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 05/17/2023

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 A complaint investigation survey was conducted from 5/16/23 to 5/17/23. Event ID# 4G6Z11. The following intakes were investigated NC00 201575; NC 200835; and NC 200136. Five of the five complaint allegations did not result in deficiency.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		5/25/23

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

Electronically Signed | 05/25/2023

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F 690	Continued From page 1 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and physician interview the facility failed to obtain a urine specimen for analysis and culture/sensitivity. This was for one of one (Resident # 1) sampled resident identified to have urinary symptoms. The findings included: Resident # 1 resided at the facility from 3/14/23 to 4/19/23. Resident # 1's diagnoses in part included recent history of small bowel obstruction with lysis of adhesions, atrial fibrillation, sick sinus syndrome, severe protein malnutrition, and history of breast cancer. Resident # 1's admission Minimum Data Set assessment, dated 3/21/23, coded Resident # 1 as cognitively intact. The resident was assessed to be incontinent of bowel and bladder and needed extensive assistance with her hygiene needs. The resident was not assessed to have any behavioral problems. Resident # 1's care plan, dated 3/14/23, noted Resident # 1 was incontinent and directed staff to assess for any signs of a urinary tract infection. The care plan noted signs could include altered mental status, increased temperature and failure to eat. On 4/10/23 at 1:26 PM Physician # 1 noted she	F 690	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 06/02/2023. 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 requirements. F690 Bowel/Bladder Incontinence, Catheter, Urinary Tract Infection Resident #1 with the alleged deficient practice is not residing at the facility. All residents have the potential to be affected. All residents current order listings were reviewed for Urinalysis Culture and Sensitivity (UA C&S) ordered by the physician to ensure the urine was collected as ordered and properly ordered into the lab system for pickup and processing for full UA C&S by 05/26/2023.	

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F 690	Continued From page 2 was seeing Resident # 1 for an acute visit due to increased confusion, being verbally aggressive, and displaying behaviors. Physician # 1 also noted Resident # 1 had "increased urination and issues." The physician noted a UA C&S (urinalysis with culture and sensitivity) would be obtained. On 4/10/23 a physician's order was entered into Resident # 1's electronic record for a UA C&S and confirmed by Nurse # 1. The order was never discontinued prior to Resident # 1's discharge date of 4/19/23. There was never a urine lab result that corresponded to the 4/10/23 order. On 4/11/23 the psychiatric Nurse Practitioner (NP) saw Resident # 1 due to behaviors. The psychiatric NP noted the urine test, which had been ordered by the primary physician the previous day, was still pending. On 4/13/23 the primary care NP (NP # 1) saw Resident # 1 and noted she discussed discharge planning with the resident and the resident was alert and able to communicate that day. The resident had no complaints. The primary care NP made no mention of the pending urine specimen result. On 4/14/23 an order was entered into Resident # 1's electronic record for a stat (right away) UA C&S to rule out UTI (urinary tract infection). On 4/15/23 at 8:25 PM Nurse # 2 noted the following. Resident # 1 continued to be confused and combative with care at times. She was having a hard time following commands and participating in therapy. The urinalysis results showed the resident had 3 + bacteria in her urine.	F 690	Any discrepancies identified, will be immediately corrected as ordered by the Medical Director. Education was provided to all Licensed Nurse Managers by the Regional Clinical Coordinator (RCC) and Licensed Nursing Home Administrator (LNHA) on physician orders and process for collecting, processing, and reviewing labs on 05/17/2023. Education was provided to all Licensed Nurses by the Director of Nursing and/or designee on physician orders and process for collecting, processing, and reviewing labs by 05/26/2023. The Director of Nursing and/or designee, after the initial full-house audit, will audit all UA C&S labs ordered five times per week for three weeks, then three times per week for two weeks, then weekly for two weeks, and then as determined by the Quality Assurance Committee—The Director of Nursing is responsible to take to the audits to the Quality Assurance Meetings. Any variances identified will be addressed immediately and additional education provided when indicated. Continued compliance will be monitored through the facility's Quality Assurance Program.	

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The culture and sensitivity were still pending. The resident's vitals were stable, and she was afebrile. The nurse further noted she spoke to NP # 1 and there were no new orders at that time.

Review of the record revealed no culture and sensitivity results were ever obtained from the 4/14/23 specimen. Only the urinalysis was reported from the 4/14/23 specimen.

On 4/17/23 orders were given to start Intravenous (IV) fluids for the resident. Nursing notes reflected the IV fluids were started on 4/17/23 at 1:55 PM.

Additionally, another order was given for a urine culture and sensitivity to be done on 4/17/23. This was noted to be obtained on 4/17/23 at 1:55 PM.

On 4/17/23 at 7:53 PM Nurse # 2 noted Resident # 1 was lethargic, difficult to arouse, and had poor oral intake. She had worsened over the week-end (4/15 and 4/16/23) and was having a low grade temperature. Nurse # 2 noted the urine culture was still pending. Nurse # 2 noted she informed Physician # 1 of Resident # 1's worsening status and an order was given for the antibiotic, Rocephin, intramuscularly for three days pending the results of the urine culture.

According to Resident # 1's April 2023 Medication Administration Record, Resident # 1 received two doses of Rocephin prior to her discharge. These doses were administered on the evenings of 4/17/23 and 4/18/23.

On 4/18/23 at 11:29 PM NP # 1 saw Resident # 1 and noted the following. Resident # 1 would give slow responses. She was not eating well, and the urine culture results were still pending. Physician

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1 had started Rocephin the previous day due to the urine lab results not being finalized. The NP noted she would continue IV fluids.

On 4/19/23 at 11:16 PM NP # 1 noted Resident # 1 gave slow responses. She had been hydrated with IV fluids and an x-ray had ruled out pneumonia. The NP noted the urine culture and sensitivity were pending and the resident was on prophylactic antibiotic treatment while awaiting results. The NP also noted she talked to the family who requested that Resident # 1 be sent to the hospital.

According to the facility record, Resident # 1 was transferred to the hospital on 4/19/23 at 12:05 PM.

The urine specimen which had been collected on 4/17/23 had a result report date of 4/20/23 at 2:50 PM. The report noted the urine had grown greater than 100,000 colonies of Escherichia coli and the bacteria was sensitive to Rocephin (the antibiotic on which the resident had been started).

Review of hospital records revealed the hospital continued treatment for Resident # 1's urinary tract infection upon hospital admission, and the resident's continued lethargy was found to be related to another medical issue other than the urinary tract infection.

Nurse # 1 and the Director of Nursing were interviewed on 5/17/23 at 12:15 PM and reported the following. There was no result for the 4/10/23 UA C&S. When Physician # 1 had given the 4/10/23 order, Nurse # 1 had confirmed the lab in the computer system. The facility system was as follows so that follow up could be done to make

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sure the urine lab was obtained. When the order was obtained, it should have been entered under "lab" in the orders. That way it would populate on the MAR (medication administration record) so the nurses would know the lab was due. The order also had to be automatically entered into the lab computer system. At midnight, the night shift nurses would print off an "expiring log" lists of labs that would need to be drawn or picked up by the lab technician when the lab technician arrived at the facility every night around 4:00 AM. If a urine lab order was on the list and the specimen had not yet been obtained and placed in the refrigerator for pick up, then the night shift nurse knew they were supposed to obtain it. For some reason, this had not occurred for Resident # 1. Nurse # 1 stated she had also entered the orders for the 4/14/23 UA & C&S into the computer. She thought she had entered everything correctly for both the urinalysis and the culture, but she could not recall for sure, and the system showed only the UA had been ordered.

Nurse # 4 was interviewed on 5/17/23 at 10:40 AM and reported the following. She (Nurse # 4) was told by Nurse # 1 to obtain a urine specimen from Resident # 1 on 4/14/23 because it had not been obtained prior to that. She performed an in and out catheterization to do so and the urine did not look like urine when it came out. It looked like a different substance. She had not been the one to put the order into to the lab system on 4/14/23, but later found out the culture had not been ordered in the system and therefore not done.

Nurse # 3 was interviewed on 5/17/23 at 10:58 AM and reported the following. She had worked on 4/11/23 from 7 AM to 7 PM. She had been told in nurse's report on 4/11/23 that Resident # 1 had

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been combative and agitated the previous day. That was not Resident # 1's baseline. It had not been called to Nurse # 3's attention that a urine specimen still needed to be obtained on 4/11/23 or she could have easily gotten one that day because Resident # 1 seemed more at her baseline and was cooperative. On 4/11/23, Nurse # 3 had not noted anything alarming. In the last few days prior to Resident # 1's hospital discharge, Resident # 1 changed and was sleeping all the time. She recalled one day in report a night nurse mentioning Resident # 1's 4/14/23 urine specimen culture was still pending, and it seemed to her as if it should have been back. She looked in the computer system and found the culture had never been put in the lab system to be performed. Therefore, she catheterized Resident # 1 again on 4/17/23 to get the culture.

Physician # 1 was interviewed on 5/17/23 at 4:40 PM revealing the following. It was her understanding that on the initial day of the urine specimen order (4/10/23), Resident # 1 had been noncooperative and combative and the specimen could not be obtained that day. It was her intent the nurses try to continue to get it. When it was not obtained and the resident seemed to worsen a broad- spectrum antibiotic was started, which worked for the urinary tract infection. The lack of obtaining the specimen as ordered had not contributed to Resident # 1's worsening or caused her any harm. Her continued lethargy had been found to be caused by another medical issue when she was hospitalized, and her urinary tract infection had already started to respond to the Rocephin started at the facility.