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 _____	C 11/28/2012

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

(X4) ID PREFIX 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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	*The Laurels of Forest Glenn requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is 12-26-2012.* *Preparation and/or execution of this plan of correction do not constitute admission to nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.* F156 Current residents and new admissions have the potential to be affected. The Division of Health Services Regulation's contact phone number and mailing address is posted in the front lobby. The	12-26-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1-7-13

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 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's	F 156	correct phone and mailing address for Division Health Services Regulation has been updated in the Resident Handbooks. The Admissions Coordinator and DOM will be in-serviced by the Administrator on the importance of having the correct contact information for Division Health Services Regulation in the Resident handbooks as well as posted in the front lobby by 12-26-12. Resident Handbooks have been reprinted with the new contact information of Division Health Services Regulation. The Admissions Coordinator and/or Administrator will audit 3 Admission Sign-ins for contact information and monitor the posting of contact numbers and addresses weekly x 4 weeks then through review of new admissions thereafter. Variances will be corrected when indicated.	

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F 156	Continued From page 2 policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to post current state contact information. The findings include: On 11/26/12 at 11:18 am, the Administrative Staff #3 was interviewed about the placement of the state contact information. On the bulletin board, in the front lobby, listed the State ' s Complaint Branch contact number, but the address and phone number to the Division Health Services Regulation, was not present. He shared that he was not sure why the information was missing. The Administrative Staff #3 had provided the resident handbook which listed the state agency as The Division of Facility Services and had an address and phone number typed that was not assigned to the state agency.	F 156	Results will be reviewed with the Administrator weekly x 4 weeks and concerns will be reported to the Quality Assurance Committee during the monthly meeting. Continued compliance will be monitored through review of new admission paperwork during the admission process and through the facility's Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns.	

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F 156	Continued From page 3 The Administrative Staff #3 mentioned that he was unsure why the resident handbook wasn ' t updated to reflect the renaming of the state agency, when it changed in 2007; but voiced that he would take of the matter. The Administrative Staff provided new information on 11/26/12 at 2:00 pm that illustrated that the facility posted current state contact information.	F 156		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to keep telephones and call bells within reach of 2 of 14 alert and oriented residents (Resident #225 and #134). The findings include: 1. Resident #225 was admitted to the facility on 11/16/12 with the following diagnoses: lung cancer and mild dementia. The Minimum Data Set (MDS) assessment was not completed due to her admission status; however the nurse ' s notes reflected that she was able to make her needs known.	F 246	F246 The facility immediately placed call lights and room telephones within reach of Residents #225 and #134. All residents able to use their call lights and/or telephones have the potential to be affected. Nurse Aide #2 was in-serviced by the DON on the facility's policy and procedures for call bell and telephone placement. All Nurse aides will be in-serviced by the DON/Staff Development Coordinator on the facility's policy and procedure for call bell and telephone placement, if 100% is not	12-26-12

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F 246	Continued From page 4 On 11/26/12 at 3:00 pm, Resident # 225 sat in a wheelchair in her room, facing her bed, with her privacy curtain pulled. Upon entering the room, she voiced that she wanted to go to bed and had been waiting. When asked if she tried to summon help, she stated yes, but couldn ' t reach her call bell. The call bell cord was noted to be placed on top of the over head bed light box which was approximately six feet off the ground. Next to the call bell, was Resident #225 ' s telephone, which rested on top of the light box as well. The bedside table was located between Resident #225 and her bed, which was placed horizontally up against the wall. The positioning of the table blocked the opportunity to tug on the call bell cord and place it within reach. Resident #225 began to become agitated, displaying a short temperament, stating that she had been waiting to be put back to bed after returning from an activity and just wanted to lie down. On 11/26/12 at 3:07 pm, the Unit Manager #1 was summoned to the room of Resident #225. Nurse Aide #2 followed her into the room. She commented that she had made up Resident #225 ' s bed earlier and forgot to put the call bell and telephone back within reach. They moved her furniture, so that the items could be removed from on top of the light box. The Administrative Staff #1 was interviewed on 11/28/12 at 9:00 am. She stated that her expectation was for staff to place all items within	F 246	achieved due to illness or vacation then staff will be re-educated upon returning back to work. New employees well be educated through orientation. A QA monitoring tool will be utilized to ensure ongoing compliance by the Unit Manager/Administrative Nurses and will observe call bell and telephone placement 3 times a week x 4 weeks then weekly thereafter. Variances will be corrected at the time of observation and additional education and/or administrative action taken when indicated. Observation results will be reported to the DON and concerns will be reported to the Quality Assurance Committee during the monthly meeting. Continued compliance will be monitored through daily round observations by the Unit Managers and through the facility's Quality Assurance Program.	

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F 246	Continued From page 5 reach of residents when they are in and out of bed. She stated no items should be placed on top of the over head bed light box. 2. Resident # 134 re-entered the facility on 2/17/12 with the following diagnoses, peripheral vascular disease and abnormality of gait. On the quarterly MDS dated 8/28/12, she was assessed as cognitively intact and needing extensive assistance for bed mobility and transfers. On 11/26/12 at 3:46 pm, while conducting an interview with Resident #134, who laid in bed, a black phone was observed, with the cord unplugged, wrapped several times around the phone, which was positioned on top of her over head bed light box. Resident #134 stated that she doesn ' t use her phone much, but received calls on it and made calls at time. She stated that it normally sat on her bedside table and that the last time she remembered using the phone was before Thanksgiving (11/22/12). The Administrative Staff #1 was interviewed on 11/28/12 at 9:00 am. She stated that her expectation was for staff to place all items within reach of residents when they are in and out of bed. She stated no items should be placed on top of the over head bed light box. A return visit was made to Resident #134 ' s room on 11/28/12 at 9:05 am. Resident #134 was seated in her wheelchair, to the right of her bed, with her back to the wall. Over the bed light box, her black phone was observed in the same position with the cord unplugged.	F 246		

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F 246	Continued From page 6 Her call bell was clipped to the bed linens on her left side and was not easily seen in her peripheral vision. She attempted to reach the cord, but was not able. She unlocked her wheelchair, moved the chair toward the bed. She had a difficult time moving her left arm, with noticeable grimacing, before she was able after several attempts to unclip the call bell and activate it. Resident #134 stated that her left side was her weak side. Unit Manager #2 entered the room on 11/28/12 at 9:10 am. She removed the phone from the over head light box and plugged it into the wall, placing it within reach of Resident #134. She shared that they can make sure the call bell was positioned to make it easier for Resident #134 to reach.	F 246		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to control odors on 1 of 2 halls. On 11/26/12 at 10:18 am, upon entering Room 130, a strong odor smelling like sewage and sulphur, was detected in the bathroom, which was located near the entrance of the room. Two female residents were present, however, they were not the source of the odor.	F 253	F253 The facility called a plumber on 11/26/2012 and the odor in Room 130 has resolved. All bathrooms and/or sinks that have a drain have the potential to be affected. The Administrator will re-educate the Director of Maintenance and Housekeeping Supervisor on the importance of having odor free rooms by 12-26-12.	12-26-12

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F 253	Continued From page 7 The housekeeper had just completed cleaning the bathroom and was asked about the source of the odor. He pointed to the toilet, left the room, returned with air freshener and began to spray the room. He mentioned that the odor had been on going problem. At 10:20 am, Nurse Aide # 1 was interviewed. She explained that only one of the residents used the bathroom and that the source of the odor had been coming from the toilet. She mentioned that she had reported the problem to maintenance and that there were plans to replace the toilet. Nurse # 3 was interviewed on 11/26/12 at 12:34 pm. She stated that Room 130 bathroom had an odor like sewage and that it had been present for awhile. She stated that the Administrative Staff # 4 had examined the bathroom before but she couldn't determine if there were any equipment changes. On 11/27/12 at 8:51 am, the Administrative Staff #4 was interviewed. He expressed that he didn't know if the sewage odors in Room 130 resulted from the sink or the toilet, but suspected it came from the sink, since the toilet had a good seal on it. He stated that the odors are more persistent when it rained. Yesterday, he had a plumber come out to examine the problem. The recommendation was to change the traps on the sinks on the 100 hall wing. He shared that once he replaced the trap for the sink in Room 130, the odor went away. On 11/28/12 at 1:15 pm, the Administrative Staff #4 stated that no one brought the concern of bathroom odors for Room 130 to his attention	F 253	Director of Maintenance will inspect all resident bathrooms/sinks utilizing a monitoring tool weekly x 4 weeks to ensure they are free of odors. Variances will be corrected as identified and monitoring results will be reviewed with Administrator weekly for the next (4) weeks. All staff will be provided additional education by the Administrator/designee relating to completion of maintenance requests when repair needs are identified. The Administrator will review resolution of maintenance requests weekly to ensure timely follow-up for the next (4) four weeks and monthly thereafter. Concerns will be reported to the quality assurance committee for further recommendations. Continued compliance will be monitored through daily facility round observations by the Maintenance Director and/or	

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

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F 279	Continued From page 9 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a care plan for mood and behaviors for one (1) of ten (10) sampled residents (Resident #101). Findings included: Resident #101 was admitted to the facility 2/6/08. Cumulative diagnoses included: mental retardation and a history of agitation and negative behaviors. A Significant change Minimum Data Set (MDS) dated 8/27/12 indicated Resident #101 had short and long term memory impairment and moderate impairment in decision making. No mood or	F 279	Worker by 12-26-12 to reflect mood and behaviors. All residents who utilize psychotropic medications and/or exhibiting mood and behaviors have the potential to be affected. Social Worker, Social Worker assistant or the Unit Managers will audit all residents that are currently on psychotropic medications and/or exhibiting mood and behaviors to ensure appropriate care planning by 12-26-12. Variances will be corrected as identified by the above designees. The Social Worker was re-educated by the Regional MDS Coordinator on Care Plan requirements pertaining to mood and behaviors by 12-26-12. The MDS Coordinator will review for appropriate care plans utilizing an audit tool during routine scheduled assessments to provide on-going compliance. Results of the review will be reviewed with the Director of Nursing for the next 3 months.	

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F 279	Continued From page 10 behaviors were noted during the assessment period. Medications administered during the observation period included antipsychotic and anxiety medications. A Care Area Assessment for Psychotrophic medications dated 9/7/12 indicated that Resident #101 received Risperdal and Buspar (antipsychotic medications) daily and remained at risk for negative side effects from the medications. He had a history of agitation and negative behaviors. Resident #101 was being seen by psychiatric services. A review of the Abnormal Involuntary Movement Scale (AIMS-a sceening tool to monitor for involuntary movements that are caused by antipsychotic medications) revealed on 9/15/12 Resident #101 had developed minimal movements inthe areas of facial and oral movements and upper extremity movements. with the severity of the movements at a minimal level. Physician orders were reviewed and revealed, in part, the following medications Buspar 7.5 milligrams (mg.) by mouth twice a day (BID), Risperdal 1 mg every evening for psychosis, Cogentin (used to control side effects of Risperdal) 1 mg. twice daily and Depakote sprinkles (a medication that can be used for agitation and aggression in dementia residents) 125 mg. 8 capsules (1000 mg) at bedtime. A psychiatric consult dated 11/2/12 indicated Resident #101 had a history of psychosis with aggressive behaviors which were managed well	F 279	New orders and changes in condition are reviewed by the IDT (Nursing, Therapy, Social Services, Activities and Dietary) during the morning clinical meeting. The Social Worker and designees will ensure that changes in behaviors and/or psychotropic medications are reflected in the care plan for identified residents when indicated. On-going compliance will be monitored through record reviews during the MDS assessment process by the MDS Coordinator and Social Worker, and by the Social Worker during the monthly behavior management meeting (Social Service Director, Activities Director, and Unit Managers), and review of new orders and changes in condition by the Unit Managers during the morning clinical meeting.	

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F 279	Continued From page 11 with the use of Risperdal. Cogentin was used to control the extrapyramidal symptoms and was effective. Continue with treatment plan and obtain Depakote level. Recommend no dosage reduction. Resident #101 was being seen by psychiatric services monthly. A review of Resident #101's care plan revealed there was not a care plan for mood and/or behaviors until 11/27/12. On 11/28/12 at 1:40 PM., MDS nurse #1 stated Resident #101 had never had any mood/ behavior problems or a care plan for mood/ behavior problems. She was not sure why he received the psychotropic medications. She stated the corporate nurse told then yesterday to check some of the charts to see if the mood/ behavior/ psychotropic medications were careplanned and they found Resident #101 did not have a care plan for mood and behaviors so the care plan was started on 11/27/12.	F 279	Continued compliance will be monitored through the facility's Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns.	
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, staff and family interview, the facility failed to administer	F 309	F309 Resident #211's physician was notified on 11/27/2012 by the nurse of the medication omission. Medication orders were verified and the current medication administration record reflects the ordered medications. The resident is receiving his medications as ordered.	12-26-12

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F 309	Continued From page 12 the Bumex (loop diuretic) for 11 days to a resident with a diagnosis of Congestive Heart Failure due to transcription error for 1 (Resident #211) of 3 sampled residents reviewed. The finding includes: Resident #211 was admitted to the facility on 11/13/12 with multiple diagnoses including CHF (Congestive Heart Failure). The admission Minimum Data Set (MDS) assessment dated 11/20/12 indicated that Resident #211's cognitive status was impaired. Review of the nurse's notes dated 11/13/12 indicated that Resident #211 was admitted at 3:00 PM. The nursing admission assessment revealed that the resident was admitted with no edema. The physician notes on the medical history and physical dated 11/15/12 indicated that Resident #211 had no edema. The nurse's notes dated 11/24/12 at 10:36 PM revealed that Resident #211 was yelling and stated that he could not breathe. The oxygen saturation was 88% on room air. The resident was encouraged to relax and oxygen at 2 liters/per minute was applied. The oxygen saturation went up to 92%. The notes further indicated that the physician was called and with orders including chest x-ray due to shortness of breath. The impression on the chest x-ray report dated 11/25/12 read " large right pleural effusion without frank evidence of Congestive Heart Failure " .	F 309	Current residents receiving medications have the potential to be affected. The Unit Managers reviewed all current residents' medication orders by 12-26-12 to ensure accuracy. Any variances were clarified with the physician by 12-26-12. All Licensed Nurses will be provided additional education by the DON/Staff Development Coordinator relating to review of new orders and new admissions and proper order transcription by 12-26-12. New admissions will be reviewed by two nurses utilizing the admission checklist to ensure orders are transcribed correctly and verified when indicated. New admissions are reviewed during the morning clinical meeting (DON, ADON, Unit Managers, Social Services, Rehab Manager, MDS Coordinator, and Administrator). The Unit Managers will monitor all new admissions and new	

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F 309	Continued From page 13 On 11/25/12 at 12:10 PM, the nurse's notes indicated that the physician was informed of the chest x-ray report with orders for Bumex 2 mgs (milligrams) by mouth twice a day and Levaquin (antibiotic) 750 mgs by mouth daily for 7 days. On 11/26/12 at 1:50 PM, Resident #211 was observed up in wheelchair in his room. His legs/feet were swollen and a water blister was noted on his right leg. On 11/26/12 at 1:54 PM, a family member was interviewed. The family member indicated that the resident's legs were swollen and with a big water blister on his right leg because he was not getting his Bumex medication from admission until 11/25/12. The family member stated that the resident was on Bumex because of his chronic CHF. On 11/26/12 at 2:00 PM, the nurse's notes revealed that Resident #211's bilateral lower legs were edematous with some weeping noted. There was also an intact blister measuring 2 x 2 cm (centimeter) noted. Review of the discharge physician medication reconciliation order from the hospital dated 11/13/12 revealed an order for Bumex 1 mgs twice a day. Review of the Medication Administration Record (MAR) for November, 2012 revealed that the Bumex was not transcribed and therefore was not administered to the resident from 11/13 through 11/24/12.	F 309	orders for accurate transcription for the next (4) four weeks. Variances will be promptly corrected. Monitoring results will be reported to the DON weekly by the Unit Managers for the next (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting. On-going compliance will be monitored through review of new admissions and new orders during the morning clinical meeting, review of medication administration records during month end change over, and record reviews during the MDS assessment process. Continued compliance will be monitored through the facility's Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns.	

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F 309	Continued From page 14 On 11/27/12 at 11:50 AM, Unit Manager #1 was interviewed. She stated that she transcribed the medications listed on the FL2 because she did not see the hospital medication reconciliation form. On 11/27/12 at 12:05 PM, administrative staff #1 was interviewed. She stated that normally when there is a new admit resident, the medications were checked against the discharge summary, medication reconciliation form, FL2, or whatever form was available. She acknowledged that the Bumex for Resident #211 was a transcription error on their part. On 11/28/12 at 1:55 PM, UM # 2 was interviewed. She stated that when a resident was admitted, the UM will receive different forms (FL2, discharge summary and medication reconciliation) from the admission coordinator. Then, the UM would compare the medications listed on the different forms and when there were discrepancies, the hospital was called to clarify the orders. On 11/28/12 at 2:03 PM, administrative staff #2 was interviewed. The administrative staff stated that when there was a new admit resident, the hospital/facility sends him a copy of the discharged medication orders via fax. Then, the orders were given to the UM immediately or as soon as possible. The administrative staff was unable to remember the name of the UM but acknowledged that the medication reconciliation form was faxed on 11/13/12 at 11:36 AM to the facility (date/time printed on the form) before Resident #211 was admitted to the facility.	F 309		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		12-26-12

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F 329 SS=D	Continued From page 15 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 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 medical record review and staff interviews, the facility failed to obtain labs that were recommended by physician/pharmacist since June for one (1) of ten (10) sampled residents (Resident #101). Findings included: Resident #101 was admitted to the facility 2/6/08.	F 329	F329 Resident #101's physician was notified by the charge nurse of the lab omission, new orders were obtained and the lab was completed on 11/28/12. No negative outcome resulted from the omission. Unit Manager #2 has been provided additional education by the DON relating to ensuring timely and proper follow up to pharmacy recommendations. Current residents with pharmacy recommendations have the potential to be affected. The Unit Managers and charge nurses will review all pharmacy recommendations for the past (3) three months to ensure physicians have been notified when indicated and follow-up is completed. Variances will be corrected as identified.	

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F 329	Continued From page 16 Cumulative diagnoses included a history of agitation and negative behaviors. A Significant change Minimum Data Set (MDS) dated 8/27/12 indicated Resident #101 had short and long term memory impairment and moderate impairment in decision making. Medications administered during the observation period included antipsychotic and anxiety medications. A Care Area Assessment for Psychotrophic medications dated 9/7/12 indicated that Resident #101 received Risperdal (antipsychotic medication) daily and remained at risk for negative side effects from the medication. Physician orders were reviewed and revealed, in part, the following medications: Risperdal 1 mg every evening for psychosis. A pharmacy consult dated 6/27/12 revealed that there was not a fasting lipid panel noted on the chart and the pharmacist wrote a recommendation for a fasting lipid panel. A pharmacy consult dated 8/28/12 revealed that the physician had agreed to have a fasting lipid panel obtained on the 6/27/12 consult but a physician's order had not been written. The pharmacist recommended a fasting lipid panel be performed. On 11/28/12 at 12:05 PM, the pharmacy consultant stated it was recommended to obtain fasting lipid panels on residents who received antipsychotic medications. She stated the facility received her recommendations within one to two days after her visit. The physicians were notified	F 329	The Director of Nurses will review all pharmacy recommendations for the next (3) three months to ensure recommendations have been addressed and completed utilizing the recommendation follow-up sheets. Variances will be corrected and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through continued review of the monthly pharmacy recommendations, monthly pharmacy consultant visits, and through the facility's Quality Assurance Program. Additional education, monitoring and/or administrative action will be initiated for any identified concerns.	

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F 329	Continued From page 17 by the nursing staff of the pharmacy recommendations. When the physician agreed to the recommendation, the charge nurse would write the physician's order. The pharmacy consultant stated she reviewed the physician responses to her recommendations on her next visit. She stated she had sent the recommendation for Resident #101 to have a fasting lipid panel two times and had spoken to the charge nurse but did not know why it had not been obtained. A review of the medical record revealed there was not an order written for a fasting lipid panel for Resident #101. On 11/28/12 at 1:45 PM, Unit manager #2 stated she thought that the June recommendation had been filed in Resident #101's chart before it had been reviewed and the physician's order had been written. She indicated she did not remember the pharmacy consultant asking about the physician's order for a fasting lipid panel. On 11/28/12.at 4:25 PM., Administrative staff #1 stated the facility tried to obtain physician responses to the pharmacy recommendations within a seven (7) day period form the time they receive the report form the pharmacy consultant. The unit managers would review the physician response to the recommendations and write the physician orders. She stated the fasting lipid panel should have been completed prior to 7/25/12.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334	F334 Resident #101's RP was provided education relating to the	12-26-12

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F 334	Continued From page 18 that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal	F 334	flu vaccine, consent was obtained and the resident received the vaccine on 11/28/2012. All residents residing in the facility during the dates of October 1st through March31st have the potential to be affected. Assistant Director of Nursing/SDC will be re-educated by the Director of Nursing on the facility's policy and procedures on Influenza and Pneumococcal Immunizations by 12-26-12. The Director of Nursing and/or Unit Managers/SDC will audit all Influenza and Pneumococcal immunization records to ensure all residents/RP have been provided education relating to the vaccine. New Admissions will be reviewed by the Unit Managers during the morning Clinical meetings to ensure that the proper education has been provided and that the acceptance or declination of Influenza and Pneumococcal Immunizations has been documented. Variances	

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F 334	Continued From page 19 representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to offer annually 1 of 5 residents (Resident #101) consent and educational material for the influenza vaccine. The findings include: The facility's March, 2010 Flu Vaccine Policy was reviewed. It read that the facility would ask guest (resident)/ family member/ legal representative if the guest wished to receive the flu vaccine annually. If the guest initially declined the flu	F 334	will be corrected as identified and concerns will be reported to the quality assurance committee during the monthly meeting. On-going compliance will be monitored through review of new admissions during the clinical meeting, and annual review of immunization records for long-term residents by the SDC/Unit Managers. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 334	Continued From page 20 vaccine, the vaccine and education on the vaccine should be re-offered on an annual basis. If the guest consents to the vaccine, at the time of each annual administration, provide the guest/family member/ legal representative with education regarding the benefits and potential side effects of the immunization. Resident #101 was admitted to the facility on 2/6/08 and re-admitted to the facility on 8/21/12. His cumulative diagnoses included: hypertension, peripheral neuropathy and scoliosis. On the significant change Minimum Data Set (MDS), dated 8/27/12, he was assessed as having cognitive impairments. A review of his medical chart revealed that the last consent for influenza (flu) vaccine was given on 10/23/10 by the Responsible Party (RP), at which time, the RP declined the vaccine. The chart did not contain any additional consents or educational material offered to the RP. On 11/28/12 at 1:45 pm, Unit Manager 2 shared that the nurse handling immunizations was recently hired and that Resident #101 previously had a history of declining the influenza shot. However, today, they contacted the RP who was verbally given information about the risks and benefits of the flu shot. She reported that once the RP consented to the influenza immunization, the shot was given to Resident #101.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.	F 356	F356 The facility is now accurately and consistently posting the daily staffing and census.	12-26-12

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F 356	Continued From page 21 o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to post daily staffing accurately. The findings include: On 11/25/12 at 2:15 pm, the facility's daily staffing was noted in the lobby, with the most current	F 356	The Assistant Director of Nursing/SDC will be re-educated by the Administrator/DON on accurately posting the daily staffing census in the front lobby. The Director of Nursing and/or SDC will monitor accuracy and posting of the daily staffing and census 3 times weekly/week x 4weeks then 2x/wk thereafter. The week-end manager will monitor week-end postings. Variances will be corrected at the time of observation and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through daily 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 356	Continued From page 22 staffing posted, dated 11/23/12. The census for residents was listed at 124. On 11/25/12 at 3:45 pm, the Administrative Staff #3 provided the Resident Census. There were 112 residents listed in the skilled nursing beds. The home for the aged (HA) beds included 14 residents. The daily staffing, marked 11/26/12 was observed in the lobby on 11/26/12 at 8:00 am. It included residents in the HA beds, with a total resident census listed as 129. The Administrative Staff #3 was interviewed on 11/26/12 at 11:15 am and stated that the HA beds are included in the resident census and that he was unaware that they should be excluded. The daily staffing, marked 11/27/12 was observed in the lobby on 11/27/12 at 8:00 am. It included residents in the HA beds, with a total resident census listed as 129. The Administrative Staffs # 1 and # 7. Both of the employees acknowledged completing the daily posting, however the Administrative Staff #1 said that she normally only does it on weekends, when she worked. She shared that when she came in on 11/25/12 around 5:00 pm, the staffing from 11/23/12 was still hung. She shared that she will ensure that her weekend nursing staffs update the form. The Administrative Staff #7 stated that she completed the staffing weekdays. She shared that she was not aware that she should exclude HA beds from the census and that she needed to	F 356		

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F 356	Continued From page 23 adjust the actual hours for nursing staff who work with the residents in the HA beds. On 11/27/12 at 1:45 pm, the Administrative Staff #1 revealed an modified staffing form, that reduced the staff and actual hours worked on the HA hall and reduced the number of residents, who were previously included from the HA beds.	F 356		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to 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	F 431	F 431 The identified medication vials were discarded on 11/28/2012. The Director of Nursing audited medication rooms and all medication carts during the survey to ensure no other expired medications remained. No other expired medications were noted. All Licensed Nurses will be provided additional education by the DON/SDC relating to dating medication vials upon opening, checking expiration dates, discarding medications upon expiration and separating/returning medications which have been discontinued and/or when a resident is discharged from the facility by 12-26-12, if 100% is not	12-26-12

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 _____	C 11/28/2012

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

(X4) ID PREFIX 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 431	Continued From page 24 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, staff interview and facility policy review, the facility failed to discard outdated Tuberculin PPD (purified protein derivative) in one (Unit 2) of two medication refrigerators, failed to discard outdated and opened undated insulin from one (Unit 1) of two refrigerators and failed to discard an open undated vial of cyanocobalamin (Vitamin B12) from one (1) of five (5) medications carts (medication cart A on 100 hall). The findings included: 1. An undated policy entitled "Expiration of Opened Multi-Dose Vials" read in part: A. Policy "all multi-dose vials of injectable medications and vaccines shall be dated by the designated staff person at the time that the seal is broken and the first dose drawn. Subsequently, the following expiration dates shall be observed: 30 Days: PPD". "These medications shall be returned to the pharmacy at such time as their respective expirations have been reached." On 11/28/12 at 2:38 PM, one vial of PPD dated as opened 10/1/12 was observed in the Unit 2 medication refrigerator. Manufacturer specifications included, "Discard 30 days after opening." Nurse #1 was interviewed at this time	F 431	achieved due to illness or vacation then staff will be re-educated upon returning back to work. New employees well be educated through orientation. The Director of Nursing or Unit Managers will check medication rooms and medication carts 3 times per week/week x 4weeks to ensure medications are labeled and dated when required, expired meds have been removed and either discarded or returned to the pharmacy. Variances will be corrected at the time of observation and concerns will be reported to the quality assurance committee during the monthly meeting.. Continued compliance will be monitored by the Unit Managers through weekly review of medication carts and med rooms and through the facility's Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns.	

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	345389	A. BUILDING _____ B. WING _____	C 11/28/2012

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F 431	Continued From page 25 and stated that the vial should have been discarded. On 11/28/12 at 2:40 PM, Unit Manager #1 indicated it was an oversight that the PPD had not been discarded. It should only be kept for 30 days after opening. 2. An undated policy entitled "Expiration of Opened Multi-Dose Vials" read in part: A. Policy "all multi-dose vials of injectable medications and vaccines shall be dated by the designated staff person at the time that the seal is broken and the first dose drawn. Subsequently, the following expiration dates shall be observed: 28 Days: insulin products." "These medications shall be returned to the pharmacy at such time as their respective expirations have been reached." a. On 11/28/12 at 3:20 PM., four opened insulin pens were observed in the Unit 1 medication refrigerator. One Lantus solostar insulin flexpen was opened and undated. Two Novolog insulin flexpens were opened and dated 10/26/12. One Lantus solostar insulin flexpen was opened and dated 10/29/12. On 11/28/12 at 3:20 PM., the pharmacy consultant stated the medication might have been for return to the pharmacy but they should not have been in the refrigerator. On 11/28/12 at 4:22 PM. Administrative staff # 1 stated all vials/ insulin vials and flexpens should be dated when opened. The medication should not have been in the refrigerator and should have	F 431		

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 _____	C 11/28/2012

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F 431	Continued From page 26 been returned to pharmacy. b. On 11/28/2012 at 2:26 PM., an open, undated multidose vial of cyanocobalamin (Vitamin B12) was observed in medication cart A on Unit 1. On 11/28/12 at 2:26 PM., Nurse # 2 stated the Vitamin B12 vial should have been dated when it was opened. On 11/28/ 12 at 4:22 PM., Administrative staff #1 stated all vials which included the B12 multidose vial should have been dated when opened.	F 431		

DRW

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

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OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING 01 - MAIN BUILDING 01 JAN 22 2013 B. WING	12/19/2012

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

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V (111) construction, one story, with a complete automatic sprinkler system and a delayed egress locking system. . The deficiencies determined during the survey are as follows:	K 000	*The Laurels of Forest Glenn requests to have this Plan of Correction serve as our written allegation of compliance.* *Our alleged date of compliance is 1/24/2013.* *Preparation and/or execution of this plan of correction do not constitute admission to nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.*	
K 029 SS=D	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 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: A. Based on observation on 12/19/2012 the door to the dry storage room in the kitchen was tied open. 42 CFR 483.70 (a)	K 029	K 029 The tie that was holding the door to the dry storage room in the kitchen open was removed on 12/19/2012. Dietary Manager and/or designee will in-service/re-educate Dietary staff on not tying open fire doors. The Director of Maintenance will conduct audits on no obstructions for all doors in the facility (1) once weekly for (4) four weeks. All variances will be corrected at the time of observation. Monitoring results will be reported to the Administrator and to the Quality Assurance committee during the monthly meeting. Continued compliance will be monitored through the facility's preventative maintenance, fire safety and Quality Assurance programs	1/24/13
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section	K 038	K038 The lock on the delayed egress door near room 133 was fixed on 12/19/2012 to release to pressure.	1/24/13

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

Administrator 1-22-13

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.

CD

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	345389	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/19/2012

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

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K 038	Continued From page 1 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 12/19/2012 the delayed egress lock near room 133 failed to release on pressure (lock was repaired during LSC survey). 42 CFr 483.70 (a)	K 038	The Director of Maintenance has received one on one counseling/education on the Preventative Maintenance Policy. The Director of Maintenance will conduct audits on delayed egress doors to ensure they release on pressure in the facility (1) once weekly for (4) four weeks. All variances will be corrected at the time of observation. Monitoring results will be reported to the Administrator and to the Quality Assurance committee during the monthly meeting. Continued compliance will be monitored through the facility's preventative maintenance, fire safety and Quality Assurance programs.	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 12/19/2012 the staff interviewed did not know the where the pull stations were . 42 CFR 483.70 (a)	K 050	K050 The staff member interviewed has received one on one counseling/education on the facility's Fire Drill Policy. The Director of Maintenance will in-service/re-educate the staff on the facility's Fire Drill Policy. The Director of Maintenance and/or designee will conduct random fire drill audits on all shifts (1) once weekly for (4) four weeks. All variances will be corrected at the time of observation. Monitoring results will be reported to the Administrator and to the Quality Assurance committee during the monthly meeting. Continued compliance will be monitored through the facility's preventative maintenance, fire safety and Quality Assurance programs.	1/24/13
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building.	K 051	K051 The fire alarm system was serviced by Eagle Fire Inc. on 12/20/2012 to allow a visible/audible trouble signal at the Fire Alarm Control Panel (FACP) with loss battery backup.	1/24/13

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 051	Continued From page 2 Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: A .Based on observation on 12/19/ 2012 the battery failed to operate the fire alarm when AC power was lost. 42 CFR 483.70 (a)	K 051	The fire alarm system will continue to be inspected through routine scheduled maintenance checks by the outside fire system contractor. The Director of Maintenance and/or designee will monitor the visible/audible trouble signal at the Fire Alarm Control Panel (FACP) with loss battery backup for proper function during the monthly fire drills. The fire system contractor will be notified of any variances and repairs will be promptly made. Continued compliance will be monitored through the facility's preventative maintenance, fire safety, and Quality Assurance programs.	