### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

PRINTED: 09/11/2012 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345421	B. WNG_		C 08/18/2012
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 000 F 371 SS=E	No deficiencies wei complaint investigat ID# JB1L11). 483.35(i) FOOD PR	re cited as a result of the ion survey of 8/18/12. Event	F 000	The Laurels of Chatham whave this submitted plan of stand as its written allegation compliance. Our alleged cois September 11, 2012.	correction on of mpliance
	considered satisfact authorities; and	m sources approved or ory by Federal, State or local listribute and serve food itions		Preparation and/or execution plan of correction does not admission to, nor agreemen either the existence of or the severity of any of the cited deficiencies, or conclusions the statement of deficiencies plan is prepared and/or exercise ensure continuing complian regulatory requirements.	constitute t with, e scope and set forth in This cuted to
	by: Based upon observe facility failed to main beverages including	T is not met as evidenced ations and staff interview the tain the temperatures of milk, at or below 41 degrees y line and for service in the		F 371 Food Procure, Store/Prepare/Serve-Sanitar  Corrective Action The gallon jug of chocolate m found to be 46 degrees, was re with a new one from the refrig was added to the juices.	ilk, when Sept 11, placed
	manager with a calib Individually poured g and juices had been held in compartments that was in close propersonnel working in beverages from the coeverages to put on i	hecked by the dietary		Corrective Action for those I potential to be affected The other milk products were at the time of the survey, by th manager. No other milk product found to be above 41 degrees, added to the bin to further cool juices.	reviewed e dietary ct was Ice was

Any deficiency state 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.

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

Event ID: JB1L11

Facility ID: 923099

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		345421	B. WN	-			C 8/2012
	ROVIDER OR SUPPLIER			72	EET ADDRESS, CITY, STATE, ZIP CODE 2 CHATHAM BUSINESS PARK ITTSBORO, NG 27312		012012
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFESTION (FOR THE APPROFESTION OF THE	D BE	(X6) COMPLETION DATE
	from the top tray by the degrees.  On 8/15/2012 at 11:50 taken of beverages or room adjacent to the lachocolate milk, sitting degrees. The other justame cart. The regulategrees, the apple juit honey-thick cranberry.  During an interview or the dietary manager in at or below 41 degrees 483.60(b), (d), (e) DRI LABEL/STORE DRUCT The facility must empleated alicensed pharmacist of records of receipt a controlled drugs in suffaccurate reconciliation records are in order are controlled drugs is main reconciled.  Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the exapplicable.  In accordance with Stafacility must store all dilocked compartments to the stafacility must store all dilocked compartments.	a AM, temperatures were a cart in the main dining kitchen. A gallon jug of in a tray with ice was 46 ices were in pitchers on the ar cranberry julce was 52 ce was 55 degrees and the julce was 74 degrees.  a 8/15/2012 at 11:54 AM, adicated the milk should be a Fahrenheit.  UG RECORDS, GS & BIOLOGICALS  by or obtain the services of who establishes a system and disposition of all ficient detail to enable an account of all intained and periodically  used in the facility must be with currently accepted, and include the and cautionary spiration date when		371	Systemic Changes The dietary employees have been educated on the process of temper monitoring. An insulated cooling been purchased, that is placed in freezer to cool, prior to placing it milks, and juices. At the tray line, have been moved away from the area. In addition, ice is being place the juices, as well as around the distribution of the juices, as well as around the distribution of the juices, as well as around the distribution of the juices, as well as around the distribution of the juices, as well as around the distribution of the juices, as well as around the distribution of the juices, as well as around the distribution of the juices, as well as around the distribution of the juices, as well as around the distribution of the juices, as well as around the distribution of the juices, as well as around the distribution of the juices. Monitoring to months, to observe for compliance temperature monitoring. Any bever found above the required temperature will be cooled, and any milk produced will be provided as necessary.  The QA committee will review find during the monthly QA committee meeting x 2 months or until resolvementing the monthly QA committee meeting x 2 months or until resolvementing the monthly QA committee additional education being provide indicated.  Continued compliance will be monthrough routine temperature monitor and through the facility's quality	rature bin has the e, , juices oven ed into rinks.  col, that lining etary y for 1 c 2 e of erages tures acts eation ed to with ed if	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE S	
		345421	B. WING			ng.	C /18/2012
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	have access to the keep the facility must proving permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when the package drug distribution quantity stored is minimal be readily detected.  This REQUIREMENT by:  Based on record revision for 1 of 7 medication for 1 of 7 medication for 1 of 7 medication of 1 of 7 medication cart is locked at all time not within you constant medication cart in the between med passes.  Observations on 8/14/medication cart unlock rooms 801 and 803. To cart was protruding, in was unlocked. Two results after the province of the passes of t	ide separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and not other drugs subject to the facility uses single unit ation systems in which the simal and a missing dose can lis not met as evidenced ew, observations and staff, the facility staff failed cart, leaving it unattended carts.  Policy and procedure for "tion" revised 07/09 sure that the medication es when it is not in use or to vision. Store the appropriate storage area "  12 at 2:01 PM revealed the ed and parked between the lock on the medication cart sidents were in the hallway used was sitting next to the	F	131	assurance program. Additional ed and monitoring will be initiated for identified concerns.  F431 Drug Records, Label/Store Drugs & Biologicals  Corrective Action The medication cart was locked by unit manager when she saw that it unlocked. The identified nurse wa provided additional education by to manager/designee relating to locki medication cart when it is not with sight of the nurse.  Corrective Action for those having potential to be affected. At the time of the survey, all of the medication carts were reviewed by Director of Nurses and/or her unit managers,. No other carts were found be unlocked.  Systemic Changes The pharmacy, after being contacted during the survey, came to the faciliand programmed all of the medicate carts to lock automatically. The Lick Nursing staff has been re-educated the Director of Nurses, to keep	y the was s the unit ing the nin the the unit to ed lity ions censed	septil

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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NAME OF D	70/4075 OD GUDSUES	345421				08/	18/2012
	ROVIDER OR SUPPLIER			7	EET ADDRESS, CITY, STATE, ZIP CODE 2 CHATHAM BUSINESS PARK ITTSBORO, NC 27312		
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F 431	medication. (the med passed) At 2:14 PM and locked the medical Interview on 8/14/12 at Manager revealed that nurses never walk away that was not locked.  Interview on 8/14/12 at medication nurse revermedication cart three to continued that she may she did not remember medication cart.  Interview on 8/14/12 at Interview on 8/14/12 at	ications had already been the Unit Manager walked by ation cart.  It 2:14 PM with the Unit ther expectation was that ay from a medication cart  It 2:20 PM with the aled that she checked her imes before she left it. She y have answered an alarm.	F	431	medication carts locked and storthe hall when not in use.  Monitoring The Director of Nurses and/or he designee will randomly check medication carts to ensure the casecurely locked daily for three wand then weekly for one quarter, utilizing a monitoring tool. Nurse be re-educated as necessary.  The QA committee will review f during the monthly QA committe meeting x 2 months or until resolmonitor for on-going compliance additional education being provided indicated.  Continued compliance will be methrough routine medication cart observations and through the faci quality assurance program. Additeducation and monitoring will be initiated for any identified concer	er  arts are veeks, es will  indings ee lved to e with ded if  onitored  lity's ional	

PRINTED: 09/10/2012 RTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 ERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 B. WING 09/06/2012 345421 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK THE LAURELS OF CHATHAM PITTSBORO, NC 27312 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** The Laurels of Chatham wishes to K 000 K 000 INITIAL COMMENTS have this submitted plan of correction stand as its written allegation of This Life Safety Code(LSC) survey was compliance. Our alleged compliance conducted as per The Code of Federal Register is September 19th, 2012 at 42CFR 483,70(a); using the Existing Health Care section of the LSC and its referenced Preparation and/or execution of this publications. This building is Type III construction, plan of correction does not constitute one story, with a complete automatic sprinkler admission to, nor agreement with, system. either the existence of or the scope and severity of any of the cited The deficiencies determined during the survey deficiencies, or conclusions set forth in are as follows: the statement of deficiencies. This K 012 NFPA 101 LIFE SAFETY CODE STANDARD K 012 plan is prepared and/or executed to SS=D ensure continuing compliance with Building construction type and height meets one regulatory requirements. of the following, 19.1.6.2, 19.1.6.3, 19.1.6.4, 19,3,5,1 K 012 Life Safety Code Standard 0/17/12 Corrective Action The penetration in the wall/ceiling of ATS#2 has been sealed with the proper This STANDARD is not met as evidenced by: fire stop sealant. 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon Corrective Action for those having the the following building construction type was potential to be affected. non-compliant, specific findings include; the All other areas of possible penetration penetration in the wall/ceiling of ATS#2 does not have been checked by the Director of meet the required fire resistance rating. Maintenance. No other areas have been K 038 NFPA 101 LIFE SAFETY CODE STANDARD K 038 identified to require sealant. SS≂D Exit access is arranged so that exits are readily Systemic Changes accessible at all times in accordance with section The Director of Maintenance will inspect 7.1. 19.2.1 areas that have been serviced by outside vendors, as they complete their work, to determine if all penetrations have been This STANDARD is not met as evidenced by: (X6) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk to denote 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.

If continuation sheet Page 1 of 2

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(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 B. WING 345421 09/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK THE LAURELS OF CHATHAM PITTSBORO, NC 27312 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DESIGIENCY K 000 INITIAL COMMENTS K 000 filled. In addition, the Director of Maintenance will on a semi-annual basis, This Life Safety Code(LSC) survey was review all areas of penetration, for conducted as per The Code of Federal Register proper sealant. at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced Monitoring publications. This building is Type III construction, The Director of Maintenance will check one story, with a complete automatic sprinkler the areas of penetration, monthly times system. three months, and then semi-annually thereafter, to confirm compliance. The deficiencies determined during the survey Continued compliance will be monitored are as follows: through the facility's preventative NFPA 101 LIFE SAFETY CODE STANDARD K 012 K 012 maintenance and quality assurance SS=D programs. The Administrator will be Building construction type and height meets one responsible to act upon any of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, recommendations coming from the 19.3.5.1 committee. K 038 Life Safety Code Standard 9/17/12 Corrective Action This STANDARD is not met as evidenced by: The throw bolts were removed at the 42 CFR 483.70(a) time of survey. By observation on 9/6/12 at approximately noon the following building construction type was Corrective Action for those having the non-compliant, specific findings include; the potential to be affected. penetration in the wall/ceiling of ATS#2 does not All other doors were checked by the meet the required fire resistance rating. Director of Maintenance and K 038 K 038 NFPA 101 LIFE SAFETY CODE STANDARD Administrator. No other doors were SS=D found to have throw bolts on them. Exit access is arranged so that exits are readily accessible at all times in accordance with section Systemic Changes 7.1. 19.2.1 The Director of Maintenance has been re-educated regarding allowable locking mechanisms. As this door was the only door with throw bolts, this door has had This STANDARD is not met as evidenced by: (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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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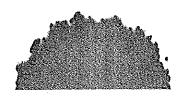
NAME OF PROVIDER OR SUPPLIER  THE LAURELS OF CHATHAM  (XA) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  K 038  Continued From page 1  42 CFR 483.70(a)  By observation on 9/6/12 at approximately noon the following exit access was non-compliant, specific findings include; throw bolls on the exit egress door from the Alzheimer's courtyard into the building. The courtyard area requires two means of egress. This item was removed during the survey.  K 052  SS=F  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  A BUILDING 01 - MAIN BUILDING 01  B. WING  O1 - MAIN BUILDING 01  B. WING  O1 - MAIN BUILDING 01  PREFIX TAG D1 - MAIN BUILDING 01  STREET ADDRESS, CITY, STATE, ZIP CODE TAGNES PARK PITTSBORO, NC 27312  TO STREET ADDRESS, CITY, STATE, ZIP CODE TAGNES PARK PITTSBORO, NC 27312  TO STREET ADDRESS, CITY, STATE, ZIP CODE TAGNES PARK PITTSBORO, NC 27312  TO STREET ADDRESS, CITY, STATE, ZIP CODE TAGNES PARK PITTSBORO, NC 27312  TO SUMMARY STATEMENT OF DEFICIENCY  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECT			A WEDICAID SERVICES	(Y2) I	U II TH	PLE CONSTRUCTION	(X3) DATE SU	JRVEY
THE LAURELS OF CHATHAM  SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR Is C IDENTIFYING INFORMATION)  K 038  Continued From page 1 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following exit access was non-compliant, specific findings include; throw bolts on the exit agrees door from the Alzheimer's courtyard into the building. The courtyard area requires two means of egrees. This item was removed during the survey.  K 052  SS=F  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.  This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following fire learns system was non-compliant, specific findings include; troop of from 6/7/12 from Eagle Fire indicated six (6) items that have not been corrected.  This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following fire learns yestem was non-compliant, specific findings include; report from 6/7/12 from Eagle Fire indicated six (6) items that have not been corrected.	STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			COMPLE	TED
THE LAURELS OF CHATHAM  THE LAURELS OF CHATHAM  THE LAURELS OF CHATHAM  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ROBERT TAG  K 038  Continued From page 1 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following exit access was non-compliant, specific findings include; throw bolls on the exit-egress door from the Alzheimer's courtyard into the building. The courtyard area requires two means of egress. This item was removed during the survey.  K 052 S8=F  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.  This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following fire alarm system was non-compliant, specific findings include; report from 6/7/12 from Eagle Fire indicated six (6) lems that have not been corrected.  The fire alarm panel is in the process of being replaced. The duct detectors noted in item 4 have been repaired. The other 5 items on the list will be addressed with the new alarm panel is replaced, the remaining items on the list will have been corrected. The realarm panel is replaced, the remaining items on the list will have been corrected. The realarm panel is replaced, the remaining items on the list will have been corrected. The fire alarm panel is replaced, the remaining items on the list will have been corrected. The fire alarm panel is replaced, the remaining items on the list will have been corrected. The fire alarm panel is replaced, the remaining items on the list will have been corrected. The dater of the alarm panel is replaced, the remaining items on the list will have been corrected. The fire alarm panel is replaced, the remaining items on the list will have been corrected. The fire alarm panel is replaced, the remainin			345421	B. WII	NG		09/0	6/2012
K 038   Continued From page 1   A2 CFR 483.70(a)   By observation on 9/6/12 at approximately noon the following exit access was non-compliant, specific findings include; throw bolts on the exit egress door from the Alzheimer's courtyard into the building. The courtyard area requires two means of egress. This item was removed during the survey.  K 052   NFPA 101 LIFE SAFETY CODE STANDARD   A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4  This STANDARD is not met as evidenced by: 42 CFR 483.70(a)   By observation on 9/6/12 at approximately noon the following fire alarm system was non-complaint, specific findings include; report from 6/7/12 from Eagle Fire indicated six (6) items that have not been corrected.					7:	2 CHATHAM BUSINESS PARK		
42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following exit access was non-compliant, specific findings include; throw bolts on the exit egress door from the Alzheimer's courtyard into the bullding. The courtyard area requires two means of egress. This item was removed during the survey.  K 052 SS=F 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.  This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following fire alarm system was non-compliant, specific findings include; report from 67/12 from Eagle Fire indicated six (6) items that have not been corrected.  **This STANDARD**  This STANDARD is not met as evidenced by: 42 CFR 483.70(a) Conform to all other doors in the facility.  MonItoring The Director of Maintenance will check all doors monthly, for two months, to confirm to all other doors in the facility.  MonItoring The Director of Maintenance will check all doors monthly, for two months, to confirm to all other doors in the facility.  MonItoring The Director of Maintenance will check all doors monthly, for two months, to confirm to all other doors in the facility.  MonItoring The Director of Maintenance will check all doors monthly, for two months, to confirm to all other doors in the facility.  MonItoring The Director of Maintenance will be monitored through the facility's preventative maintenance and quality assurance programs.  The Administrator will be responsible to act upon any recommendations coming from the committee.  Corrective Action The fire alarm panel is in the process of being replaced. The duet detectors noted in item 4 have been repaired. The other 5 items on the list will be addressed with the new alarm panel is in the process of being replaced. The duet detectors noted in item 4 have been repaire	PREFIX	/FACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	
	K 052	42 CFR 483.70(a) By observation on the following exit as specific findings indegress door from the building. The omeans of egress. The survey. NFPA 101 LIFE SAAA fire alarm system installed, tested, as with NFPA 70 Natio 72. The system has and testing program requirements of NF  This STANDARD 42 CFR 483.70(a) By observation on the following fire all non-compliant, specific from 6/7/12 from E	9/6/12 at approximately noon occess was non-compliant, clude; throw bolts on the exit he Alzheimer's courtyard into courtyard area requires two this item was removed during AFETY CODE STANDARD in required for life safety is not maintained in accordance on a proved maintenance in complying with applicable FPA 70 and 72. 9.6.1.4		•	conform to all other doors in the  Monitoring The Director of Maintenance wi all doors monthly, for two mont confirm compliance. Continue compliance will be monitored the the facility's preventative mainte and quality assurance programs. The Administrator will be respo act upon any recommendations from the committee.  K 052 Life Safety Code Standa  Corrective Action The fire alarm panel is in the pro being replaced. The duct detecto in item 4 have been repaired. Th items on the list will be addresse the new alarm panel is in the pro being replaced. The duct detecto in item 4 have been repaired. Th items on the list will be addresse the new alarm panel.  Systemic Changes Once the fire alarm panel is repla remaining items on the list will h been corrected. The fire alarm co	e facility.  ill check hs, to d nrough enance nsible to coming  ard  occess of ors noted e other 5 ed with  ving the occess of ors noted e other 5 d with	12-19-12 Requester Doubler Days



Event ID: JB1L21

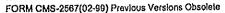
Facility ID: 923099

If continuation sheet Page 2 of 2



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(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 A. BUILDING B. WING 09/06/2012 345421 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 72 CHATHAM BUSINESS PARK THE LAURELS OF CHATHAM PITTSBORO, NC 27312 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 038 K 038 Continued From page 1 and identify any items that need repair. 42 CFR 483.70(a) The Director of Maintenance will ensure By observation on 9/6/12 at approximately noon that the repairs take place and will report the following exit access was non-compliant, as such to the Administrator. specific findings include; throw bolts on the exit egress door from the Alzheimer's courtyard into Monitoring the building. The courtyard area requires two The Director of Maintenance will test the means of egress. This item was removed during alarm system weekly for one month and the survey. monthly for two months to confirm NFPA 101 LIFE SAFETY CODE STANDARD K 052 K 052 compliance of new system, when in place. The alarm company will review SS=F A fire alarm system required for life safety is system as scheduled and at least installed, tested, and maintained in accordance quarterly. Continued compliance will be with NFPA 70 National Electrical Code and NFPA monitored through the facility's 72. The system has an approved maintenance preventative maintenance and quality and testing program complying with applicable assurance programs. requirements of NFPA 70 and 72. 9.6.1.4 The Administrator will be responsible to act upon any recommendations coming from the committee. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following fire alarm system was non-compliant, specific findings include; report from 6/7/12 from Eagle Fire indicated six (6) items that have not been corrected.









PRINTED: 09/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION  G 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
		345421	B. Wil	∤G		09/0	06/2012
	ROVIDER OR SUPPLIER	l.		72	EET ADDRESS, CITY, STATE, ZIP CODE CCHATHAM BUSINESS PARK ITTSBORO, NC 27312		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPLETION DATE
K 038	the following exit as specific findings indegress door from the building. The comeans of egress. In the survey.  NFPA 101 LIFE SA  A fire alarm system installed, tested, an with NFPA 70 Nation 72. The system has	9/6/12 at approximately noon ceess was non-compliant, clude; throw bolts on the exit ne Alzheimer's courtyard into courtyard area requires two This item was removed during AFETY CODE STANDARD a required for life safety is not maintained in accordance and Electrical Code and NFPA is an approved maintenance in complying with applicable		052	a special lock system installed, conform to all other doors in the Monitoring The Director of Maintenance wall doors monthly, for two more confirm compliance. Continue compliance will be monitored to the facility's preventative mains and quality assurance programs. The Administrator will be respect upon any recommendations from the committee.  K 052 Life Safety Code Stand Corrective Action The fire alarm panel is in the probeing replaced. The duct detection item 4 have been repaired. The items on the list will be addresse the new alarm panel.	rill check ths, to ed hrough enance consible to coming ard occess of ors noted ne other 5	12-19-1 Requester Wourer Boo
	42 CFR 483.70(a) By observation on the following fire all non-compliant, spe	2/6/12 at approximately noon arm system was cific findings include; report agle Fire indicated six (6)			Corrective Action for those had potential to be affected. The fire alarm panel is in the probeing replaced. The duct detected in item 4 have been repaired. The items on the list will be addressed the new alarm panel.  Systemic Changes Once the fire alarm panel is replacementaring items on the list will be been corrected. The fire alarm cowill continue to make quarterly will be addressed to the continue to make quarterly will be addressed to the continue to make quarterly will be addressed to the continue to make quarterly will be addressed to the continue to make quarterly will be addressed to the continue to make quarterly will be addressed to the continue to make quarterly will be addressed to the continue	ocess of ors noted e other 5 d with	



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STATEM AND PL	IENT	. OI	DEFIC	IENCIES
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

345421

B. WING

09/06/2012

NAME OF PROVIDER OR SUPPLIER

#### THE LAURELS OF CHATHAM

STREET ADDRESS, CITY, STATE, ZIP CODE 72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

	42 CFR 483.70(a) By observation on 9/6/12 at approximately noon	ID PREFIX TAG K 038	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	(X5) COMPLETION DATE
	42 CFR 483.70(a) By observation on 9/6/12 at approximately noon	K 038	and identify any teams that and noneth	
K 052 SS=F	the following exit access was non-compliant, specific findings include; throw bolts on the exit egress door from the Alzheimer's courtyard into the building. The courtyard area requires two means of egress. This item was removed during the survey.  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	K 052	and identify any items that need repair. The Director of Maintenance will ensure that the repairs take place and will report as such to the Administrator.  Monitoring The Director of Maintenance will test the alarm system weekly for one month and monthly for two months to confirm compliance of new system, when in place. The alarm company will review system as scheduled and at least quarterly. Continued compliance will be monitored through the facility's preventative maintenance and quality assurance programs. The Administrator will be responsible to act upon any recommendations coming from the committee.	
	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/6/12 at approximately noon the following fire alarm system was non-compliant, specific findings include; report from 6/7/12 from Eagle Fire indicated six (6) items that have not been corrected.			

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

Event ID: JB1L21

Facility ID: 923099

If continuation sheet Page 2 of 2

