PRINTED: 12/12/2012 FORM APPROVED

		MEDICAID SERVICES			8MO	NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE : COMPL	
		345389	B. WING		C 11/28/2012	
NAME OF P	ROMDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		72072072
THE LAU	RELS OF FOREST GLE	NN	1	101 HARTWELL STREET BARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	KOULD BE	(XS) COMPLETION DATE
E 150	100 100 100			The Laurels of Forest G	lenn	
F 156 SS=C	483.10(b)(5) - (10), 4	183.10(b)(1) NOTICE OF ERVICES, CHARGES	F 156	requests to have this Pla	n of	
33=€	MOTTO, NOLES, S	ENVICES, CHARGES		Correction serve as our		
	The facility must info	rm the resident both orally		allegation of compliance		
	and in writing in a lar	nguage that the resident		Our alleged date of comp		
	understands of his or	r her rights and all rules and g resident conduct and		is 12-26-2012.		
	responsibilities durin	g the stay in the facility. The			1	
	facility must also pro-	vide the resident with the		Preparation and/or exec	ution of	
	notice (if any) of the	State developed under		this plan of correction do		
		ct. Such notification must be		constitute admission to n		
		n admission and during the aipt of such information, and		agreement with either the	į.	1
		t, must be acknowledged in		existence of, or scope and		
	writing.	ū		severity of any of the cite		-
	The feeliths are the					]
	entitled to Medicaid b	rm each resident who is enefits, in writing, at the time		deficiencies, or conclusion forth in the statement of	ns sei	
	of admission to the n	ursing facility or, when the			•	
	resident becomes elig	gible for Medicaid of the	1	deficiencies. This plan of		
İ	items and services th	at are included in nursing		correction is prepared an		
		r the State plan and for ay not be charged; those		executed to ensure contin	• •	
	other items and service	ces that the facility offers		compliance with Federal	and	
	and for which the resi	dent may be charged, and		State regulatory law.		
Ī	the amount of charge	s for those services; and			į	-
	inform each resident	when changes are made to				
	(i)(A) and (B) of this s	s specified in paragraphs (5) ection.		F156		12-26-12
		m each resident before, or		Current residents and new	,	
		on, and periodically during		admissions have the poter	itial to	
	the resident's stay, of facility and of charges	services available in the		be affected.	1	
	including any charges	for services not covered			í	
	under Medicare or by	the facility's per diem rate.		The Division of Health Se	rvices	
				Regulation's contact phon		
		sh a written description of		number and mailing addre		
	legal rights which inclu	ides:				
			1	posted in the front lobby.	rne	

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

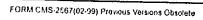
1-7-13

Any deficiency statement ending with an esterior () 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.

		T OLIVIOLO				OWR	NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. 8UII		PLE CONSTRUCTION IG	(X3) DATE COMP	SURVEY LETED
		345389	B. WIN	ß.			С
MANE OF D	POMOCO OD OVIDOVICO	340369					1/28/2012
FORME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF FOREST GLEN	N			1101 HARTWELL STREET		
<del></del>	T			<u> </u>	GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XS) COMPLETION DATE
F 156	Continued From page	1		156	correct phone and mailing	Ť	
		anner of protecting personal		טכו	address for Division Healt	h	
	funds, under paragrap	anner or protecting personal			Services Regulation has be	-	
	rando, undor paragrap	or (o) or this section,				Cit	
	A description of the re	quirements and procedures			updated in the Resident		
	for establishing eligibi	lity for Medicaid, including assessment under section			Handbooks.		
	1924(c) which determ	ines the extent of a couple's			The Admissions Coordinat	aw and	-
	non-exempt resources				1		ļ
	institutionalization and	attributes to the community			DOM will be in-serviced by	•	
	spouse an equitable s	hare of resources which			Administrator on the import		
	cannot be considered	cannot be considered available for payment			of having the correct conta	ct	
	loward the cost of the	institutionalized spouse's			information for Division H	ealth .	
	medical care in his or	her process of spending	Į		Services Regulation in the	1	
	down to Medicaid eligi	bility levels.			Resident handbooks as wel	Lac	
	A posting of names, a	ddresses, and telephone		1		1	
	numbers of all pertiner	nt State client advocacy			posted in the front lobby by	y 12-	
	groups such as the Sta	ate survey and certification			26-12.		-
	agency, the State licer	sure office, the State					
	ombudsman program,	the protection and			Resident Handbooks have	heen	
	advocacy network, and	I the Medicaid fraud control			reprinted with the new con-		
	complaint with the State	hat the resident may file a e survey and certification		- 1	information of Division He	alth	
	adency concerning res	ident abuse, neglect, and				aum	
	misappropriation of res	ident property in the			Services Regulation.	1	
	facility, and non-compli	ance with the advance					
	directives requirements	<b>3.</b>			The Admissions Coordinate	or	
					and/or Administrator will a	udit 3	
	The facility must compl	y with the requirements			Admission Sign-ins for con		
	specified in subpart I of	part 489 of this chapter	-		information and monitor the		
	related to maintaining v	vritten policies and					
	requirements include p	dvance directives. These		ļ	posting of contact numbers	and	]
1	provide written informat	ion to all adult residents			addresses weekly x 4 weeks	then	]
	concerning the right to	accept or refuse medical		ĺ	through review of new		]
-	or surgical treatment an	id, at the individual's			admissions thereafter. Varia	nces	
-	option, formulate an ad-	vance directive. This			will be corrected when indic	ented	
	includes a written descr	iption of the facility's		1	The second with the second	arca.	

2012 VED 391

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FOI	ED: 12/12/ RM APPRO IO: 0938-0	
STATEMENT AND PLAN C	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY		
			A. BUILDIN	IG	COMPLI	COMPLETED	
van-t		345389	B. WNG			С	
NAME OF P	ROVIDER OR SUPPLIER				11/	28/2012	
<del> </del>	RELS OF FOREST GLI			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIE)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETA DATE	
	Continued From page 2 policies to implement advance directives and applicable State law.  The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.  The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff		F 156	Results will be reviewed Administrator weekly wand concerns will be rethe Quality Assurance Committee during the meeting.  Continued compliance was monitored through review admission paperwork duadmission process and the facility's Quality As Program. Additional edand monitoring will be if for any identified concerns.	vill be ew of new uring the hrough surance ucation nitiated		
( ) ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	contact information.  The findings include:  On 11/26/12 at 11:18  3 was interviewed at tale contact informat he front lobby, listed in the franch contact number to the tale gulation, was not pi	am, the Administrative Staff cout the placement of the ion. On the bulletin board, in the State 's Complaint or, but the address and Division Health Services resent. He shared that he information was missing.					



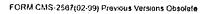
The Administrative Staff #3 had provided the resident handbook which listed the state agency as The Division of Facility Services and had an address and phone number typed that was not

assigned to the state agency.





CENTERS FOR MEDICARE &		MEDICAID SERVICES			OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A BUILO	LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
			TX BOILD	ing		С
		345389	B. WNG		11/:	28/2012
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF FOREST GLEN	N		1101 HARTWELL STREET GARNER, NC 27529		
(X4) ID PREFIX IAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROMDER'S PLAN OF CORREC	ULD BE	(X5) COMPLETION DATE
F 156	The Administrative St was unsure why the rupdated to reflect the agency, when it changhe would take of the rupdated to the rupdated to reflect the agency when it changhe would take of the rupdated to rupdated t	aff #3 mentioned that he esident handbook wasn't renaming of the state ged in 2007; but voiced that natter.  aff provided new information n that illustrated that the	F 15	S6		
F 246 SS=D	483.15(e)(1) REASON OF NEEDS/PREFERI		F 24	F246  The facility immediately	nlaced	12-26-12
	services in the facility accommodations of in	dividual needs and hen the health or safety of		call lights and room telep within reach of Residents and #134.	hones	
	This REQUIREMENT by: Based on observation interviews, the facility if and call bells within re-	failed to keep telephones each of 2 of 14 alert and		All residents able to use the lights and/or telephones is potential to be affected.  Nurse Aide #2 was in-serve by the DON on the facility	have the	
THE THE PARTY OF T	oriented residents ( Re	esident #225 and #134).		policy and procedures for bell and telephone placem	call	
	11/16/12 with the follow cancer and mild demen	ntia.		All Nurse aides will be inserviced by the DON/Staff Development Coordinator	f	1,9 8
	The Minimum Data Sel not completed due to h however the nurse 's n was able to make her r	otes reflected that she	Control of the Contro	facility's policy and proce for call bell and telephone placement, if 100% is not	dure	



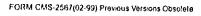






PRINTED: 12/12/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-	(X2) M A. 8UI		PLE CONSTRUCTION G	(X3) DATE	SURVEY LETED
		345389	0. WN	ю		C 11/28/2012	
	ROMDER OR SUPPLIER	in		1	REET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET BARNER, NC 27529		1/20/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(X5) COVPLETION DATE
THE PARTY OF LABOUR PARTY OF L	On 11/26/12 at 3:00 p wheelchair in her rooi privacy curtain pulled she voiced that she w been waiting. When a help, she stated yes, bell.  The call bell cord was of the over head bed i approximately six feet call bell, was Residen rested on top of the lig bedside table was loc. #225 and her bed, wh up against the wall. Th blocked the opportunit and place it within rea  Resident #225 began displaying a short tem had been waiting to be returning from an activ down.  On 11/26/12 at 3:07 pr was summoned to the Nurse Aide #2 followed commented that she he 's bed earlier and forge telephone back within a furniture, so that the ite from on top of the light  The Administrative Stat 11/28/12 at 9:00 am. Si	am, Resident # 225 sat in a m, facing her bed, with her . Upon entering the room, ranted to go to bed and had isked if she tried to summon but couldn't reach her call . Indeed to be placed on top light box which was a off the ground. Next to the tried to be well. The ated between Resident ich was placed horizontally ne positioning of the table by to tug on the call bell cord ch.  It become agitated, perament, stating that she is put back to bed after ity and just wanted to lie.  In the Unit Manager #1 room of Resident #225. If her into the room. She and made up Resident #225 of to put the call bell and reach. They moved her ims could be removed box.	F	246	achieved due to illness or vacation then staff will be educated upon returning twork. New employees we educated through orientat.  A QA monitoring tool will utilized to ensure ongoing compliance by the Unit Manager/Administrative to and will observe call bell telephone placement 3 tim week x 4 weeks then week thereafter. Variances will corrected at the time of observation and additional education and/or administraction taken when indicated.  Observation results will be reported to the DON and concerns will be reported to th	oack to li be lon.  I	





Facility ID 923173

If continuation sheet Page 5 of 27



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	
		345389	8 WING		С	
	ROMDER OR SUPPLIER	N	110	ET ADDRESS, CITY, STATE, ZIP CO IT HARTWELL STREET IRNER, NC 27529		/28/2012
(X4) ID PREFIX FAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROMDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	bed. She stated no ite of the over head bed on 11/28/12 at 9:05 am. seated in her wheelchais at the over head bed light over head bed light of the over head bed light over head	en they are in and out of tems should be placed on top light box.  entered the facility on wing diagnoses, peripheral abnormality of galt. On the 3/28/12, she was assessed and needing extensive bility and transfers.  In, while conducting an at #134, who laid in bed, a sirved, with the cord everal times around the itioned on top of her over that she doesn't use her oved calls on it and made d that it normally sat on that the last time she phone was before 2.  If #1 was interviewed on the stated that her if to place all items within an they are in and out of as should be placed on top with the conduction of the stated that her in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in they are in and out of the stated that her in the stated that her	F 246			



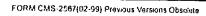






PRINTED: 12/12/2012 FORM APPROVED

		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE S	
			A BUILDII		С	
	***	345389	B WNG_		11	/28/2012
	ROMDER OR SUPPLIER RELS OF FOREST GLEN	N	-	REET ADDRESS, CHY, STATE, ZIP CODE 1101 HARTWELL, STREET GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROMDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 246	Continued From page	6	F 246			
F 253 SS=D	left side and was not vision. She attempted not able. She unlocke the chair toward the b moving her left arm, whefore she was able a unclip the call belf and Resident #134 stated weak side. Unit Manage 11/28/12 at 9:10 am. Sfrom the over head light the wall, placing it with She shared that they contains the state of	that her left side was her ger #2 entered the room on She removed the phone ht box and plugged it into hin reach of Resident #134. can make sure the call bell e it easier for Resident	F 253	F253	a <b>h</b> an an	12-26-12
	The facility must provic maintenance services sanitary, orderly, and o	necessary to maintain a		The facility called a plun 11/26/2012 and the odor Room 130 has resolved.	in	
;	by: Based on observation, interviews, the facility for	is not met as evidenced record review and staff ailed to control odors on 1		All bathrooms and/or sind have a drain have the potential be affected.	ks that ential to	
300,140	130, a strong odor sme sulphur, was detected i	n the bathroom, which ntrance of the room. Two present, however, they		The Administrator will re educate the Director of Maintenance and Houseke Supervisor on the importa having odor free rooms by 26-12.	eeping Ince of	



were not the source of the odor.



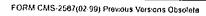
Facility ID 923173

If continuation sheet Page 7 of 27



PRINTED: 12/12/2012 VED <u> 391</u>

		ND HUMAN SERVICES MEDICAID SERVICES		FORM APPI ———————————————————————————————————					
STATEMENT MID PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE S COMPLI	URVEY			
		345389	8. WW	3	C				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		28/2012			
THE LAU	RELS OF FOREST GLEN	IN		1101 HARTWELL STREET GARNER, NC 27529					
(X4) ID PREFIX FAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X 5) COMPLET DATE			
	the bathroom and wathe odor. He pointed in returned with air fresh the room. He mention on going problem. At was interviewed. She the residents used the source of the odor had toilet. She mentioned problem to maintenant plans to replace the to Nurse #3 was interviewed. She stated that Redor like sewage and awhile. She stated that 4 had examined the bacouldn't determine if the changes.  On 11/27/12 at 8:51 ar #4 was interviewed. He know if the sewage odd from the sink or the toil from the sink or the toil from the sink, since the it. He stated that the od when it rained. Yesterd come out to examine the recommendation was to sinks on the 100 hall with the return of the sinks on the 100 hall with the return of the sinks on the 100 hall with the return of the sinks on the 100 hall with the return of the sinks on the 100 hall with the return of the sinks on the 100 hall with the return of the sinks on the 100 hall with the return of the sinks on the 100 hall with the sinks of the	d just completed cleaning a asked about the source of to the toilet, left the room, tener and began to spray ted that the odor had been 10:20 am, Nurse Aide # 1 explained that only one of a bathroom and that the dibeen coming from the that she had reported the ce and that there were silet.  Siewed on 11/26/12 at 12:34 from 130 bathroom had an that it had been present for the Administrative Staff # athroom before but she tere were any equipment to, the Administrative Staff expressed that he didn't for in Room 130 resulted tet, but suspected it came to toilet had a good seaf on thors are more persistent ay, he had a plumber	F 2	Director of Maintenancinspect all resident bathrooms/sinks utilizing monitoring tool weekly weeks to ensure they accorrected as identified monitoring results will reviewed with Administratoring results will reviewed with Administrator/designee to completion of maintenance to completion of maintenance to completion of maintenance and the monitoring results will requests when repair nesidentified.  The Administrator will resolution of maintenance and monthly ther Concerns will be reported quality assurance committed further recommendation	ng a / x 4 re free of be and be strator weeks.  ed the relating enance eds are  review ce re timely 4) four eafter. ed to the ittee for				



odor went away.

On 11/28/12 at 1:15 pm, the Administrative Staff

#4 stated that no one brought the concern of

bathroom odors for Room 130 to his attention



Continued compliance will be

round observations by the

Maintenance Director and/or

monitored through daily facility



PRINTED: 12/12/2012 FORM APPROVED OMB NO. 0938-0391

4	
i	STATEMENT OF DEFICIENCIES
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROMOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A BUILDING

B. WHG\_

(XJ) DATE SURVEY COMPLETED

C 11/28/2012

345389

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LAU	RELS OF FOREST GLENN	1	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)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE				
F 253	Continued From page 8 before. In fact, he stated that he was working in the building on 11/24/12 and didn't smell sewage odors on the 100 hall.  On 11/28/12 at 1:25 pm, the housekeeper stated that the sewage odor in Room 130 comes and goes. He shared that he mentioned to the Administrative Staff #6 a week or two ago about the problem in the bathroom and together, they wrote up a repair requisition for the maintenance department. Normally, he stated that he can pour a chemical agent into the sink to help dissolve the odors. The Administrative Staff #6 stated that she was present when she assisted the housekeeper with presenting his concerns for Room 130's bathroom odors.  The Administrative Staff # 5 was interviewed on 11/28/12 at 1:05 pm. He stated that the sewage odors had been on and off again for the last three weeks. He shared that stronger odors are created after it rains. He stated that the maintenance department was aware of the problem however, treated the concern with a chemical agent.  On 11/28/12, the maintenance repair requisitions were examined. There were over 200 requisitions stacked neatly in a box, in no apparent order. Months May through November, 2012 were examined and no requisition for Room 130's problems with sewage odors could be found. Another room in the vicinity of Room 130 complained of worsening bathroom odors on 10/23/12.	F 253	Housekeeping Supervisor and through the facility's Preventative Maintenance and Quality Assurance Programs. Additional education and monitoring will be initiated for any identified concerns.					
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	F279	12-26-12				
117300	A facility must use the results of the assessment	-	The care plan for Resident #101 was updated by the Social					



ED 91

		ND HUMAN SERVICES MEDICAID SERVICES				F	ORM.	12/12/20 APPROV 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-	(X2) M A. BUI		LE CONSTRUCTION	(X3) ĐATË	(X3) DATE SURVEY COMPLETED	
	345389		B. WING			C 11/28/2012		
	ROVIDER OR SUPPLIER RELS OF FOREST GLEN	1N		11	EET ADDRESS, CITY, STATE, ZIP CODE 01 HARTWELL STREET ARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) CONPLETION DATE
F 279	Continued From page 9 to develop, review and revise the resident's comprehensive plan of care.		F 279		Worker by 12-26-12 to remood and behaviors.	eflect		
	The facility must deve plan for each residen objectives and timeta medical, nursing, and	or care.  alop a comprehensive care  t that includes measurable  bles to meet a resident's  mental and psychosocial  ied in the comprehensive			All residents who utilize psychotropic medications and/or exhibiting mood and behaviors have the potential to be affected.			

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on medical record review and staff interview, the facility failed to develop a care plan for mood and behaviors for one (1) of ten (10) sampled residents (Resident #101). Findings included:

Resident #101 was admitted to the facility 2/6/08. Cumulative diagnoses included: mental retardation and a history of agitation and negative behaviors.

A Significant change Minimum Data Set (MDS) dated 8/27/12 indicated Resident #101 had short and long term memory impairment and moderate impairment in decision making. No mood or

Social Worker, Social Worker assistant or the Unit Managers will audit all residents that are currently on psychotropic medications and/or exhibiting mood and behaviors to ensure appropriate care planning by 12-26-12. Variances will be corrected as identified by the above designees.

The Social Worker was reeducated by the Regional MDS Coordinator on Care Plan requirements pertaining to mood and behaviors by 12-26-12. The MDS Coordinator will review for appropriate care plans utilizing an audit tool during routine scheduled assessments to provide on-going compliance. Results of the review will be reviewed with the Director of Nursing for the next 3 months.

FORM CMS-2587(02-99) Previous Versions Obsolete

assessment.

EvenUD: 473M11

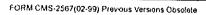
Facility ID 923173

If continuation sheet Page 10 of 27



PRINTED: 12/12/2012 /ED 91

		ND HUMAN SERVICES  MEDICAID SERVICES			FOI	RM APPROV IO. 0938-0
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULI A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345389	B. WING		C	
NAME OF P	ROVIUER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	28/2012
THE LAU	RELS OF FOREST GLE	NN		1101 HARTWELL STREET GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	CCMPLETE DATE
F 279	period. Medications observation period in anxiety medications.  A Care Area Assessmedications dated 9/#101 received Rispe (antipsychotic medications. He had negative behaviors. seen by psychiatric s  A review of the Abnor Scale (AIMS-a sceen involuntary movement antipsychotic medical Resident #101 had do movements and upper with the severity of the level.  Physician orders were part, the following memilligrams (mg.) by m Risperdal 1 mg every Cogentin (used to con Risperdal) 1 mg. twice sprinkles (a medications).	d during the assessment administered during the included antipsychotic and ment for Psychotrophic (7/1/2 indicated that Resident erdal and Buspar ations) daily and remained at effects from the district and a sistery of agitation and Resident #101 was being ervices.  The line of the district and	F 279	New orders and changes in condition are reviewed by IDT (Nursing, Therapy, S Services, Activities and D during the morning clinical meeting. The Social Work designees will ensure that changes in behaviors and/psychotropic medications reflected in the care plant identified residents when indicated.  On-going compliance will monitored through record reviews during the MDS assessment process by the Coordinator and Social Worker of the monthly behavior management meeting (Soc Service Director, Activities Director, and Unit Manage and review of new orders a changes in condition by the Managers during the mornical meeting.	the ocial pietary) all cer and or are for be MDS orker, during ial s and e Unit	



A psychiatric consult dated 11/2/12 indicated Resident #101 had a history of psychosis with aggressive behaviors which were managed well



clinical meeting.



	(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL		ULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A BUIL	LDING		Comp	C
	345389	B. WIN	G		1	1/28/2012
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN			11	EET ADDRESS, CITY, STATE, ZIP CODE 01 HARTWELL STREET ARNER, NC 27529	· <b>.</b> · · · · · · · · · · · · · · · · · · ·	
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFI TAG	T	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
F 279 Continued From page 11 with the use of Risperdal. Control the extrapyramidal seffective. Continue with treobtain Depakote level. Recreduction. Resident #101 wpsychiatric services monthly  A review of Resident #101's there was not a care plan for behaviors until 11/27/12.  On 11/28/12 at 1:40 PM., M. Resident #101 had never have behavior problems or a care behavior problems. She was received the psychotropic mestated the corporate nurse to check some of the charts to behavior/psychotropic medicareplanned and they found not have a care plan for most the care plan was started on 483.25 PROVIDE CARE/SE HIGHEST WELL BEING  Each resident must receive a provide the necessary care a or maintain the highest practimental, and psychosocial we accordance with the comprehand plan of care.  This REQUIREMENT is not a by:	atment plan and commend no dosage ras being seen by a care plan revealed remood and/or  DS nurse #1 stated and any mood/ plan for mood/ s not sure why he edications. She old then yesterday to see if the mood/ cations were Resident #101 did and behaviors so 11/27/12.  RVICES FOR  and the facility must and services to attain cable physical, ill-being, in nensive assessment	F 30		Continued compliance will monitored through the fact Quality Assurance Program Additional education and monitoring will be initiated any identified concerns.  F309  Resident #211's physician was notified on 11/27/2012 by the nurse of the medication omission. Medication orders were verified and the current medication administration reflects the ordered medication is receiving his medications as ordered.	vas ne tecord ons.	12-21-12

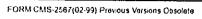






		MEDICVID SEVAICES				OMB	1O. 0938-039
STATEMENT AND PLAN Q	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-	(X2) M A. BUI		IPLE CONSTRUCTION KG	(X3) DATE SURVEY COMPLETED C	
		345389	ANV B	ю_			
NAME OF P	ROVIDER OR SUPPLIER		I.	C.	DEC. AND CO.	1 11/	28/2012
THELAU	RELS OF FOREST GLEN	N			REET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET		
	TELO OF TOREST GEEN			1	GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROMDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	the Burnex (loop diuretic) for 11 days to a resident with a diagnosis of Congestive Heart Failure due to transcription error for 1 (Resident #211) of 3 sampled residents reviewed. The finding includes:  Resident #211 was admitted to the facility on 11/13/12 with multiple diagnoses including CHF (Congestive Heart Failure). The admission Minimum Data Set (MDS) assessment dated 11/20/12 indicated that Resident #211's cognitive status was impaired.  Review of the nurse's notes dated 11/13/12 indicated that Resident #211 was admitted at 3:00 PM. The nursing admission assessment revealed that the resident was admitted with no edema.		F	309	medications have the pote be affected.  The Unit Managers review current residents' medicat orders by 12-26-12 to ens accuracy. Any variances we clarified with the physicia 12-26-12.  All Licensed Nurses will be provided additional educat the DON/Staff Developme Coordinator relating to rev	ved all ion ure vere n by	
	physical dated 11/15/1 #211 had no edema.  The nurse's notes date revealed that Resident stated that he could no saturation was 88% on was encouraged to relatiters/per minute was assaturation went up to 93 indicated that the physical edem in the state of the state	#211 was yelling and t breathe. The oxygen room air. The resident ix and oxygen at 2 oplied. The oxygen 2%. The notes further cian was called and with t-ray due to shortness of thest x-ray report dated ght pleural effusion			new orders and new admiss and proper order transcript 12-26-12. New admissions be reviewed by two nurses utilizing the admission checto ensure orders are transcrictorrectly and verified when indicated. New admissions reviewed during the morning clinical meeting (DON, AD Unit Managers, Social Service Rehab Manager, MDS Coordinator, and Administrate The Unit Managers will mo all new admissions and new	on by will cklist libed are on on, ices, ator).	

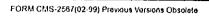
	OF DEFICIENCIES	(X1) PROMOER/SUPPLIER/CLIA	(X2) M	ULTIF	PLE CONSTRUCTION	(X3) DATE SU	U. 0930-0391 JRVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A BUI			COMPLE	TED
		345389	,   0. WA	ю		111	C 28/2012
1	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HARTWELL STREET  GARNER, NC 27529  ID PROVIDER'S PLAN OF COI PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		CTION DULD BE	(X5) CCMPLETION DATE
	On 11/25/12 at 12:10 indicated that the physichest x-ray report with (milligrams) by mouth (antibiotic) 750 mgs by On 11/26/12 at 1:50 Pobserved up in wheeld legs/feet were swollen noted on his right leg.  On 11/26/12 at 1:54 Pointerviewed. The familithe resident's legs were water blister on his right leg. White the resident was on Burner until 11/25/12. The familithe resident was on Burner CHF.  On 11/26/12 at 2:00 Pointervealed that Resident were edematous with start were edemato	PM, the nurse's notes sician was informed of the norders for Bumex 2 mgs twice a day and Levaquin y mouth daily for 7 days.  M, Resident #211 was chair in his room. His nand a water blister was ly member indicated that se swollen and with a big that leg because he was not dication from admission mily member stated that the x because of his chronic  M, the nurse's notes #211's bilateral lower legs some weeping noted. ct blister measuring 2 x 2  e physician medication in the hospital dated order for Bumex 1 mgs	F	309	orders for accurate transe for the next (4) four week Variances will be prompt corrected. Monitoring res be reported to the DON we by the Unit Managers for next (4) four weeks and c will be reported to the quassurance committee duri monthly meeting.  On-going compliance will monitored through review admissions and new order during the morning clinical meeting, review of medical administration records during the assessment process.  Continued compliance with monitored through the fact Quality Assurance Program Additional education and monitoring will be initiated any identified concerns.	cs. cly sults will veekly the concerns ality ng the l be of new rs al ation ring nd MDS ll be cility's im.	





PRINTED: 12/12/2012 FORM APPROVED

CENTER	NO FUR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A BUIL		TIPLE CONSTRUCTION NG	(X3) DATE	
		345389	B. WIN	4G _		1	C 1/28/2012
NAME OF P	PROVIDER OR SUPPLIER			sı	IREET ADDRESS, CITY, STATE, ZIP CODE		17407-0-1
THETALL	inel o ne endegt di ek	***	,		1101 HARTWELL STREET		
INE ENG	IRELS OF FOREST GLEN	N	,	1	GARNER, NC 27529		
(X4) ID PREFIX FAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COVPLETION DATE
İ			+				
F 309	On 11/27/12 at 11:50 interviewed. She state medications listed on	a 14  AM, Unit Manager #1 was ted that she transcribed the the FL2 because she did nedication reconciliation	F	309			
	form.	iddioallori 1000/10iiialiori					
	was interviewed. She there is a new admit re were checked against medication reconciliation was available. S	PM, administrative staff #1 a stated that normally when resident, the medications t the discharge summary, tion form, FL2, or whatever She acknowledged that the #211 was a transcription					
	She stated that when a the UM will receive diff discharge summary ar						
The state of the s	Then, the UM would co fisted on the different for	e admission coordinator. compare the medications forms and when there were spital was called to clarify					
The control of the second of t	was interviewed. The that when there was a hospital/facility sends he discharged medication orders were given to the soon as possible. The unable to remember the acknowledged that the	n orders via fax. Then, the ne UM immediately or as administrative staff was ne name of the UM but medication reconciliation 13/12 at 11:36 AM to the					
	Resident #211 was adn 483.25(I) DRUG REGIN	mitted to the facility.	F 32	29			



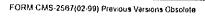


F 329



PRINTED: 12/12/2012 FORM APPROVED OMB NO. 0938-0391

VALUE OF THE OFFICE OF THE OFFICE OF THE						OMB NO. 0938-03		
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-	(X2) M A BUI		PLE CONSTRUCTION	(X3) DATE		
		345389	B. WIN	ю <u> </u>			C	
	ROVIDER OR SUPPLIER RELS OF FOREST GLEN	N	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529			1/28/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		<del></del>		JLD BE	(XS) COMPLETION DATE	
	UNNECESSARY DRU  Each resident's drug runnecessary drugs. A drug when used in exiduplicate therapy); or without adequate mon indications for its use; adverse consequence should be reduced or combinations of the re  Based on a comprehe resident, the facility min who have not used and given these drugs unlet therapy is necessary to as diagnosed and door record; and residents with drugs receive gradual of the behavioral intervention contraindicated, in an edurugs.  This REQUIREMENT is by: Based on medical record.	egimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or citoring; or without adequate or in the presence of a which indicate the dose discontinued; or any asons above.  Insive assessment of a cust ensure that residents hipsychotic drugs are not insecuted in the clinical who use antipsychotic drug or treat a specific condition cumented in the clinical who use antipsychotic dose reductions, and so unless clinically effort to discontinue these is not met as evidenced ard review and staff cited to obtain labs that physician/pharmacist of ten (10) sampled	F	329	Resident #101's physician notified by the charge nurs the lab omission, new orde were obtained and the lab completed on 11/28/12. No negative outcome resulted the omission.  Unit Manager #2 has been provided additional education the DON relating to ensuring timely and proper follow uppharmacy recommendations.  Current residents with pharmacy recommendations have the potential to be affected.  The Unit Managers and chanurses will review all pharmacy recommendations for the pathree months to ensure physicians have been notified when indicated and follow-completed. Variances will be corrected as identified.	e of rs vas of from on by ig to to s. macy set (3) ed up is		
	Findings included: Resident #101 was adm	nitted to the facility 2/6/08.						



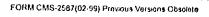
EventIO:473M11

Facility ID 923173

If continuation sheet Page 16 of 27



	OF CORRECTION  IDENTIFICATION NUMBER:  A BUILDING		ИС	(X3) DATE SURVEY COMPLETED			
·	······································	345389	8. WNC			11/	C 28/2012
	ROVIDER OR SUPPLIER RELS OF FOREST GL	ENN		STREET ADDRESS, CI 1101 HARTWELL S GARNER, NC 23		•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRE I CORRECTIVE ACTION SHI REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
	Cumulative diagnos agitation and negative and long term memimpairment in decis administered during included antipsychological and long term memimpairment in decis administered during included antipsychological and long term medications dated 8 #101 received Risp medication) daily ar negative side effects. Physician orders we part, the following mevery evening for part, the following mevery evening for part, the following mevery evening for part, the physician orders we part, the following mevery evening for part, the following mevery evening for part, the following mevery evening for part, the physician orders and the pharmacommendation for A pharmacy consult the physician had agpanel obtained on the physician's order had pharmacist recommendation.  On 11/28/12 at 12:08 consultant stated it we fasting lipid panels of antipsychotic medical received her recommendation for received her recommendation for the physician's order had pharmacist recommendation for the physician's order had pharmacist recommendation for the physician's order had agreed the physician's order had agr	ses included a history of live behaviors.  e Minimum Data Set (MDS) ated Resident #101 had short ory impairment and moderate ion making. Medications the observation period dic and anxiety medications.  Sment for Psychotrophic 207/12 indicated that Resident erdal (antipsychotic and remained at risk for strom the medication.  The reviewed and revealed, in redications: Risperdal 1 mg sychosis.  Idated 6/27/12 revealed that ing lipid panel noted on the acist wrote a a fasting lipid panel.  Idated 8/28/12 revealed that irreed to have a fasting lipid e 6/27/12 consult but a d not been written. The ended a fasting lipid panel be	F3	review a recomme three mo recomme addresse utilizing follow-u be correct reported committe meeting.  Continue monitore review o recomme pharmacy through the Assurance administration admi	ed compliance wed through contired the monthly phendations, monthly consultant visithe facility's Quare Program. Address, monitoring and rative action will for any identifice	e next (3) been lation ces will is will be surance onthly ill be nued harmacy hly ts, and ality litional d/or l be	







PRINTED: 12/12/2012

CENTE	RS FOR MEDICARE &	MEDICAID SERVICES					RM APPROVE
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A BUIL	JLTIPLE CONSTRUCTION DING		COMPL	
		345389	B. WINC	3	_		С
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	L	CIDER MADERA AND A		11	/28/2012
THE LAU	RELS OF FOREST GLEN	N		STREET ADDRESS, CITY, STATE, ZIP 1101 HARTWELL STREET GARNER, NC 27529	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX IAG	PROVIDER'S PLAN	ACTION SHOUL TO THE APPROI	O 8E	COMPLETION OATE
	by the nursing staff of recommendations. We the recommendation, write the physician's of consultant stated she responses to her recommendation for Resident glipid panel two the charge nurse but dispenses to the medical was not an order writter for Resident #101.  On 11/28/12 at 1:45 PM she thought that the Jubeen filed in Resident # been written. She indicate reviewed and the been written. She indicate in the physician's order for the physician's order for the physician's order for the physician's order form the physician's the physician's order form the physician's order form the physician's order form the physician's order form the physician's order form the physician's order form the unit managers would have been the physician's order form the unit managers would have been the physician's order form the unit managers would have been the physician's order form the unit managers would have been the physician's order form the unit managers would have been the physician's order form the unit managers would have been the physician's order form the unit managers would have been the physician's order form the unit managers would have been the physician's order for the physi	the pharmacy then the physician agreed to the charge nurse would rder. The pharmacy reviewed the physician mendations on her next had sent the resident #101 to have a times and had spoken to lid not know why it had not  If record revealed there in for a fasting lipid panel  M. Unit manager #2 stated the recommendation had full's chart before it had physician's order had rated she did not ry consultant asking about r a fasting lipid panel.  If, Administrative staff #1 to obtain physician lacy recommendations teriod form the time they the pharmacy consultant. If review the physician tendations and write the stated the fasting lipid	F 3.	29			
F 334		AND PNEUMOCOCCAL	F 334	F334			12-26-12

FORM CMS-2567(02-99) Previous Versions Obsolete

The facility must develop policies and procedures

Event (D: 473M1)

Facility ID 923173

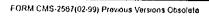
Resident #101's RP was

provided education relating to the

If continuation sheet Page 18 of 27



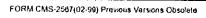
07175115117		E O INCOMO OCAVIOLO				OMB NO. 0938-03		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILI		PLE CONSTRUCTION	(X3) DATE SE COMPLE	TED	
		345389	B. WING	3_		440	C	
HAME OF P	ROVIDER OR SUPPLIER		<del></del>	ero	SECT LODDEGG COM CALLE	11/2	28/2012	
THEIAN	RELS OF FOREST GLEN	IM			REET ADDRESS, CITY, STATE, ZIP CODE			
1112 220	ALLS OF FOREST GLEN	101			SARNER, NC 27529			
(X4) ID PREFIX FAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	D BY FULL PREFIX (EACH CORRECT CROSS-REFEREN CROSS-REFEREN			OF CORRECTION CTION SHOULD BE O THE APPROPRIATE (CY)		
F 334	Continued From page	. 10			flu vaccine, consent was o	btained		
	that ensure that	9 10	F3	34	and the resident received t	he		
		influenza immunization, resident's legal			vaccine on 11/28/2012.			
	representative receive benefits and potential	es education regarding the			All residents residing in th	e		
	immunization;	and directs of file			facility during the dates of	•		
	(ii) Each resident is of				October 1st through March	31st		
	immunization October				have the potential to be aff			
	annually, unless the ir	nmunization is medically resident has already been			•			
	immunized during this				Assistant Director of	:		
	(iii) The resident or the	resident's legal			Nursing/SDC will be re-ed	lucated		
	representative has the	opportunity to refuse			by the Director of Nursing			
	immunization; and (iv) The resident's med	dical record includes			facility's policy and proced			
		dicates, at a minimum, the			on Influenza and Pneumoc			
	following:				Immunizations by 12-26-1	2.		
	(A) That the resident	or resident's legat ovided education regarding			•	1		
	the benefits and poten	tial side effects of influenza						
	immunization; and				The Director of Nursing a			
	(B) That the resident	either received the			Unit Managers/SDC will	198		
	influenza immunization influenza immunization				Influenza and Pneumococ	1 6		
	contraindications or rel				immunization records to $\epsilon$	nsure		
ĺ		<b>x</b>	1		all residents/RP have beer			
		op policies and procedures			<ul> <li>provided education relating</li> </ul>	ig to the		
	that ensure that (i) Before offering the p	nneumococcal			vaccine. New Admissions	will be		
	immunization, each res				reviewed by the Unit Man	agers		
	legal representative red	eives education regarding			during the morning Clinic	al		
	the benefits and potent	ial side effects of the			meetings to ensure that the			
	immunization; (ii) Each resident is offe	ared a negumenced			proper education has been	I .		
7	immunization, unless th	a pheumococcal			provided and that the acce			
	medically contraindicate	ed or the resident has			or declination of Influenza	and		
j.	already been immunize	d;			Pneumococcal Immunizat		ļ	
	(iii) The resident or the	resident's legal			has been documented. Va	i	[	
			1	J	- mas occur documented. Va	Harres	i	







	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) M		PLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		345389	B. WIN	ю		11/	C 28/2012
	ROVIDER OR SUPPLIER	N		1	REET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET BARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 334	immunization; and (iv) The resident's me documentation that in following: (A) That the resident representative was pr the benefits and poter pneumococcal immun (B) That the resident pneumococcal immun the pneumococcal immun contraindication or ref (v) As an alternative, t and practitioner recom pneumococcal immun years following the firs immunization, unless	medical record includes It indicated, at a minimum, the lent or resident's legal Is provided education regarding Intential side effects of Inunization; and Ient either received the Inunization or did not receive Immunization due to medical Irefusal. Ire, based on an assessment Icommendation, a second Inunization may be given after 5 Ifirst pneumococcal Iss medically contraindicated or Iresident's legal representative		3334	and concerns will be repaired the quality assurance of during the monthly meet on-going compliance was monitored through review admissions during the competing, and annual review immunization records for term residents by the SI Managers.  Continued compliance was monitored through the formulative assurance programments.	will be corrected as identified and concerns will be reported to the quality assurance committee during the monthly meeting.  On-going compliance will be monitored through review of new admissions during the clinical meeting, and annual review of immunization records for long-term residents by the SDC/Unit Managers.  Continued compliance will be monitored through the facility's quality assurance program.  Additional education and	
TOTAL COMMISSION OF THE PROPERTY OF THE PROPER	by: Based on record revie facility failed to offer ar	is not met as evidenced ew and staff interviews, the nnually 1 of 5 residents ent and educational material ne.			.*		
	The findings include:						
	reviewed. It read that the					100000	







PRINTED: 12/12/2012 FORM APPROVED

STATELICA	T OF DESIGNATIONS	S MEDIO WO CENTICES			(	OMB NO. 0938-0391		
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M A. BUII	ULTIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED		
		345389	8 WN	3		C		
NAME OF F	PROVICER OR SUPPLIER		—- L	STREET ADDRESS, CITY, S	CEATE III CODE	11/28/2012		
THE LAU	JRELS OF FOREST GLEN	N		1101 HARTWELL STRE	ET			
(X4) ID	CHAMADY CT	ATCHENT OF RECOMMEN	لـــــ	GARNER, NC 27529				
PREFIX FAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI FAG	(EACH COR	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)		TICH	
F 334	Continued From page	20	F	34				
	vaccine, the vaccine a	and education on the						
	If the quest consents	offered on an annual basis. to the vaccine, at the time of						
	each annual administr	ration, provide the						
	guest/family member/	legal representative with						
	side effects of the imm	ne benefits and potential						
	Resident #101 was ad	Imitted to the facility on I to the facility on 8/21/12,						
	His cumulative diagno	ses included: hypertension,						
	peripheral neuropathy	and scoliosis. On the						
	dated 8/27/12, he was	imum Data Set (MDS),						
	cognitive impairments.	account as naving						
	A review of his medica	t chart revealed that the						
	last consent for influen	za (flu) vaccine was given						
	on 10/23/10 by the Res	sponsible Party (RP), at						
	chart did not contain ar	ny additional consents or						
	educational material of	fered to the RP.						
	On 11/28/12 at 1:45 pm	n, Unit Manager 2 shared	-					
	that the nurse handling	immunizations was	1					
-	recently hired and that had a history of declining	Resident #101 previously						
ĺ	However, today, they co	ontacted the RP who was						
	verbally given information	on about the risks and						
1	benefits of the flu shot.	She reported that once influenza immunization,				Ī		
[	the shot was given to R	esident #101.						
F 356	483.30(e) POSTED NU	RSE STAFFING	F 356	F356		12-26-17	_	
SS=C	INFORMATION					1 6 60	_	
Ì	The facility must post the	e following information on		The facility is	now accurately			
	a daily basis: o Facility name.				tly posting the daily	y		
İ	o r domy name.	ļ		staffing and o				

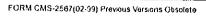






CENTERS FOR MEDICARE & MEDICAID SERVICES

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345389	а уми				4410	C
THE LAUR	OMDER OR SUPPLIER ELS OF FOREST GLEN	IN		1	REET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET GARNER, NC 27529		11/2	28/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
T bb ! ir a	by the following cated unlicensed nursing stresident care per shift - Registered nursing the resident care per shift - Registered nurses - Licensed practice vocational nurses (as - Certified nurses as Resident census.  The facility must post specified above on a confeach shift. Data must be confeach shift. Data must be confeached and visitors.  The facility must, upon make nurse staffing disor review at a cost not standard.  The facility must main staffing data for a minimal equired by State law, which is REQUIREMENT by: Based on observation interviews, the facility is ccurately.	nd the actual hours worked gories of licensed and aff directly responsible for t: es. cal nurses or licensed defined under State law). lides.  the nurse staffing data daily basis at the beginning ust be posted as follows: format.	F	356	The Assistant Director Nursing/SDC will be a by the Administrator/I accurately posting the staffing census in the IThe Director of Nursing SDC will monitor accurately posting of the daily stances as a times weekly. The weeks then 2x/wk the The weeks end manage monitor weeks end post Variances will be correctime of observation and will be reported to the classurance committee dumonthly meeting.  Continued compliance amonitored through daily observations and through daily observations and through daily observations. Additional ed and monitoring will be if or any identified concerns.	re-edu DON ( daily front I  ng and aracy a affing a /week ereafte r will tings. d conc quality aring t  will be y roun the ance lucation nitiate	obby.  //or and and x r.  at the erns // he	





PRINTED: 12/12/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 8 WNG 345389 11/28/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET THE LAURELS OF FOREST GLENN GARNER, NC 27529 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) **fAG** CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 356 Continued From page 22 F 356 staffing posted, dated 11/23/12. The census for residents was listed at 124. On 11/25/12 at 3:45 pm, the Administrative Staff #3 provided the Resident Census. There were 112 residents listed in the skilled nursing beds. The home for the aged (HA) beds included 14 residents. The daily staffing, marked 11/26/12 was observed in the lobby on 11/26/12 at 8:00 am. It included residents in the HA beds, with a total resident census listed as 129. The Administrative Staff #3 was interviewed on 11/26/12 at 11:15 am and stated that the HA beds are included in the resident census and that he was unaware that they should be excluded. The daily staffing, marked 11/27/12 was observed in the lobby on 11/27/12 at 8:00 am. It included residents in the HA beds, with a total resident census listed as 129. The Administrative Staffs # 1 and # 7. Both of the employees acknowledged completing the daily posting, however the Administrative Staff #1 said that she normally only does it on weekends, when she worked. She shared that when she came in on 11/25/12 around 5:00 pm, the staffing from 11/23/12 was still hung. She shared that she will ensure that her weekend nursing staffs update the form.

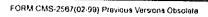


The Administrative Staff #7 stated that she completed the staffing weekdays. She shared that she was not aware that she should exclude HA beds from the census and that she needed to





	NO FOR WEDICARE &					OMB I	NO. 0938-0391
AND PLAN C	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ħ		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345389	0 1/1/1	ю_			С
NAME OF P	ROMDER OR SUPPLIER	0.000		_			/28/2012
	RELS OF FOREST GLEN	N		1	REET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET		
	T			(	3ARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	0.05	(X5) COMPLETION DATE
	adjust the actual hours with the residents in the On 11/27/12 at 1:45 pr #1 revealed an modific reduced the staff and a HA hall and reduced the who were previously in 483.60(b), (d), (e) DRU LABEL/STORE DRUG.  The facility must emploa licensed pharmacists of records of receipt an controlled drugs in suff accurate reconciliation; records are in order an controlled drugs is main reconciled.  Drugs and biologicals to labeled in accordance with professional principles, appropriate accessory a instructions, and the exapplicable.  In accordance with Stat facility must store all drulocked compartments unlocked.	as for nursing staff who work the HA beds.  m, the Administrative Staff and staffing form, that actual hours worked on the ne number of residents, included from the HA beds.  JG RECORDS, S & BIOLOGICALS  Dy or obtain the services of who establishes a system and disposition of all include the and determines that drug do that an account of all intained and periodically assed in the facility must be with currently accepted and include the and cautionary piration date when the and Federal laws, the ags and biologicals in ander proper temperature of authorized personnel to		356		lited spired other oted.	12.2612
	The facility must provide permanently affixed con controlled drugs listed in Comprehensive Drug Ab Control Act of 1976 and	partments for storage of Schedule II of the buse Prevention and			separating/returning medical which have been discontinue and/or when a resident is discharged from the facility 12-26-12, if 100% is not	ed	1000

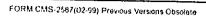






PRINTED: 12/12/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)				OMB NO				
		(X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(XJ) DATE SURVEY	
		- I I I I I I I I I I I I I I I I I I I		A BUILDING			COMPLETED	
		345389	B. WING	8. WING			С	
NAME OF P	ROVIDER OR SUPPLIER	340308	,			11/	/28/2012	
			[		ET ADDRESS, CITY, STATE, ZIP CODE		***************************************	
THE LAU	RELS OF FOREST GLEN	4		110	01 HARTWELL STREET			
	1			GA	ARNER, NC 27529			
(X4) ID PREFIX FAG	[ (EACH DEFICIENCY	NEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX FAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE	
F 431	abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can			31	achieved due to illness or			
				اد	vacation then staff will be			
					educated upon returning ba			
				İ	work. New employees well t			
	be readily detected.				advantad dans 1	100		
					educated through orientation	on,		
					The Director of Nursing or	Linit		
	This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to discard outdated Tuberculin PPD (purified protein derivative) in one (Unit 2) of two medication refrigerators, failed to discard outdated and opened undated insulin from one (Unit 1) of two refrigerators and failed to discard an open undated vial of cyanocobalamin (Vitamin B12) from one (1) of five (5) medications carts (medication cart A on 100 hall).				The Director of Nursing or Unit			
					Managers will check medication			
					rooms and medication carts			
					times per week/week x 4we	eks to		
					ensure medications are labe			
į					and dated when required, ex	kpired		
					meds have been removed as	nd		
1					either discarded or returned			
					the pharmacy. Variances wi			
					corrected at the time of	11 00		
r c b tt 3 p e	The findings included:	ngs included:			observation and concerns w			
	An undated policy entitled "Expiration of				reported to the quality assur-	ance		
	Opened Multi-Dose Vial	s" read in part:			committee during the month	ılv 📗	l	
	<ul> <li>A. Policy "all multi-do</li> </ul>	se vials of injectable			meeting			
	medications and vaccin	es shall be dated by the			8			
	designated staff person	at the time that the seal is		1.	Continued compliance will t	. ! [	1	
	broken and the first dos	e drawn. Subsequently,		1 .	Continued compliance will be	se	Ī	
	30 Days: PPD".	dates shall be observed:			monitored by the Unit Mana	gers	ľ	
		hall be returned to the		1	hrough weekly review of	:	ľ	
	pharmacy at such time a	is their respective		1	nedication carts and med roo	oms 📙		
	expirations have been re	eached."		a	and through the facility's Qu	ality 📙		
				/	Assurance Program. Additio	mal	1	
	On 11/28/12 at 2:38 PM,	one vial of PPD dated as		10	ducation and monitoring wi	ll bo	]	
	pened 10/1/12 was obs	erved in the Unit 2			nitiated for any ideast con-	n de		
l in	medication refrigerator. N	Manufacturer			nitiated for any identified	1	j	
o	specifications included, " opening." Nurse #1 was	Discard 30 days after interviewed at this time		C	oncerns.			



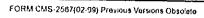


Facility ID 923173





STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION		(X3) DATE	
		345389	8 WIN					C
	ROMDER OR SUPPLIER	NN	<del></del>	110	EFADDRESS, CITY, STATE, ZIP COI 1 HARTWELL STREET RNER, NC 27529	DE.	<u>[ 11</u>	1/28/2012
(X4) ID PREFIX FAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOUL THE APPROF	D 8E	COMPLETION DATE
	and stated that the vidiscarded.  On 11/28/12 at 2:40 indicated it was an orbeen discarded. It shafter opening.  2. An undated policy Opened Multi-Dose V. A. Policy "all multi-domedications and vaccidesignated staff persibroken and the first dithe following expirations. 28 Days: insulin productions in the following expirations have been a. On 11/28/12 at 3:20 pens were observed in refrigerator. One Land was opened and undated flexpens were opened Lantus solostar insulindated 10/29/12.  On 11/28/12 at 3:20 Piconsultant stated the infor return to the pharm have been in the refrigerated all vials/ insuling the dated when opened dated whe	PM, Unit Manager #1 versight that the PPD had not ould only be kept for 30 days  entitled "Expiration of fials" read in part: ose vials of injectable cines shall be dated by the on at the time that the seal is ose drawn. Subsequently, on dates shall be observed: lucts."  hall be returned to the e as their respective n reached."  O PM., four opened insulin the Unit 1 medication tus solostar insulin flexpen ted. Two Novolog insulin and dated 10/26/12. One of flexpen was opened and  M., the pharmacy medication might have been acy but they should not	F	131				







PRINTED: 12/12/2012 FORM APPROVED OMB NO. 0938-0391

/ Po	STATEMENT OF DEFICIENCIES
	AND PLAN OF CORRECTION
T-2-1-7-1	1

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

345389

8 WNG\_\_\_

C 11/28/2012

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HE LAUI	RELS OF FOREST GLENN		STREET ADDRESS, CITY, STATE, ZIP CODE  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	(X5) COMPLETION DATE
F 431	Continued From page 26 been returned to pharmacy.  b. On 11/28/2012 at 2:26 PM., an open, undated multidose viat of cyanocobalamin (Vitamin B12) was observed in medication cart A on Unit 1.  On 11/28/12 at 2:26 PM., Nurse # 2 stated the Vitamin B12 vial should have been dated when it was opened.  On 11/28/ 12 at 4:22 PM., Administrative staff #1 stated all vials which included the B12 multidose vial should have been dated when opened.	F 45	DEFICIENCY)	UATE
T PRODUING THE PROPERTY OF THE				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 473M11

Facility ID 923173

If continuation sheet Page 27 of 27



9197724814

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/02/20 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVI OMB NO. 0938-03 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY DENTIFICATION NUMBER: 01 - MAIN BUILDING 01 8 2 2018 COMPLETED A BUILDING B. WING 34538B 12/19/2012 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 SUMMARY STATEMENT OF DEFICIENCIES Ю PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION! TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) K 000 | INITIAL COMMENTS The Laurels of Forest Glenn requests to have this K 000 Plan of Correction serve as our written allegation of compliance. This Life Safety Code(LSC) survey was Our alleged date of compliance is 1/24/2013. conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Preparation and/or execution of this plan of Care section of the LSC and its referenced correction do not constitute admission to nor publications. This building is Type V (111) agreement with either the existence of, or scope and severity of any of the cited deficiencies, or construction, one story, with a complete conclusions set forth in the statement of automatic sprinkler system and a delayed egress deficiencies. This plan of correction is prepared locking system. and executed to ensure continuing compliance with Federal and State regulatory law. The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD K 029 K 029 K 029 SS=D The tie that was holding the door to the dry One hour fire rated construction (with % hour storage room in the kitchen open was removed on fire-rated doors) or an approved automatic fire 12/19/2012. extinguishing system in accordance with 8.4.1 and/or 19,3,5.4 protects hazardous areas. When Dietary Manager and/or designee will inservice/re-educate Dietary staff on not tying open the approved automatic fire extinguishing system option is used, the areas are separated from fire doors. other spaces by smoke resisting partitions and The Director of Maintenance will conduct audits doors. Doors are self-closing and non-rated or on no obstructions for all doors in the facility ()) field-applied protective plates that do not exceed once weekly for (4) four weeks. All variances 48 inches from the bottom of the door are will be corrected at the time of observation, permitted. Monitoring results will be reported to the 19.3.2.1 Administrator and to the Quality Assurance committee during the monthly meeting. Continued compliance will be monitored through the facility's preventative maintenance, fire safety This STANDARD is not met as evidenced by: and Quality Assurance programs A. Based on observation on 12/19/2012 the door to the dry storage room in the kitchen was tied open. 42 CFR 483,70 (a) K 038 NFPA 101 LIFE SAFETY CODE STANDARD K 038 K038 SS=D The lock on the delayed ogress door near room Exit access is arranged so that exits are readily 133 was fixed on 12/19/2012 to release to

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

accessible at all times in accordance with section

Administrator

TITLE

1-22-13

(X6) DATE

Any deficiency statement ending with an asterical densities 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.

pressure.

PRINTED: 01/02/20 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 01 - MAIN BUILDING 01 B. WING 345389 12/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET . THE LAURELS OF FOREST GLENN GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DAYE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG ... CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY The Director of Maintenance has received one on K 038 Continued From page 1 one counseling/education on the Preventative K 038 Maintenance Policy. 7.1. 19.2.1 The Director of Maintenance will conduct audits! on delayed egress doors to ensure they release on pressure in the facility (1) once weekly for (4) four weeks. All variances will be corrected at the time of observation. Monitoring results will be reported to the Administrator and to the Quality This STANDARD is not met as evidenced by: Assurance committee during the monthly A Based on observation on 12/19/2012 the meeting. Continued compliance will be monitored through delayed egress lock near room 133 failed to release on pressure ( lock was repaired during the facility's preventative maintenance, fire safety and Quality Assurance programs. LSC survey). 42 CFr 483,70 (a) K 050 NFPA 101 LIFE SAFETY CODE STANDARD 124/13 K 050 The staff member interviewed has received one SS=D on one counseling/education on the facility's Fire Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift, Drill Policy. The staff is familiar with procedures and is aware The Director of Maintenance will in-service/rethat drills are part of established routine. educate the staff on the facility's Fire Drill Policy. Responsibility for planning and conducting drills is assigned only to competent persons who are 'The Director of Maintenance and/or designee will qualified to exercise leadership. Where drills are conduct random fire drill audits on all shifts (1) conducted between 9 PM and 6 AM a coded once weekly for (4) four weeks, All variances announcement may be used instead of audible will be corrected at the time of observation. alarms. 19.7.1.2 Monitoring results will be reported to the Administrator and to the Quality Assurance committee during the monthly meeting. Continued compliance will be monitored through This STANDARD is not met as evidenced by: the facility's preventative maintenance, fire safety A. Based on observation on 12/19/2012 the staff and Quality Assurance programs.

stations were . 42 CFR 483,70 (a)

K 051

SS≃D

interviewed did not know the where the pull

NFPA 101 LIFE SAFETY CODE STANDARD

A fire alarm system with approved components,

devices or equipment is installed according to

NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building.

The fire alarm system was serviced by Eagle Fire

Inc. on 12/20/2012 to allow a visible/audible

trouble signal at the Pire Alarm Control Panel

(FACP) with loss battery backup,

K 051

01/22/2013 10:18 9197724814

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

	ter i dittipppi int	T OF MICHIGAN OF WALKAICES				CIND NO	<u>. บยงต-บงย</u>	
		The state of the s		IULTI	PLE CONSTRUCTION IG D1 - MAIN BUILDING D1	G 01 (X3) DATE SURVEY COMPLETED 12/19/2012		
		345389	e. Wil	0. WING				
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF FOREST GLENN			•	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETIO DATE	
K 051	Continued From page 2 Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6		K 051		The fire slarm system will continue to be inspected through routine scheduled maintenance checks by the outside fire system contractor.  The Director of Maintenance and/or designee will monitor the visible/audible trouble signal at the Fire Alarm Control Panel (FACP) with loss battery backup for proper function during the monthly fire drills. The fire system contractor will be notified of any variances and repairs will be promptly made.  Continued compliance will be monitored through the facility's preventative maintenance, fire safety, and Quality Assurance programs.			
	A .Based on obser	is not met as evidenced by: vation on 12/19/ 2012 the erate the fire alarm when AC						