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	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Forest Glenn	1101 Hartwell Street Garner, NC 27529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49074 Based on record review, observation, and staff interviews, the facility failed to ensure medications were not left unattended on top of the medication cart (100 Hall medication cart) and failed to dispose or discard out of date medications stored in 2 of 5 medication carts (100 Hall middle A/B medication cart). The findings included: 1a. On 4/03/24 a continuous observation from 9:50 AM through 9:55 AM was conducted during a medication pass. Nurse #2 was observed to have left 2 medicine cups of prepared medication unattended on top of the 100-hall medication cart. Nurse #2 was observed to have covered each medication cup with a plastic cup. Nurse #2 was then observed to have left the medication cart and proceeded down the 100 hallway toward the 100-hall nursing desk looking for a vital signs monitor to take a resident's blood pressure. Nurse #2 went to a resident's room, donned on personal protective equipment, then entered a resident room to check a resident's blood pressure. At 9:55 AM Nurse #2 returned to the medication cart. Two residents, one from room [ROOM NUMBER] and another from room [ROOM NUMBER], (semi-private rooms) were in the hall near the medication cart during the period when the nurse left the medication cups unattended. The two residents had cognitive loss and were up in their wheelchairs self-mobilizing around the hall. 1b. On 4/03/24 a continuous observation from 1:44 PM through 1:49 PM during a medication pass, Nurse #2 was observed to have left a medicine cup of prepared medication unattended on top of the 100-hall medication cart. Nurse #2 was observed to have covered the medication cup with a plastic cup. Nurse #2 went to the medication room and returned at 1:49 PM to the medication cart. Two residents, room [ROOM NUMBER] and room [ROOM NUMBER] were observed to have been in the hallway near the medication cart. The two residents had cognitive loss and were in their wheelchairs self-mobilizing around the hall. An interview with Nurse #2 on 4/3/24 at 1:56 PM revealed the nurse acknowledged she left the medications cups unattended on top of 100 hall medication cart during both observations. Nurse #2 stated she normally doesn't go that far away from the medications cart but explained she was in a rush. (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a. An observation was conducted on 4/4/24 at 2:43 PM of middle A/B medication cart with Nurse #3. A vial of multidose lidocaine hydrochloride injection 1% (used as a local injectable anesthetic) was found open in the medication cart and was not dated when opened. 2b. The manufacturer's recommendations for Ipratropium-albuterol stated to keep the medication in the container it came in, and to keep the packaging tightly closed. Keep the unused vials of nebulizer solution in the foil pouch until they were used. Once removed from the foil pouch, the individual vials should be used within one week. An observation was conducted on 4/4/24 at 2:43 PM of middle A/B medication cart. Ipratropium-albuterol 0.5-3 milligrams (mg)/3 (used for chronic obstructive pulmonary disease) vials were observed in the medication cart. The individual vials were found outside of the foil in two different boxes in the medication cart with no date. An interview with Nurse #3 on 4/4/24 at 2:45PM revealed nursing staff should be checking the medication cart and remove all non-dated medications. Nurse #3 also stated that the vial of multidose lidocaine hydrochloride and vials of Ipratropium-albuterol 0.5-3mg/3 should have been removed and returned to the pharmacy. An interview with the Nurse Supervisor on 4/4/24 at 2:48 PM revealed the vial of multidose lidocaine hydrochloride should have been dated and the vials of Ipratropium-albuterol 0.5-3mg/3 should have been inside of the foil packaging. An interview with the Director of Nursing (DON) on 4/4/24 at 3:20 PM revealed that all medication when pulled from the medication cart should be secured, and not left unattended. Nursing staff should check all medication rooms and medication carts for any expired medications on a weekly basis and remove multidose vials with no dates and remove Ipratropium-albuterol 0.5-3mg/3 when out of the foil packaging. Medication rooms and medication carts were inspected for proper medication storage monthly by the pharmacy staff.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49502 Based on observations, record review and staff interview the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 6/21/21 recertification and complaint investigation. This was for 1 recited deficiency on the current recertification and complaint survey of 2/23/24 in the area of label/store drugs and biologicals (F761). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F671- Label/store drugs and biologicals: Based on record review, observation and staff interviews, the facility failed to ensure that medication were securely stored in a locked medication cart and not left unattended that was inaccessible by residents and failed to dispose or discard out of date medications in 2 of 5 medication carts. During the 6/21/21 recertification and complaint investigation survey the facility failed to discard insulin medications in accordance with the manufacturer's instruction for 1 medication cart (100 hall) out of 4 medication carts observed for medication storage.