STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF FOREST GLENN	**1101 HARTWELL STREET** **GARNER, NC 27529**

(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
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 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V (111) construction, one story, with a complete automatic sprinkler system utilizing special locking. In the exit conference all deficiencies noted were discussed with administration. At time of survey the: Total Certified Bed Count = 140 Census = 132 The deficiencies determined during the survey are as follows:	K 000		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 4/8/15 at approximately 11 AM onward, the following deficiencies were noted: The portable fire extinguisher was non-compliant, specific findings include: The fire extinguisher in the laundry room was due for the six year testing. The current date read 2008.	K 064	The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is May 23, 2015. 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	5/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/24/2015

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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K 064	Continued From page 1 Reference NFPA 101, Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10. This deficiency affected one of six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 064	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. Eagle Fire has replaced the portable fire extinguisher that was in laundry. The Maintenance Director will be provided additional education by the Administrator relating to the requirement. The Maintenance Director will audit all fire extinguishers monthly to ensure that we are in compliance with Reference NFPA 101. All variances will be corrected at the time of observation and concerns will be reported to the Quality Assurance Committee during the monthly meeting. Continued compliance will be monitored through the facility□s fire safety, preventative maintenance and quality assurance programs.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by:	K 072		5/23/15

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K 072	Continued From page 2 42 CFR 483.70 (a) Based on observations, on 4/8/15 at approximately 11 AM onward, the following deficiencies were noted: The means of egress was non-compliant, specific findings include: Four janitors carts stored in the exit near laundry, a lift near room 214 and two wheel chairs near room 225. Reference NFPA 101, 7.1.10 Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. This deficiency affected two of six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 072	Administrator was submitted a 2000 Edition National Fire Protection Association (NFPA) 101 Life Safety Code (LSC) Waiver allowing for temporary placement of wheeled carts in the corridor. Housekeeping/laundry staff will be re-educated on keeping the corridors free of equipment i.e. furniture and lifts when not in use by the Maintenance Director/Administrator. The Administrative Nursing Staff, Maintenance Director and/or Administrator will conduct hallway observations (2) two times a week times (4) four weeks to ensure corridors are free of equipment. Variances will be corrected at the time of observation and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through routine round observations and through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		5/23/15

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K 144	Continued From page 3 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 4/8/15 at approximately 11 AM onward, the following deficiencies were noted: The generator was non-compliant, specific findings include: The emergency generator located on the exterior of the building has no remote manual stop switch located outside the generator set location. Reference NFPA 101, 110, 3-5.5.6 All level 1 and level 2 installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover, where so installed, or located elsewhere on the premises where the prime mover is located outside the building. This deficiency affected all smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 144	A remote manual stop switch has been installed on the outside of the emergency generator. The Director of Maintenance has received one on one education by the Administrator on the requirement. The Director of Maintenance will perform emergency shut off via the remote access per requirements for testing. Concerns will be reported to the Administrator and to the quality assurance committee. Continued compliance will be monitored through the facility□s preventative maintenance and quality assurance programs.	