STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE LAUREL S 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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation, staff interview and facility policy and procedure review it was determined that the facility failed to screen 1 of 1 visitor entering the facility per CDC recommendations. This occurred during the COVID 19 Pandemic. Findings included : Per review of the facility infection control policy dated 5/29/2020, visitors, if allowed would be screened as directed by Centers for Disease Control and CMS (Centers for Medicare and Medicaid services) guidance. The policy stated that caregivers and all facility staff would be screened as directed by CDC and CMS guidance. This surveyor entered the facility at 12:04 AM on 7/12/2020. The surveyor's temperature was taken by a staff person sitting in the foyer. The surveyor was also asked to sign in. The surveyor was then allowed to enter the facility. As the surveyor prepared to move down the hall, the staff person asked if she would like a mask and proceeded to provide the mask. Facility staff did not ask the surveyor screening questions nor ask her to complete a form with the screening questions. Interview with the screener at 1:08 AM on 7/12/2020 revealed that she did not ask everyone screening questions. The business office manager who was also present stated, we usually don't allow anyone in but staff. Review of facility documents on 7/24/2020 revealed that the facility had a Coronavirus COVID-19 Employee Associate Daily screening Log (created 6/10/2020 per the date on the bottom of the form) dated 7/11/20. The form included columns for Employee/Associate Name, Temperature at the start of shift, temperature at the end of shift, symptoms of COVID-19, Masked and sent home for self isolation, and the name of the screener. Review of a log sheeted dated 7/11/220 revealed that the surveyor's name was recorded, the entry temperature, exit temperature, no for COVID symptom was documented, no was documented for masked and sent home, and a screener signature was documented. Policy and procedure review also revealed a visitor's log-COVID-19 form created 6/10/2020 per the date on the bottom of the page. This form included the date, visitors name, phone number and 3 screening questions. The questions were related to international travel, contact with an exposed person and having signs or symptoms of COVID 19. Interview with the Director of Nurses at 4:24 PM on 7/21/2020 revealed that they check temperatures and ask questions about signs and symptoms of COVID at the front door. The DON stated the screener was asking questions and that there was a sign posted a the front door. When asked,what should happen at surveillance?, the DON stated come in the front door, screen takes temperature, screener asks questions regarding s/s (signs and symptoms) and the screener should offer PPE (personal protective equipment). The individual has the right to say they will use their own PPE.

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

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.