SEP 20 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345421	A. BUILDING _____ B. WING _____	C 08/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 8/18/12. Event ID# JB1L11).	F 000	**The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is September 11, 2012.**	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based upon observations and staff interview the facility failed to maintain the temperatures of beverages including milk, at or below 41 degrees Fahrenheit at the tray line and for service in the dining room. The findings included: At 11:45 AM on 8/15/2012, the lunch food temperatures were checked by the dietary manager with a calibrated thermometer. Individually poured glasses of lemonade, water and juices had been prepared and were being held in compartmentalized trays stacked on a cart that was in close proximity to a hot oven. Kitchen personnel working in the tray line were taking beverages from the compartmentalized tray of beverages to put on individual trays with resident meals. The temperature of a glass of lemonade	F 371	**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 continuing compliance with regulatory requirements.** **F 371 Food Procure, Store/Prepare/Serve-Sanitary** **Corrective Action** The gallon jug of chocolate milk, when found to be 46 degrees, was replaced with a new one from the refrigerator. Ice was added to the juices. **Corrective Action for those having the potential to be affected** The other milk products were reviewed at the time of the survey, by the dietary manager. No other milk product was found to be above 41 degrees. Ice was added to the bin to further cool the juices.	Sept 11, 2012

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

John R Farrell — Administrator — Sept 13th, 2012

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.

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F 371	Continued From page 1 from the top tray by the oven registered at 60 degrees. On 8/15/2012 at 11:53 AM, temperatures were taken of beverages on a cart in the main dining room adjacent to the kitchen. A gallon jug of chocolate milk, sitting in a tray with ice was 46 degrees. The other juices were in pitchers on the same cart. The regular cranberry juice was 52 degrees, the apple juice was 55 degrees and the honey-thick cranberry juice was 74 degrees. During an interview on 8/15/2012 at 11:54 AM, the dietary manager indicated the milk should be at or below 41 degrees Fahrenheit.	F 371	**Systemic Changes** The dietary employees have been re-educated on the process of temperature monitoring. An insulated cooling bin has been purchased, that is placed in the freezer to cool, prior to placing ice, milks, and juices. At the tray line, juices have been moved away from the oven area. In addition, ice is being placed into the juices, as well as around the drinks. **Monitoring** A QA Temperature Monitoring tool, that includes beverages served in the dining room, will be reviewed by the Dietary Manager and/or his designee, daily for 1 month then randomly each week x 2 months, to observe for compliance of temperature monitoring. Any beverages found above the required temperatures will be cooled, and any milk products will be replaced. Additional education will be provided as necessary. The QA committee will review findings during the monthly QA committee meeting x 2 months or until resolved to monitor for on- going compliance with additional education being provided if indicated. Continued compliance will be monitored through routine temperature monitoring and through the facility's quality	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431		

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F 431	Continued From page 2 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with facility staff, the facility staff failed to lock the medication cart, leaving it unattended for 1 of 7 medication carts. The findings include: Record review of the policy and procedure for " Medication Administration " revised 07/09 revealed, " 13. Make sure that the medication cart is locked at all times when it is not in use or not within you constant vision. Store the medication cart in the appropriate storage area between med passes. " Observations on 8/14/12 at 2:01 PM revealed the medication cart unlocked and parked between rooms 801 and 803. The lock on the medication cart was protruding, indicating the medication cart was unlocked. Two residents were in the hallway and one resident confused was sitting next to the unlocked medication cart, asking for his	F 431	assurance program. Additional education and monitoring will be initiated for any identified concerns. **F431 Drug Records, Label/Store Drugs & Biologicals** **Corrective Action** The medication cart was locked by the unit manager when she saw that it was unlocked. The identified nurse was provided additional education by the unit manager/designee relating to locking the medication cart when it is not within the sight of the nurse. **Corrective Action for those having the potential to be affected** At the time of the survey, all of the medication carts were reviewed by the Director of Nurses and/or her unit managers,. No other carts were found to be unlocked. **Systemic Changes** The pharmacy, after being contacted during the survey, came to the facility and programmed all of the medications carts to lock automatically. The Licensed Nursing staff has been re-educated by the Director of Nurses, to keep	Sept 11th 2012

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F 431	Continued From page 3 medication. (the medications had already been passed) At 2:14 PM the Unit Manager walked by and locked the medication cart. Interview on 8/14/12 at 2:14 PM with the Unit Manager revealed that her expectation was that nurses never walk away from a medication cart that was not locked. Interview on 8/14/12 at 2:20 PM with the medication nurse revealed that she checked her medication cart three times before she left it. She continued that she may have answered an alarm. She did not remember why she left the medication cart. Interview on 8/14/12 at 2:25 PM with the DON revealed that the medication carts must be locked at all times.	F 431	medication carts locked and stored off of the hall when not in use. **Monitoring** The Director of Nurses and/or her designee will randomly check medication carts to ensure the carts are securely locked daily for three weeks, and then weekly for one quarter, utilizing a monitoring tool. Nurses will be re-educated as necessary. The QA committee will review findings during the monthly QA committee meeting x 2 months or until resolved to monitor for on- going compliance with additional education being provided if indicated. Continued compliance will be monitored through routine medication cart observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345421	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/06/2012

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SEP 19 2012

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	**The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is September 19th, 2012** **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 continuing compliance with regulatory requirements.**	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following building construction type was non-compliant, specific findings include; the penetration in the wall/ceiling of ATS#2 does not meet the required fire resistance rating.	K 012	**K 012 Life Safety Code Standard** **Corrective Action** The penetration in the wall/ceiling of ATS#2 has been sealed with the proper fire stop sealant. **Corrective Action for those having the potential to be affected.** All other areas of possible penetration have been checked by the Director of Maintenance. No other areas have been identified to require sealant. **Systemic Changes** The Director of Maintenance will inspect areas that have been serviced by outside vendors, as they complete their work, to determine if all penetrations have been	9/17/12
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by:	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/17/12

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	filled. In addition, the Director of Maintenance will on a semi-annual basis, review all areas of penetration, for proper sealant. **Monitoring** The Director of Maintenance will check the areas of penetration, monthly times three months, and then semi-annually thereafter, to confirm compliance. Continued compliance will be monitored through the facility's preventative maintenance and quality assurance programs. The Administrator will be responsible to act upon any recommendations coming from the committee.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following building construction type was non-compliant, specific findings include; the penetration in the wall/ceiling of ATS#2 does not meet the required fire resistance rating.	K 012	**K 038 Life Safety Code Standard** **Corrective Action** The throw bolts were removed at the time of survey.	9/17/12
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by:	K 038	**Corrective Action for those having the potential to be affected.** All other doors were checked by the Director of Maintenance and Administrator. No other doors were found to have throw bolts on them. **Systemic Changes** The Director of Maintenance has been re-educated regarding allowable locking mechanisms. As this door was the only door with throw bolts, this door has had	

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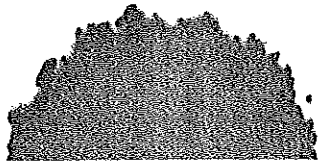
K 038	Continued From page 1 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following exit access was non-compliant, specific findings include; throw bolts on the exit - egress door from the Alzheimer's courtyard into the building. The courtyard area requires two means of egress. This item was removed during the survey.	K 038	a special lock system installed, to conform to all other doors in the facility. **Monitoring** The Director of Maintenance will check all doors monthly, for two months, to confirm compliance. Continued compliance will be monitored through the facility's preventative maintenance and quality assurance programs. The Administrator will be responsible to act upon any recommendations coming from the committee.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following fire alarm system was non-compliant, specific findings include; report from 6/7/12 from Eagle Fire indicated six (6) items that have not been corrected.	K 052	**K 052 Life Safety Code Standard** **Corrective Action** The fire alarm panel is in the process of being replaced. The duct detectors noted in item 4 have been repaired. The other 5 items on the list will be addressed with the new alarm panel. **Corrective Action for those having the potential to be affected.** The fire alarm panel is in the process of being replaced. The duct detectors noted in item 4 have been repaired. The other 5 items on the list will be addressed with the new alarm panel. **Systemic Changes** Once the fire alarm panel is replaced, the remaining items on the list will have been corrected. The fire alarm company will continue to make quarterly visits	12-19-12 Requested Waiver 360 days.



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K 038	Continued From page 1 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following exit access was non-compliant, specific findings include; throw bolts on the exit egress door from the Alzheimer's courtyard into the building. The courtyard area requires two means of egress. This item was removed during the survey.	K 038	and identify any items that need repair. The Director of Maintenance will ensure that the repairs take place and will report as such to the Administrator. **Monitoring** The Director of Maintenance will test the alarm system weekly for one month and monthly for two months to confirm compliance of new system, when in place. The alarm company will review system as scheduled and at least quarterly. Continued compliance will be monitored through the facility's preventative maintenance and quality assurance programs. The Administrator will be responsible to act upon any recommendations coming from the committee.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following fire alarm system was non-compliant, specific findings include; report from 6/7/12 from Eagle Fire indicated six (6) items that have not been corrected.	K 052		

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K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following fire alarm system was non-compliant, specific findings include; report from 6/7/12 from Eagle Fire indicated six (6) items that have not been corrected.	K 052	K 052 Life Safety Code Standard Corrective Action The fire alarm panel is in the process of being replaced. The duct detectors noted in item 4 have been repaired. The other 5 items on the list will be addressed with the new alarm panel. Corrective Action for those having the potential to be affected. The fire alarm panel is in the process of being replaced. The duct detectors noted in item 4 have been repaired. The other 5 items on the list will be addressed with the new alarm panel. Systemic Changes Once the fire alarm panel is replaced, the remaining items on the list will have been corrected. The fire alarm company will continue to make quarterly visits	12-19-12 Requested Waiver 360 days.

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K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following fire alarm system was non-compliant, specific findings include; report from 6/7/12 from Eagle Fire indicated six (6) items that have not been corrected.	K 052		