

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER The Laurels of Forest Glenn		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with facility staff and the Pharmacist, the facility failed to have effective systems in place for the return of discontinued narcotic medications to prevent the diversion of controlled medications (Percocet 5/325 milligrams 4 tablets and six (6) 1/2 tablets of Oxycodone 5 milligrams) for 2 of 2 discharged residents reviewed for pharmacy services (Resident #106 and Resident #107). The findings included: a. Resident #106 was admitted into the facility on [DATE] and was discharged home on [DATE]. Resident #106 Physician orders revealed an order dated [DATE] for Percocet 5/325 mg (milligrams) one tablet by mouth every 12 hours as needed for hip or knee pain for 10 days. On [DATE] the facility received 20 tablets of Percocet 5/325 mg from the pharmacy for Resident #106. A review of Resident #106's Medication Administration record for [DATE] and [DATE] revealed he was administered 16 tablets of Percocet 5/325 milligrams. The facility was unable to locate Resident #106's Declining Inventory Narcotic Sheet and Controlled Substance Return form for review. b. Resident #107 was admitted into the facility on [DATE] and He was discharged home on [DATE]. Resident #107's Physician Orders revealed an order dated [DATE] for Oxycodone 5 mg give 1/2 tablet every 6 hours as needed for moderate pain for 3 days. On [DATE] the facility received ten (10) 1/2 tablets of Oxycodone 5 milligrams from the pharmacy for Resident #107. A review of Resident 107's Medication Administration Record for [DATE] indicated four (4) of the 1/2 tablets of Oxycodone 5 milligrams were administered. The facility was unable to locate Resident #107's Declining Inventory Narcotic Sheet and Controlled Substance Return form for review. The Investigation Report (5-day) dated [DATE] completed by the Director of Nursing indicated that on [DATE] the facility became aware of two missing cards of narcotic pain medication (Percocet 5/325 mg and Oxycodone 5 mg) for two residents (Resident #106 and Resident #107). An investigation was initiated by the facility immediately and on [DATE] Nurse #2 admitted to taking the medications out of the building. Nurse #2 was immediately terminated by the facility and the appropriate State agencies along with law-enforcement were notified of the diversion. An interview with the Director of Nursing (DON) on [DATE] at 10:30 AM revealed she was notified by Nurse #1 on [DATE] at approximately 10:54 PM concerning a discrepancy with the narcotic count. The DON asked Nurse #1 to remain in the facility until she arrived. The DON indicated that 4 tablets of Percocet 5/325 mg were missing for Resident #106 and six (6) 1/2 tablets of Oxycodone 5mg were missing for Resident #107 when she arrived at the facility. The DON indicated Nurse #1 stated in her interview on [DATE] she had placed Resident #106 and Resident #107's discontinued narcotic medications in an unsealed pharmacy return bag in the narcotic box on the medication cart, so the medication would remain in the narcotic count. Nurse #1 explained she then placed the completed Controlled Substance Return to the Pharmacy form in the back of the narcotic book. On [DATE] Nurse #1 realized the narcotic (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing arrived. The Director of Nursing reviewed staffing assignments from [DATE] through [DATE] to identify all licensed nurses who had possession of the narcotic keys for the medication cart during the applicable timeframe. Each nurse who had worked the medication cart during [DATE] through [DATE] was contacted by the Director of Nursing on [DATE], interviewed, and instructed to report to the facility for reasonable suspicion drug screening. Upon discovery of the missing narcotics on [DATE], the Director of Nursing reviewed Resident #106's Medication Administration Record (MAR) and narcotic declining inventory sheets to ensure the resident had not missed any prescribed doses prior to discharge. No negative findings were identified. On [DATE], the Director of Nursing conducted a thorough search of all medication carts, medication rooms, and designated narcotic storage areas but was unable to locate the missing medications. On [DATE], the Director of Nursing contacted the pharmacy and spoke to the Control Pharmacist to verify whether the narcotics had been returned. The pharmacy confirmed they had no record of receiving the medications. On [DATE], the Director of Nursing interviewed Resident #107 regarding pain management and medication administration. Resident #107 voiced no concerns and reported pain was adequately managed. The Director of Nursing attempted to reconcile Resident #107's Medication Administration Record with the narcotic declining inventory sheet; however, the declining inventory sheet could not be located. At approximately 11:27 a.m. on [DATE], Nurse #2 admitted responsibility for the missing narcotics via text message to the Director of Nursing. The Nursing Home Administrator notified local law enforcement, the DEA, and the State Bureau of Investigation on [DATE] at 12:25 p.m. and submitted the initial report to the North Carolina Health Care Personnel Registry (HCPR) on [DATE] at 2:13 p.m. On [DATE], the Director of Nursing contacted the pharmacy to ensure the narcotics for Resident #1 and Resident #2 were not billed to either resident or their insurance providers. The pharmacy confirmed the facility would be billed directly for the replacement medications. On [DATE], the Director of Nursing terminated Nurse #2 verbally via the phone. On [DATE], the Unit Manager completed a pain assessment for Resident #107 to ensure pain remained adequately controlled. No negative findings were identified. On [DATE], the Director of Nursing reported Nurse #2 to the North Carolina Board of Nursing via telephone and completed the employer complaint form on the NC BON website. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On [DATE], the Director of Nursing reviewed licensed nursing assignments from [DATE] through [DATE] to identify all residents who received care from Nurse #2 during the identified timeframe. On [DATE] the Director of Nursing reviewed each identified resident's Medication Administration Record and narcotic declining inventory sheets for discrepancies. No negative findings were identified. All alert and oriented residents identified were interviewed on [DATE] by the Director of Nursing regarding concerns related to medication administration or pain management. No concerns were identified. On [DATE] the Director of Nursing assessed all identified residents who were unable to reliably communicate for signs and symptoms of unrelieved pain. No negative findings were noted. Additionally, on [DATE], the Director of Nursing reviewed nursing progress notes for these residents from [DATE] through [DATE] for documentation of uncontrolled pain, missed medications, or other concerns. No negative findings were identified. On [DATE] the Director of Nursing audited resident who were discharged in past 7 days narcotics had been returned to the pharmacy. No concerns were identified. On [DATE], the Director of Nursing audited orders for narcotics that had been discontinued from [DATE] to [DATE] to ensure they had been sent back to the pharmacy. No concerns were identified. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: On [DATE], all licensed nurses who had possession of the narcotic keys for the affected medication cart (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received one-on-one education by the Director of Nursing regarding the facility's Inventory Control of Controlled Substances policy. One licensed nurse who was unavailable received the required education prior to working on [DATE]. Education emphasized that all controlled substances, including medications awaiting return to the pharmacy, must remain on the declining inventory record and be counted at every shift change and whenever narcotic keys are transferred. Narcotics awaiting return to the pharmacy may not be bundled with inventory sheets and placed unsecured in the narcotic drawer. Once prepared for return, controlled substances must immediately be placed in the designated sealed return bag and secured in the approved narcotic return storage area until retrieved by the pharmacy courier. All licensed nurses employed by the facility as of [DATE] received this education. No licensed nurse will be permitted to work until the required education has been completed. On [DATE] the Nursing Home Administrator notified the Director of Nursing to ensure this education will be provided to any newly hired license nurse in orientation. This education will be provided by the Assistant Director of Nursing during orientation for all newly hired licensed nurses. Indicate how the facility plans to monitor its performance to ensure the solutions are sustained: An Ad Hoc QAPI meeting was held on [DATE] with the Nursing Home Administrator, Director of Nursing, Regional Clinical Coordinator, and the interdisciplinary team (IDT). The incident, root cause, and corrective action plan were reviewed and approved. The root cause was the deficient practice resulted from the intentional diversion of controlled substances by Nurse #2, combined with the absence of a standardized verification process to confirm that narcotics prepared for return to the pharmacy were immediately secured, reconciled, and accounted for until pharmacy pickup. Beginning [DATE], the Director of Nursing and/or Unit Managers will conduct random audits of narcotic declining inventory sheets and perform visual inspections of controlled substances stored on one medication cart each audit day, five times per week for 4 weeks, then 3 times per week for 4 weeks and then weekly for 4 weeks to verify compliance with the facility's Inventory Control of Controlled Substances policy. Audits will include residents with active narcotic orders as well as residents whose narcotic medications have been discontinued, changed, or are awaiting return to the pharmacy. Any identified variances will be addressed immediately through corrective action, including additional staff education, counseling, or disciplinary action as appropriate by the Director of Nursing. The Nursing Home Administrator reviewed the corrective action plan with the facility Medical Director on [DATE]. Audit results will be presented to the QAPI Committee by the Director of Nursing monthly for three (3) months for review, evaluation of effectiveness, and recommendation of additional interventions as indicated. Alleged Date of Compliance: [DATE]. Onsite validation of the corrective action plan was completed on [DATE]. Interviews with nursing staff confirmed they received in-service training on how to return narcotics to the pharmacy including where to store narcotics while waiting for the pharmacy to pick up the narcotics, when and how to complete narcotic counts. A review of the audit tool was conducted including a review of the resident questionnaires for all alert and oriented residents completed and the audit tool to determine pain on non-alert residents. A review of the audit was completed by Director of Nursing to ensure there were no other narcotic discrepancies from other discharged residents. The corrective action plans compliance date of [DATE] was validated.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and staff interviews, the facility failed to post the daily nurse staffing information for 1 of 4 days of the survey (7/12/26). The findings included: During the initial tour on Sunday, 7/12/26 at 10:15 AM the daily nurse staffing information posted on the table by the Administrator's office was observed to be dated Friday, 7/10/26. During an interview on 7/14/26 at 2:07 PM the Staffing Coordinator revealed she prepared the daily nurse staffing information for the weekend (Saturday and Sunday) and placed them in the holder behind Friday's posting. The posting was to be changed by the Manager on Duty or the Nursing Supervisor on Saturday and Sunday. The Staffing Coordinator further indicated that on Monday, 7/13/26 she exchanged the staffing information and noted the one posted was dated for Friday, 7/10/26. The Staffing Coordinator stated that the Manager on Duty had not arrived at the facility prior to the survey team's entry. An interview conducted on 7/15/26 at 2:15 PM with the Nurse Supervisor who worked on 7/12/26 from 7:00AM to 7:00 PM indicated she did not know who was responsible for changing the daily nurse staffing information on the weekend. An interview with the Administrator on 7/14/26 at 2:30 PM indicated he expected the daily nurse staffing information to be changed daily in the morning. He further revealed that either the Nursing Supervisor or the Manager on Duty should have ensured daily nurse staffing information were posted for the correct day on the weekends.		