STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING _____ B. WING _____	10/06/2011

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
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to 1) follow a doctor's order to hold the blood pressure medications for 1 (Resident #101) of 10 sampled residents and 2) failed to use gravity when administering a medication via gastrostomy feeding tube (g-tube) for 1 (Resident #44) of 2 sampled residents. Findings include: 1. Resident # 101 was admitted to the facility on 11/12/09 with multiple diagnoses including Hypertension. On 11/12/09, there was a doctor's order for Lopressor 25 mgs (milligram) by mouth once a day, hold for SBP (systolic blood pressure) or HR (heart rate) less than 60. The MARs (Medication Administration Records) were reviewed. The MAR for August, 2011 had 7 boxes (8/8, 8/11, 8/14, 8/19, 8/26, 8/27 and 8/28/11) with no HR recorded. Eleven (8/1, 8/2, 8/9, 8/10, 8/12, 8/13, 8/15, 8/22, 8/23, 8/24 & 8/25/11) of twenty three HR recorded were below 60 (between 51-59). The 7 boxes with no HR recorded and the 11 days with HR below 60 had nurse's initials indicating that the Lopressor was given. The MAR for September, 2011 had 7 boxes (9/2, 9/5, 9/11, 9/19, 9/23, 9/24 & 9/25/11) with no HR recorded. Eleven (9/6, 9/7, 9/8, 9/9, 9/10, 9/13,	F 281	The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is 11/03/2011. 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. F281 Resident #101's physician was notified of the HR's less than 60. No new orders were received. The resident's medication is being administered as ordered by the physician. No negative outcome resulted from this observation. Current residents receiving medications with parameters for administration will be reviewed by the Unit Managers to ensure vital	11/3/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/2/11

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 281	Continued From page 1 9/15, 9/16, 9/17, 9/18, 9/26/11) of twenty three HR recorded were below 60 (between 58-59). The MAR for October, 2011 was reviewed on 10/5/11. The HR on 10/02/11 was 58 and on 10/03/11, the HR was 59. The boxes on the MAR for October 2 and 3 had nurse's initials indicating that the Lopressor was administered to the resident. On 10/05/11 at 5:22 PM, Nurse #1 was interviewed. She stated that she was scheduled to work 7-3 shift and she acknowledged that she had administered the Lopressor with the HR of less than 60. She stated that she was not aware of the order to hold it if below 60. 2. Review of the facility policy titled " Restoring Patency of Feeding Tube " (dated 11/02) revealed " Policy: Clogged feeding tubes are restored to patency as soon as clog is noted. Clogged tubes are replaced if attempts to unclog are unsuccessful. " The procedure read, in part, " Warm Water Method a) draw up 30 ml (milliliters) warm water in syringe b) attach syringe to tube c) gently push in fluid and pull back fluid, alternating positive and negative pressure. Avoid continued excessive pressure. " " Alternate Warm Water Method a) draw up 5 ml of warm water in syringe, attach syringe to tube. Inject warm water into tube and clamp for 5 minutes c) flush with water until clear. " Review of the facility policy titled " Administration of Medication via Feeding Tube " (dated 11/02)	F 281	signs are documented as specified and medications are administered as ordered. Variances will be reported to the physician if indicated. Nurse #1 received one to one counseling/education regarding our policy on following physician orders in regards to holding blood pressure medications by the DON on 11/01/2011. Nurse #3 received one to one counseling/education regarding the procedure for administering medications via gastrostomy tube, flushing the tube, procedures for unclogging a gastrostomy tube and ensuring the syringe, and plunger are free of debris before placing the syringe back in the protective bag by the DON on 11/02/2011. . Licensed nursing staff will receive additional education by the DON/designee on the facility's policies and procedures for medication administration, following physicians' orders in regards to holding medications per designated parameters, administering	

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F 281	Continued From page 2 revealed in part " powder from crushed tablets or capsule contents should be dispersed well in 30 ml of water. All particles must be in solution prior to administering the medication. " Step #13 of the Procedure for Administration of Medications via Feeding Tube read, in part, " Pour the liquefied medication into the syringe and allow to flow by gravity into the tube; never force fluid into the tube. " Resident #44 was admitted on 10/25/10 with diagnoses including history of dysphasia, gastritis, gallstones, chronic kidney disease, and gastric esophageal reflux disease. Review of the most recent Quarterly Minimum Data Set (MDS) dated 8/30/11 revealed the resident was moderately cognitively impaired and had a feeding tube. Review of the Physicians Order Summary for 10/1/11 through 10/30/11 revealed the following order " Tums Regular Cal-Gest CHW (chewable) 500 mg (milligrams) 3=600 mg via tube once daily for calcium supplement. " On 10/5/11 at 4;10 pm observation of a medication pass for Resident #44 revealed that Nurse #3 dispensed 4 crushed and one liquid medication in separate medication cups and used a spoon to mix them with approximately 20 - 30 ml of water from the jug on her med cart. One of these medications was 3 tablets of Tums 500 mg each. Nurse # 3 took the medications into Resident #44 ' s room along with 175 ml of water from the jug on her med cart. She then checked the gastrostomy feeding tube (g-tube) for placement. After this Nurse #3 attached the	F 281	medications via gastrostomy tube, flushing the tube, procedures for unclogging a gastrostomy tube and ensuring the syringe, and plunger are free of debris before placing the syringe back in the protective bag. In-Servicing was held on 10/19/2011, 10/20/2011, and 10/21/2011 by Administrative nurse. Unit Managers/designee will conduct a medication pass observation utilizing a med pass observation tool with varying licensed nurses on various shifts on various days of the week, including weekends (3) three times a week for the next (4) four weeks to ensure vital signs are documented when required, medications are administered as ordered, and medications via gastrostomy tube are administered properly and syringes stored appropriately. Corrections will be made immediately upon identification.	

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F 281	Continued From page 3 syringe without it ' s plunger to the g-tube and added some water that infused by gravity. She administered the resident ' s medications individually with a small amount of water in between each dose. When she poured the Tums into the syringe it failed to flow into the g-tube via gravity. Nurse #3 removed the syringe while clamping the tubing with one hand and tapped the tip of the syringe with the gloved finger of her other hand to dislodge anything that might be stuck. She then reattached the syringe and added more water but after releasing her hand as a clamp the medication still did not flow via gravity. Nurse #3 then placed the plunger in the syringe and shook the syringe while it was attached to the g-tube, while holding the g-tube in place. She then pushed the plunger to infuse the crushed Tums via the g-tube. The medication cup that the Tums had been in still had residue in it. She added more water and stirred the substance up off the bottom of the medication cup with her gloved finger. Nurse #3 then removed the syringe while clamping the g-tube with one hand. She removed the plunger from the syringe and reattached the syringe to the g-tube. She poured the Tums residue and water mixture into the syringe. When she unclamped the tube and the medication did not flow via gravity Nurse #3 inserted the plunger in the syringe and pushed the plunger to infuse the solution. During the medication pass for Resident #44, on 10/5/11 at 4:15 PM, Nurse #3 revealed that the Tums typically did not infuse well into the g-tube via gravity and had to be pushed to get it to infuse.	F 281	Monitoring results will be reported to the Director of Nursing weekly for the next (4) four weeks and concerns will be reported to the Quality Assurance committee during the monthly meeting. Continued compliance will be monitored through routine med pass observations, routine review of MARs, and review of new orders during the morning clinical meeting and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 281	Continued From page 4 During an interview with Nurse #3 on 10/5/11 at 4:30 PM, she indicated that when medications will not infuse via gravity the accepted practice at the facility was to use the syringe plunger to push them in. Interview with Administrative Nurse #4 at 5 PM revealed that medications administered via g-tube were to be infused via gravity.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to follow their policy on fluid restriction for 1 (Resident #115) of 1 sampled resident on dialysis. The finding includes: The facility ' s policy on fluid restriction dated 04/10 was reviewed. The policy read in part " all guests with a nutrition prescription for a fluid restriction shall receive only the amount of fluids as prescribed by the physician. 4. The distribution of fluids shall be documented on the dietary progress notes, care plan and the Medication Administration Record or Treatment Administration Record. 7. The diet card/cardex	F 309	F309 Resident #115's physician was notified. The resident's care card, care plan and dietary card have been updated to include the fluid restriction and the allocation of fluids per department. Current residents with orders for fluid restrictions have been reviewed by the Unit Manager and Dietary Manager to ensure the fluid restriction is identified in the plan of care, on the nursing care card, and on	11/3/11

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F 309	Continued From page 5 and care plan shall be changed to reflect the fluid restriction. 8. The diet card shall denote the fluid preferences and breakdowns allocated to dietary. 9. Water pitchers shall not be placed in the guest ' s room " . Resident #115 was admitted to the facility on 01/19/11 with multiple diagnoses including ESRD (End Stage Renal Disease). The quarterly MDS assessment dated 08/07/11 indicated that Resident #115 had memory and decision making problems and was on dialysis. The care plan indicated that the resident was scheduled for hemo dialysis 3 times a week on Monday, Wednesday and Friday. On 02/15/11, there was a doctor ' s order for 1200 ml (milliliter) fluid restriction as recommended by the dialysis clinic. The dietary notes revealed that dietary to provide 200 ml of fluid every meal and nursing to provide 280 ml of water in 24 hours to include the water flush and with medication pass. On 10/05/11 at 9:21 AM, administrative nurse #2 was interviewed. She stated that the RD (Registered Dietician) was responsible in figuring out how much fluid the dietary and nursing would provide in 24 hours. She also stated that intake and output was not necessary for resident on fluid restriction. On 10/05/11 at 5:48 PM, Resident #115 was observed eating dinner in the dining room. He had 3 glasses of fluids (480 ml total) in front of him. His dietary card did not reflect the fluid restriction and the breakdowns allocated for	F 309	the dietary card and water pitchers removed from identified resident rooms if indicated. The nursing and dietary staff will be provided additional education relating to communication of orders for fluid restrictions by an Administrative nurse and Dietary Manager. In-Servicing was held on 10/26/2011 and 10/27/2011. The Licensed Nurses and Dietary Manager will be provided additional education relating to inclusion of fluid restrictions in the plan of care, on the nursing care card and dietary card. The Licensed Nurses will ensure water pitchers are removed from identified resident rooms when indicated. The Unit Managers will ensure that any new orders for fluid restrictions are included in the plan of care, on the nursing care card, the fluid allocation sheet is present in the MAR and communicated to the Dietary department. The Dietary Manager will ensure fluid restrictions are documented on the dietary card. Care plans and care	

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F 309	Continued From page 6 dietary. On 10/06/11 at 9:15 AM, Resident #115 was observed in his room with breakfast tray in front of him. There were 2 cups (240 ml cup) of coffee on the tray. There was a water pitcher full of water observed at the resident ' s bedside. The diet card did not indicate fluid restriction and the breakdown allocated for the dietary. On 10/06/11 at 9:16 AM, the RD was interviewed. She went to observe Resident #115 in his room with his breakfast tray in front of him. She saw the 2 cups of coffee and the diet card. She stated that the resident should only get 200 ml of fluid on each meal and nurses to provide 280 ml with med pass and flushes. She also stated that the resident should not have a water pitcher at bedside and his diet card should reflect the fluid restriction and the breakdown for dietary. She stated that she had entered this information in the computer and did not know why they were gone. On 10/06/11 at 9:24 AM, NA #1 was interviewed. NA #1 was assigned to Resident #115. She stated that she was not aware that the resident was on water restriction. On 10/06/11 at 9:45 AM, administrative nurse #3 was interviewed. She stated that the resident was on 1200 fluid restriction and should not have a water pitcher at bedside. She also stated that NAs were informed of the fluid restriction through the care guide. When checked, the resident ' s care guide did not have fluid restriction written for Resident #115. On 10/06/11 at 9:50 AM, the dietary staff was	F 309	cards are reviewed with new physician's orders and at least quarterly. The Dietary Manager will monitor the allocation of fluids during meals for identified residents (3) three times a week at varying times for the next (2) two weeks then weekly times (2) two weeks then randomly thereafter to ensure accuracy. Variances will be corrected at the time of observation. The Unit Managers/designees will monitor that fluid allocation sheets are present with the MAR of identified residents and water pitchers removed from identified resident rooms (3) three times a week for the next (2) two weeks then weekly for (2) weeks then randomly thereafter. Variances will be corrected at the time of observation. Monitoring results will be reported to the Director of Nursing weekly for the next (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting.	

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F 309	Continued From page 7 interviewed. She stated that they did not have any resident on fluid restriction at this time. She further stated that the dietary manager also indicated that there was no resident currently on fluid restriction.	F 309	Continued compliance will be monitored through routine review of new admissions and new orders during the morning clinical meeting, routine meal and round observations, record reviews and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and medical record review the facility failed to provide the pressure relieving cushion on the wheelchair, as care planned for the care of pressure ulcer for one (1) of three (3) sampled residents (Resident #210). Findings include: Resident #210 was admitted on 9/14/11 with diagnoses including hyperglycemia, peripheral vascular disease, renal insufficiency, rheumatoid arthritis and hypertension. Review of the Nursing Admission Assessment dated 9/14/11 revealed that Resident #210 was admitted with an unstageable pressure ulcer on his sacrum that measured 3.5 cm (centimeters) x 1 cm.	F 314	F314 Resident #210 has been discharged from the facility to home. Current residents who are at risk for the development of pressure ulcers and/or present with pressure ulcers will be reviewed by the Unit Managers and designees to ensure pressure relieving devices are identified and implemented. Variances will be corrected as identified.	11/3/11

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F 309	Continued From page 7 interviewed. She stated that they did not have any resident on fluid restriction at this time. She further stated that the dietary manager also indicated that there was no resident currently on fluid restriction.	F 309	Continued compliance will be monitored through routine review of new admissions and new orders during the morning clinical meeting, routine meal and round observations, record reviews and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and medical record review the facility failed to provide the pressure relieving cushion on the wheelchair, as care planned for the care of pressure ulcer for one (1) of three (3) sampled residents (Resident #210). Findings include: Resident #210 was admitted on 9/14/11 with diagnoses including hyperglycemia, peripheral vascular disease, renal insufficiency, rheumatoid arthritis and hypertension. Review of the Nursing Admission Assessment dated 9/14/11 revealed that Resident #210 was admitted with an unstageable pressure ulcer on his sacrum that measured 3.5 cm (centimeters) x 1 cm.	F 314	F314 Resident #210 has been discharged from the facility to home. Current residents who are at risk for the development of pressure ulcers and/or present with pressure ulcers will be reviewed by the Unit Managers and designees to ensure pressure relieving devices are identified and implemented. Variances will be corrected as identified.	11/3/11

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F 314	Continued From page 8 Review of the Admission Minimum Data Set (MDS) assessment dated 9/21/11 revealed the resident was cognitively intact and was coded as having one (1) unstageable pressure ulcer with slough (yellow or white tissue that adheres to the ulcer bed) and as having a pressure relieving device for his bed. He was not coded as having a pressure relieving device for his wheel chair. Review of the weekly Pressure Ulcer Record revealed the wound was improving with treatment and on 9/29/11 the Pressure ulcer measured 1.2 cm x 0.8 cm. Review of the Plan of Care for Resident #210 dated 9/30/11 revealed the following goal " skin breakdown will be healed within 90 days. " Interventions for achieving the goal included: " Pressure reduction surface to chair at all times. " On 10/6/11 at 11:15 AM the dressing change for the resident ' s pressure ulcer was observed. The pressure ulcer measured 1.0 cm x 0.5 cm and had 100 percent yellow slough. During the dressing change on 10/6/11 at 11:15 AM the resident stated that the pressure ulcer can be painful particularly when he sits down. Resident #210 said that for the first couple of weeks he had a cushion on the seat of his wheelchair that was " half soft " and provided comfort when he sat down. He went on to say that the cushion had disappeared and that he mentioned it to some of the staff but no one seemed to know anything about it. Observation of the resident ' s wheelchair on	F 314	The nursing staff was re-educated by the DON/designee on 10/27/11 relating to the implementation of pressure reducing devices and the procedures for obtaining devices when needed. The Unit Managers/designees will conduct pressure relieving device observations (3) three times a week for (2) two weeks then weekly for (2) two weeks to ensure devices are in place. All variances will be corrected at the time of observation. Monitoring results will be reported to the Director of Nursing weekly for the next (4) four weeks and concerns will be reported to the Quality Assurance committee during the monthly meeting. All residents are assessed for the prevention of pressure ulcers by the IDT upon admission, with a change in condition, at least quarterly and as needed to ensure risks are identified and interventions implemented when indicated.	

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F 314	Continued From page 9 10/6/11 at 11:20 AM reveled there was not a pressure reliving cushion on the wheelchair seat. Interview with Nurse #4 on 10/6/11 at 11:25 AM revealed that she recalled the resident having a cushion on his wheelchair previously but that he never mentioned to her that it was missing. She also indicated that residents with pressure ulcers on the buttocks area would typically have a pressure relieving device for their wheel chair seat. On 10/6/11 at 3 PM NA #2 stated that Resident #210 told her that his wheel chair cushion was missing. She said that she looked for it in his closet and told him that she could not find it. She further said that she did not recall him having a cushion on his wheel chair during his stay at the facility and she thought that perhaps he had it at the hospital before he was transferred here, but that it was not sent with him when he came to the facility.	F 314	Continued compliance will be monitored through routine assessments, routine round observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329	F329 Resident #155's physician was notified of no blood pressures being recorded. The resident's medication is being administered as ordered by the physician. The lipid panel for Resident #155 has been obtained. No negative outcome has resulted from this observation.	11/3/11

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329	F329 Resident #155's physician was notified of no blood pressures being recorded. The resident's medication is being administered as ordered by the physician. The lipid panel for Resident #155 has been obtained. No negative outcome has resulted from this observation.	11/3/11

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F 329	Continued From page 10 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to monitor the blood pressure and the Lipid panel for 1 (Resident #155) of 10 sampled residents. The findings include: 1 a. Resident #155 was originally admitted to the facility on 11/29/10 with multiple diagnoses including Hypertension. The MDS assessment dated 09/08/11 indicated that Resident #155 had memory and decision making problems. Review of the doctor's orders revealed that on 11/29/10, Resident #155 had doctor's orders for Norvasc 5 mgs (milligrams)via tube daily (12:00 AM) for Hypertension-hold for SBP (systolic blood pressure)of less than 110 and Coreg 25 mgs via tube twice a day (11:00 AM & 12:00 AM) for Hypertension- hold for SBP of less than 110. The MARS for August, September and October, 2011 were reviewed. The MARs for August, September and October, 2011 had nurse's initials indicating that the Coreg and Norvasc were	F 329	Current residents receiving medications with parameters for administration will be reviewed by the Unit Managers to ensure vital signs are documented as specified and medications are administered as ordered. Current residents with orders for lab testing will be reviewed by the Unit Managers and designees to ensure labs have been completed as ordered and results are retained in the medical record. Variances will be corrected as identified. Nurse #2 has received one to one counseling/education on the policy for following physician's orders and to take and document residents' blood pressures before administering medications if ordered by the physician by the DON on 11/02/2011. Licensed Nursing Staff was re-educated on 10/27/11 by the DON/designee relating to following physician's orders, monitoring and documenting vital signs when ordered and ensuring labs are completed as ordered, and results are retained in the medical record.	

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F 329	Continued From page 11 administered as ordered but there were no blood pressure recorded prior to giving the medications. The boxes on the MAR for the blood pressure were all blank. On 10/05/11 at 3:20 PM, Nurse #2 was interviewed. She stated that she was scheduled to work 7-3 shift. She acknowledged that she was not checking the resident's blood pressure before administering the medication. On 10/5/11 at 5:18 PM, administrative nurse #1 was interviewed. She stated that if the doctor had ordered parameters to hold the medications, the nurses were expected to check the blood pressure before administering the medications. 1b. Resident #155 was originally admitted to the facility on 11/29/10 with multiple diagnoses including Hyperlipidemia. The MDS assessment dated 09/08/11 indicated that Resident #155 had memory and decision making problems. Review of the doctor's orders revealed that Resident #155 was on Lipitor 80 mgs via tube daily started on 11/29/10 for Hyperlipidemia. On 04/28/11, the physician had ordered for lipid panel every 6 months (June - December). Review of the records revealed that there was no lipid panel result in the chart.	F 329	The Unit Managers will monitor the lab tracking log, (a tool for tracking labs and completion of labs) utilizing a monitoring tool (3) three times a week for (2) two weeks then weekly for (2) two weeks then randomly thereafter to ensure labs are completed as ordered and results are present in the medical record. Variances will be corrected as identified. Continued compliance will be monitored through review of new orders during the morning clinical meeting, routine review of the MARs and lab tracking logs, routine record reviews, during the month end change over process and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
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	F 371	F371 The identified lunch meat was discarded.	11/3/11

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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	F 371	F371 The identified lunch meat was discarded.	11/3/11

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F 371	Continued From page 12 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy and temperature log review, the facility failed to (1) discard outdated food, (2) monitor the temperature of 1 of 2 reach in refrigerators (refrigerator #1), and (3) ensure dome lids were dry prior to use. The findings included: 1. A facility policy entitled "Storage of Food" revised on 4/11 read in part, "Lunchmeats, after opening" (can be kept) "refrigerated 3-5 days". On 10/3/11 at 3:32 PM, an unsealed container of lunchmeat, dated 9/19/11, was observed in the walk-in cooler. During an interview on 10/3/11 at 3:32 PM, the dietary manager (DM) said that lunchmeats could be refrigerated up to 7 days. The DM added that the cook generally discarded outdated foods at the end of the evening, after supper. The DM then discarded the lunchmeat. 2. A facility policy entitled "Refrigeration/Freezer Temperature Records" dated 4/10 read in part, "Temperatures shall be monitored in all refrigeration and freezer equipment to ensure that food is stored at the proper temperatures."	F 371	An additional temperature log for reach in refrigerator #2 has been posted to document the daily temperatures. All walk-in coolers, refrigerators and freezers were checked for outdated food items. No other variances were identified. The Dietary Manager and cook have received one to one counseling/education on the policy for the "Storage of Food" and "Refrigeration/Freezer Temperature Records." The Dietary staff was in-serviced on the facility's policy for the "Storage of Food", maintaining "Refrigeration/Freezer Temperature Records" and ensuring the dome lids are dried properly before tray line by the Dietary Manager on 10/26/2011.	

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F 371	Continued From page 13 During the initial tour of the kitchen on 10/3/11 at 3:32 PM, 2 reach-in refrigerators were observed side by side. The refrigerators were independent of each other, and each had its own interior and exterior thermometers. Review of the "Refrigerator/Freezer Temperature Record" log used by the facility to record temperatures revealed only one column designated "Reach-In Refrigerator". During an interview of 10/6/11 at 3:45 PM, the cook said it was her responsibility to record refrigerator and freezer temperatures on the log. The cook stated that the log did not have an area to record temperatures of both reach-in refrigerators. She said that she recorded the temperature of the refrigerator on the right (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #1). The cook indicated that she expected readings between 39 - 40 degrees Fahrenheit (F) and had not seen any problems. During an interview on 10/6/11 at 3:45 PM, the dietary manager acknowledged that due to an oversight on the temperature log, there was no record that temperatures of both reach-in refrigerators were being monitored. 3. A facility policy entitled "Dish Machine Practices" dated 4/10 read in part, "Employees shall follow standards of practice to ensure that all utensils and dishes are sanitized." "Dishes shall be air-dried, and never stored wet."	F 371	The Dietary Manager/designee will conduct audits utilizing the Dietary Sanitation Audit tool (which includes monitoring that utensils and dishware (Dome lids) are air dried) weekly for the next (4) four weeks to ensure food is labeled, identified and within the guidelines of our policy for "Storage of food" daily. Unidentified and/or outdated food items will be discarded at the time of observation. The Dietary Manager/designee will monitor the temperature logs daily to ensure temperatures are recorded on all refrigerators and freezers per policy. Corrections will be made immediately upon identification. Monitoring results will be reported to the Administrator weekly for the next (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting.	

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F 371	Continued From page 14 A kitchen observation on 10/6/11 at 11:34 AM revealed staff preparing the tray line for lunch. Twenty (20) of the thirty-three (33) dome lids, stacked on a serving cart at the end of the tray line, were wet. During an interview on 10/6/11 at 11:34 AM, the dietary manager (DM) stated that wet lids were pulled by the staff member responsible for placing the lids on the plates. The DM then removed the wet lids and put them on the drying cart. The drying cart was observed to have rows divided into slots by thin metal separators. Most of the slots contained 2 dome lids nestled together. The surfacess of the dome lids that were exposed to air were dry. The surfaces that were nestled were wet. On 10/6/11 at 12:14 PM, the dietary staff (DS#2) who was responsible for placing the dome lids during the tray line was observed. DS#2 repeatedly took a dome lid off the serving cart and placed it on a plate without visualizing the inside of the dome lid. When asked to look at the inside of dome lid that was just placed, DS#2 acknowledged it was wet and removed it. DS#2 then inspected the remaining 6 dome lids on the serving cart and found them all wet. DS#2 placed those 6 on the drying rack, each in individual slots. DS#2 then searched for additional dry dome lids on the rack, inspecting each lid and removing only those that were dry. During an interview on 10/6/11 at 3:50 PM, the DM indicated that the facility needed an additional drying cart for the dome lids.	F 371	Continued compliance will be monitored through daily kitchen observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 15 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 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 observation and staff interview the	F 431	F431 All expired medications were discarded. All medication rooms and medication refrigerators were checked and no other variances were identified. The Licensed Nurses were re-educated relating to the storage of medications and checking for expiration dates by the DON/designee 10/19/2011, 10/20/2011, and 10/21/2011. The Unit Managers will monitor the medication rooms and medication carts utilizing the expired medication audit tool weekly for the next (4) four weeks then randomly thereafter to ensure medications are either returned to the pharmacy or discarded upon expiration. Variances will be corrected at the time of observation.	11/3/11

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F 431	Continued From page 16 facility failed to discard expired medications from one (1) of two (2) medication rooms. Findings include: On 10/6/11 at 2:30 PM the medication room on 100 hall was observed. In the stock medication cupboard the following stored expired medications were observed: Oyst-Cal C 250 mg (milligrams) in an unopened 100 tablet container (expiration date 9/11), and Rena-vite 100 mg (vitamin B Complex with vitamin C and folic acid) in an unopened container (expiration date 11/10). In the medication room refrigerator the following expired medications were observed: two vials of procrit 10,000 units/ml (milliliter) both with a 9/16/11 expiration date, and two open boxes of acetaminophen suppositories that had expiration dates of 9/11. Interview with Nurse #5 on 10/6/11 at 3 PM revealed that the pharmacy was responsible for checking for expired medications in the medication rooms monthly. In addition, she stated that she checks the expiration date before placing a new stock medication in her medication cart. Nurse #5 also indicated that the expired medications should have been discarded by placing them in the box of medications to be sent back to pharmacy.	F 431	Monitoring results will be reported to the Director of Nurses weekly for the next (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through routine inspection of the medication rooms, refrigerators and med carts, and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	F441 Resident #44's tube feed syringe has been replaced. No negative outcomes were identified from this observation.	11/3/11

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F 441	Continued From page 17 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to clean an enteral feeding / enteral medication administration syringe after use for one (1) of two (2) residents (Resident # 44). Findings include:	F 441	Current residents receiving tube feed will be reviewed by the Unit Managers to ensure that syringes are free of debris and stored appropriately. Corrections will be made immediately upon identification. Licensed Nurses were in-serviced by the DON/designee on the requirement for rinsing the gastrostomy administration syringe after all feedings and/or medication administration and that the syringe is free of debris before storing in the protective bag on the 10/19/2011, 10/20/2011 and 10/21/2011. Unit Manager/designees will observe the administration syringes of residents with gastrostomy tubes by utilizing an audit tool weekly for (4) four weeks to ensure the cleanliness of supplies and proper storage. All variances will be corrected at the time of observation. Monitoring results will be reported to the Director of Nursing weekly for the next (4) four weeks and concerns will be reported to the Quality Assurance committee during the monthly meeting.	

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	345389	A. BUILDING _____ B. WING _____	10/06/2011

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

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F 441	Continued From page 18 Review of the facility policy titled " Flushing of Feeding Tube " (dated 11/02) indicated that after intermittent and bolus feedings that the feeding tube should be flushed with water and then step #11 of the procedure was " clean syringe and store in protective container labeled with guest ' s name and date. " Review of the facility policy titled " Administration of Medication via Feeding Tube " (dated 11/02) revealed, in part, that during this procedure step #20 was " clean syringe until all residue is removed and store in protective container labled with guest ' s name and date. " Resident #44 was admitted on 10/25/10 with diagnoses including history of dysphasia, gastritis, gallstones, chronic kidney disease, and gastric esophageal reflux disease. Review of the most recent Quarterly Minimum Data Set (MDS) dated 8/30/11 revealed the resident was moderately cognitively impaired and had a feeding tube. Review of the Physician ' s order Summary for 10/1/11 - 10/31/11 revealed the resident had an order for " glucerna 1.5 1 can every 4 hours ", which was administered via the resident ' s g-tube. On 10/5/11 at 4:10 PM observation of a medication pass and bolus tube feed for Resident #44 revealed that Nurse #3 gave Resident #44 five medications per the resident ' s gastrostomy feeding tube (g-tube), using a syringe that had been stored in a clear bag on the resident ' s	F 441	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.	

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F 441	Continued From page 19 bedside table. She also used this syringe to infuse 1 can of glucerna 1.5 formula as well as 175 ml of water which was used as a flush between each medication and before and after the bolus tube feeding. After the medications, water and formula were infused Nurse #3 put the syringe and its plunger back in the bag she had obtained them from. The syringe still had visible droplets of formula on it. Nurse #3 did not clean the syringe or plunger On 10/5/11 at 4:30 PM Nurse #3 stated that she had never cleaned the syringe after using it but " if I dropped it I would wash it. " The nurse went on to explain that since the syringe was replaced by third shift with a new syringe every 24 hours, there was no need to do additional cleaning. In an interview with Administrative Nurse #4 on 10/5/11 at 5 PM, she indicated that since the syringe was used to flush the g-tube with water there was no need to clean the syringe unless there was visible formula still on the syringe.	F 441		

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

PRINTED: 11/07/
FORM APPRO
OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 018 5S=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is 12/17/2011. 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 018 The corridor doors to residents' rooms 122, 206, 215, 228, 234, and the corridor door to the employee lounge have been adjusted to close, latch and seal. All corridor doors will be checked by the Maintenance Director to ensure compliance. Repairs/adjustments will be made as identified. The Director of Maintenance has received one to one counseling/education on the requirements by the Administrator on 11/15/2011.	12-17-20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/16/11

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 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) The corridor doors to the resident rooms 122, 206, 215, 228, 234 and employee lounge did not close, latch and seal. 42 CFR 483.70(a)	K 018	The Director of Maintenance will check all corridor doors weekly to ensure compliance with the regulation. All variances will be corrected at the time of observation. Monitoring results will be reported to the Administrator and to the Quality Assurance committee during the monthly meeting. Continued compliance will be monitored through the facility's preventative maintenance, fire safety and quality assurance programs.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When	K 029	K 029 The laundry room corridor door and the door separating the soiled holding room and laundry room have been adjusted to close, latch and seal.	12/17/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/16/11

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K 029	Continued From page 1 the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) The Laundry room corridor door did not close, latch and seal and the door seperating the soiled holding room and laundry room did not close and latch. 2) The dry storage room in the kitchen has two doors, one towards the front of the kitchen would not close, latch and seal, (strike plate taped over) and the rear door was not self closing. 3) The house keeping closet on 100 Hall corridor door did not close latch and seal. 4) The boiler room located on the service hall had the following defficiencies a) Fire dampers were tripped and did not close due to condition of units and/or foregn material accumilated around the units b) The area around the combustion air inlets at the ceiling were not sealed in order to maintain the required rating of the area. c) There are holes and/or penetrations in the walls and ceiling that were not sealed in order to maintain the required fire resistance rating of the area.	K 029	The tape has been removed from the kitchen's front dry storage door, and the rear door has been adjusted. Both doors now close, latch and seal. The Dietary Staff will be provided additional education by the Maintenance Director/designee relating to not taping doors that are required to close, latch and seal. The corridor door to the housekeeping closet on 100 Hall has been adjusted to close, seal and latch. The fire dampers will be cleaned and/or repaired to allow closing when tripped. The area around the combustion air inlets, and the penetrations in the walls and ceiling will be filled and/or sealed with approved fire rated material. The Director of Maintenance has received one to one counseling/eduoation by the Administrator on 11/15/2011 relating to the requirements of the regulation.	

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K 029	Continued From page 2 42 CFR 483.70(a)	K 029	The Director of Maintenance will monitor weekly all corridor and fire doors to ensure proper closure, latching and seal and ensure the fire dampers are free of debris and close when tripped. Adjustments will be made as identified. The Maintenance Director will monitor all outside contractors to ensure any penetrations in the fire walls are sealed upon completion of any work. Concerns will be reported to the Administrator and to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through the facility's preventative maintenance, fire safety and quality assurance programs.	

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K 029	Continued From page 2 42 CFR 483.70(a)	K 029		
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: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) When testing the fire alarm system the magnetic holders for the cross corridor smoke doors and the magnetic locks for the exit doors would re-engage when when the fire alarm notification devices were silenced.	K 052	K 052 The fire alarm system was serviced by Eagle Fire Inc. to allow the magnetic locks for the exit doors to remain disengaged when the fire alarm notification devices were silenced. The fire alarm system will continue to be inspected through routine scheduled maintenance checks by the outside fire system contractor. The Director of Maintenance or designee will monitor the magnetic locks for the exit doors to disengage when the fire alarm notification devices are silenced during the monthly fire drills. The Administrator and 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.	12-17-11
K 056 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056	K 056 The yellow sprinkler heads in the Laundry room (Soiled side and clean side), soiled holding room, kitchen, HVAC room (100 hall), housekeeping closet (100 hall), and maintenance office by laundry have been replaced with the red sprinkler heads by Eagle Fire.	1-17-12

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K 056	Continued From page 3 Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) There are sprinkler heads in the facility rated for Intermediate Temperature Classification, Glass Bulb Color of Yellow temperature rating of (175°F) in place of Ordinary Temperature Classification, Glass Bulb Color of Red (155°F). Areas were the Yellow (175°F) heads were found in the following; a) Laundry Room (Soiled and clean side), b) Soiled holding room, c) Kitchen, d) HVAC room, 100 Hall e) House keeping closet 100 Hall f) maintenance office by laundry 42 CFR 483.70(a)	K 056	No other sprinkler head bulbs needing replacement were identified. The Director of Maintenance has received one to one education on the requirements by the Administrator. The Director of Maintenance will ensure that any new installations or replacements of sprinkler heads are equipped with the correct temperature classification bulb colors. Continued compliance will be monitored through the facility's preventative maintenance, fire safety and quality assurance programs.	
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1	K 061	K 061 The accelerator line to the dry side of the sprinkler riser has two valves that are now monitored by an electronically supervised tamper alarm that sounds locally when the valves close.	12-17-11

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K 081	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) The accelerator line to the dry side of the sprinkler riser has two valves (one on both sides of the accelerator) that when closed will affect the operation of the system and are not equipped with an electronically supervised tamper alarm.	K 081	The accelerator line will be monitored through routine scheduled maintenance checks by the outside contractor and the Maintenance Director to ensure the system remains functional when the valves are closed. Any variances will be corrected. Concerns will be reported to the Administrator and to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through the facility's preventative maintenance, fire safety and quality assurance programs.	

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K 061	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) The accelerator line to the dry side of the sprinkler riser has two valves (one on both sides of the accelerator) that when closed will affect the operation of the system and are not equipped with an electronically supervised tamper alarm. 42 CFR 483.70(a)	K 061		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) Throughout the facility in the resident's bathrooms the ceiling radiation dampers were not maintained clean and in good condition. There was an excessive amount of lint and dust accumulated on the units. 2) Fire dampers in the following areas were found to have broken linkage and failed to close. a) Rehab director office b) ceiling in corridor outside resident room 208 NFPA 90A, 3-4.6 Damper Closure. 3-4.7	K 067	K 067 The radiation dampers in resident bathrooms have been cleaned and are free from lint and dust. The fire dampers in then rehab office and ceiling in the corridor outside resident room 208 have had the fusible linkage replaced and are properly shutting. All fire dampers in the facility have had the fusible links removed and have been tested to show that they properly close. The Director of Maintenance has received one to one education by the Administrator on the Preventative Maintenance Policies and the requirements.	12-17-11

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K 067	Continued From page 5 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. 42 CFR 483.70(a)	K 067	The Director of Maintenance will ensure the ceiling radiation dampers in the resident's bathrooms are free of lint and dust weekly. Any variances will be corrected. Monitoring results will be reported to the Administrator weekly for the next (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting. The Director of Maintenance will ensure the fusible links in he fire dampers are removed, and all fire dampers tested to ensure they close, latch and are lubricated every (4) four years. Records of maintenance for the fire dampers will be retained by the Maintenance Director. Continued compliance will be monitored through the facility's preventative maintenance, fire safety and quality assurance programs.	

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K 067	Continued From page 5 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. 42 CFR 483.70(a)	K 067		
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) A soiled linen tub/cart with a capacity greater than 32 gallons was left unattended in the corridor outside resident room 122. 42 CFR 483.70(a)	K 075	K 075 The laundry aides, housekeepers and nursing assistants will be reeducated by the Director of Nurses/designee relating to not leaving a soiled linen cart of 32 gallons or more unattended in the corridors. The Housekeeping/Laundry Supervisor will monitor the location of the soiled linen containers in the corridors (3) three times a week for (4) four weeks then randomly thereafter to ensure on-going compliance. Variances will be corrected at the time of observation. Monitoring results will be reported to the Director of Nurses weekly for the next (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through routine facility round observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	12-17-11

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	345389	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/02/2011

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 076	Continued From page 6 (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) The oxygen storage room located at the 200 Hall nurse station had the following; a) An unsecured oxygen cylinder, b) Full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4- 3.5.2.2b(2)] (oxygen storage near the nurses station) 42 CFR 483.70(a)	K 076	K 076 The identified oxygen cylinder was secured. Appropriate signage designating full and empty cylinders has been placed in the oxygen storage room. All nursing and therapy staff will be re-educated by the Director of Nurses/designee on the need to secure oxygen cylinders at all times, the requirement for storing full and empty cylinders in their designated areas, and marking empty cylinders with an "empty" tag identification. The Director of Nursing and designees will monitor the oxygen storage rooms (5) five times a week for the next (2) two weeks then (3) three times a week for (2) two weeks then randomly thereafter to ensure compliance. Variances will be corrected at the time of observation. Monitoring results will be reported to the Administrator weekly for the next (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through routine observations of the oxygen storage rooms and through the facility's preventative maintenance and quality assurance programs. Additional education/administrative action and or monitoring will be initiated for any identified concerns.	12-17-11

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K 076	Continued From page 6 (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) The oxygen storage room located at the 200 Hall nurse station had the following; a) An unsecured oxygen cylinder, b) Full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4- 3.5.2.2b(2)] (oxygen storage near the nurses station) 42 CFR 483.70(a)	K 076	K 076 The identified oxygen cylinder was secured. Appropriate signage designating full and empty cylinders has been placed in the oxygen storage room. All nursing and therapy staff will be re-educated by the Director of Nurses/designee on the need to secure oxygen cylinders at all times, the requirement for storing full and empty cylinders in their designated areas, and marking empty cylinders with an "empty" tag identification. The Director of Nursing and designees will monitor the oxygen storage rooms (5) five times a week for the next (2) two weeks then (3) three times a week for (2) two weeks then randomly thereafter to ensure compliance. Variances will be corrected at the time of observation. Monitoring results will be reported to the Administrator weekly for the next (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through routine observations of the oxygen storage rooms and through the facility's preventative maintenance and quality assurance programs. Additional education/administrative action and or monitoring will be initiated for any identified concerns.	12-17-11

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K 078	Continued From page 6 (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) The oxygen storage room located at the 200 Hall nurse station had the following; a) An unsecured oxygen cylinder, b) Full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4- 3.5.2.2b(2)] (oxygen storage near the nurses station) 42 CFR 483.70(a)	K 078		
K 144 SS=D	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	K 144 A load bank test has been completed. The monthly load test will be conducted for 30 minutes under 30% of the EPS nameplate rating or the minimum exhaust gas temperature as recommended by the manufacturer and documented on the monthly generator log.	12-17-11

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K 144	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) Documentation for monthly load test was conducted without recording percent rated load or temperature rise. A load bank test had not been completed within the past year. NFPA 99 3-4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes,	K 144	The Director of Maintenance has received one on one counseling/education on the required documentation by the Administrator. The Administrator will review the generator log monthly for the next (3) three months to ensure appropriate documentation. Variances will be corrected as identified and concerns will be reported to the quality assurance committee. Continued compliance will be monitored through random review of the generator log by the administrator and through the facility's preventative maintenance and quality assurance programs. Additional education and monitoring will be initiated for any identified concerns.	

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K 144	Continued From page 8 followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. (load bank testing) 42 CFR 483.70(a)	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation on Wednesday 11/2/11 at approximately 8:30 AM onward the following was noted: 1) Broken receptacles were found in the following areas; a) Laundry room both clean and soiled side, b) Resident rooms 134, 237 along corridor wall. c) The electrical panel located by the 200 hall nurse station was blocked with a cart. (Three foot clearance in front of panel was not maintained). 42 CFR 483.70(a)	K 147	K 147 The broken receptacles have been replaced in the laundry room on both clean and soiled sides, resident room 134, and along the corridor wall near room 237. The electrical panel located on 200 hall nurse station is free and clear of carts. The Director of Maintenance has received one on one counseling/education on broken receptacles and 3 foot clearance from electrical panels. All Staff will be provided additional education relating to not blocking the electrical panels and the process for completing maintenance requests for equipment in need of repair by the Director of Maintenance/designee. The Director of Maintenance will monitor clearance for the electrical panels (3) three times a week for next (4) four weeks. Variances will be corrected at the time of observation.	12-17-11

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			Repairs will be monitored through review of the facility maintenance requests and routine facility round observations. Concerns will be reported to the Administrator and to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through the facility's preventative maintenance and quality assurance programs. Additional education and monitoring will be initiated for any identified concerns.	