 000	INITIAL COMMENTS The surveyor entered the facility on 11/30/21 to conduct a complaint investigation and follow up survey. The surveyor was onsite 11/30/21 and 12/1/21. Additional information was obtained offsite on 12/9/21. Therefore, the exit date was 12/9/21. Event ID# IT6U11. One of the four complaint allegations was substantiated.	F 000		
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, staff interview, and Nurse Practitioner interview for one (Resident # 1) of three sampled residents reviewed for professional standards, the facility failed to assess a resident's vital signs when he experienced a change in condition. The findings included: Record review revealed Resident # 1 resided at the facility from 9/24/21 until his discharge to the hospital on 10/8/21. According to records, prior to the resident's facility residency he had been hospitalized for fevers and joint pain which the physician felt was possibly related to polyarticular gout. Additionally, the	F 684	F684 QUALITY OF CARE The Laurels of Forest Glenn wishes to have this submitted Plan of Correction (POC) to stand as the allegation of compliance. Our allegation of compliance date is 12/22/21. Preparation and/or execution of this POC 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 requirements.	12/22/21

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

Electronically Signed | 12/20/2021

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F 684	Continued From page 1 resident had diagnoses of hypertension, chronic kidney disease, congestive heart failure, gastroesophageal reflux disease, and a history of pericardial effusion.. The resident's admission minimum data set assessment, dated 9/30/21, coded the resident as cognitively intact and as needing supervision with his dressing and toileting. He was independent for his bathing needs. According to the record, on 10/4/21 the resident was diagnosed with COVID, evaluated by the physician per a virtual visit in conjunction with a nurse, and found to have clear lung sounds. He was started on a COVID-19 protocol which included the anticoagulant medication Eliquis 2.5 mg (milligrams) twice per day for 30 days. Other medications, which were included on the protocol, were Z-Pac, dexamethasone, and hydroxychloroquine. According to the record, the resident was evaluated by either the NP or the physician on the dates of 10/4/21, 10/5/21, 10/6/21 and 10/7/21. On the 10/7/21 assessment, the physician noted the resident was "doing well" on the COVID protocol. His lungs were clear to auscultation. On 10/8/21 at 7:58 AM the resident's vital signs were documented to be: Blood pressure: 135/59; temperature- 97.6; Pulse 82; and respirations 18. There were no further vital signs after this time. On 10/8/21 at 11:40 AM Nurse # 1 documented the following. "Resident has what appeared to be two episodes of a seizure and the second one was followed by him throwing up some coffee ground emesis. NP was made aware and gave	F 684	The facility will ensure that all residents are assessed with vital signs taken when experiencing a change in condition. Resident #1 has been discharged from the facility. All residents who exhibit a change in condition are at risk of being affected. Facility nurses will be educated by 12/22/21 by the Asst. Dir. Of Nursing or Designee regarding appropriate assessments of residents post change in condition. The nurse managers will monitor for vital signs post change in condition of all residents during clinical operations meetings 3x/week for 4 weeks, then weekly for 4 weeks or until substantial compliance is achieved. Any discrepancies from the standard will be addressed at the time of discovery. Results will be presented to the Quality Assurance Performance Improvement Committee for 2 months or until substantial compliance is achieved.	

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F 684	Continued From page 2	F 684		

me the ok to send him out. I've spoken with his daughter numerous times this AM and she's aware of what's going on and agrees he should be sent out. I am sending him to (hospital name), waiting on EMS to come get him, report has been called to the ER as well."

Nurse # 1 was interviewed on 11/30/21 at 4:20 PM and reported the following. On the AM of 10/8/21 she was called into the room by the resident's NA (nurse aide) who felt like the resident was not acting like himself. When she got to the room, the resident was sitting on the side of the bed where the NA had been assisting him to get dressed. He was not responding and his whole body was shaking. To the nurse, it resembled seizure activity and it only lasted a few seconds. She called his name and they laid him down. He became alert and had not realized what had happened. That morning, the resident also had some brown, dark, coffee ground emesis two different times. She talked to the NP twice about the resident and had reported both the shaking and the emesis. The nurse recalled the episodes of emesis and the shaking episode occurred all within an approximate 45- minute time frame. When she talked to the NP the second time, she let the NP know she felt the resident needed to be sent out and orders were received to do so. She could not recall obtaining the resident's vital signs or his oxygen level after he was noted to have the shaking and emesis. She did not recall he was short of breath or in need of oxygen.

Review of EMS documentation revealed EMS arrived in the resident's room on 10/8/21 at 11:52 AM.

EMS documented they found the resident sitting

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F 684	Continued From page 3	F 684		

in a wheelchair appearing weak with coffee ground emesis in a towel nearby. They also documented "ABCs without compromise." (Airway-breathing-circulation). His lungs were clear to auscultation with diminished bases. His mental status was documented to be his norm.

Initial EMS Vital signs and Oximetry readings indicated the resident's respirations were abnormally high and his oxygen level was abnormally low but eventually rose with oxygen. Initial readings were:
11:59- B/P 93/38; pulse 57; respirations 40 and oxygen level 85% on room air
12:04- B/P 91/38; pulse 54; respirations 39 and oxygen level 84% on oxygen
12:09- B/P 88/41; pulse 58; respirations 39 and oxygen level 59% on oxygen
12:14-pulse 56; respirations 32; and oxygen level 94% on oxygen

One of the EMS responders was interviewed on 12/9/21 at 9:00 AM and reported the following. The resident's pulse oximetry at their time of arrival indicated the resident was in need of oxygen when they arrived.

Review of hospital records revealed the resident was admitted and treated for intestinal inflammation and COVID pneumonia.

The DON and Nurse Practitioner were interviewed on 12/9/21 at 9:24 AM via phone. The DON reported that it was her expectation that nurses obtain vital signs and oximetry readings when there is a change of condition. The NP also reported that this would be an expectation with any change in condition. The NP validated that the nurse had talked to her twice on the morning

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F 684	Continued From page 4 of 10/8/21 within a short time frame. She saw the resident as he was being transferred out. He did not appear in distress. The NP stated residents with COVID can experience a change in their breathing very quickly and the facility has standing orders to administer oxygen at 2 to 4 liters to maintain residents' oxygen saturation levels greater than 90%.	F 684		