NOV 03 200

PRINTED: 10/18/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345389	B. WIN	G		10/06/	/2011
*****	ROVIDER OR SUPPLIER RELS OF FOREST GLEN	N		11	EET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET ARNER, NC 27529		
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F 281 SS=D	PROFESSIONAL STA	CES PROVIDED MEET ANDARDS I or arranged by the facility al standards of quality.	F	281	The Laurels of Forest Glenr to have this submitted plan correction stand as its writte allegation of compliance. Of alleged compliance is 11/03	of ' en Our	
	by: Based on observation interview, the facility of order to hold the blood 1 (Resident #101) of failed to use gravity with wardication via gastro for 1 (Resident #44) of Findings include: 1. Resident # 101 ward 11/12/09 with multiple Hypertension. On 11	stomy feeding tube (g-tube) of 2 sampled residents. Its admitted to the facility on the diagnoses including of 12/09, there was a doctor's of mgs (milligram) by mouth of BP (systolic blood			Preparation and/or execution plan of correction does not admission to, nor agreement either the existence of or the and severity of any of the condeficiencies, or conclusions in the statement of deficiency plan is prepared and/or execution ensure continuing compliant regulatory requirements.	constitute it with, e scope ited s set forth cies. This cuted to	11/8/11
	were reviewed. The I boxes (8/8, 8/11, 8/14 8/28/11) with no HR r 8/9, 8/10, 8/12, 8/13, 8/25/11) of twenty thr 60 (between 51-59). recorded and the 11 c nurse's initials indicat given. The MAR for Septem 9/5, 9/11, 9/19, 9/23,	on Administration Records) MAR for August, 2011 had 7 MAR for August, 2012 had a seconded. Eleven (8/1, 8/2, 8/2, 8/24 & see HR recorded were below and the Foundation of the Foundation of the Foundation of the Lopressor was seen as a seconded with the Lopressor was seconded			notified of the HR's less the new orders were received resident's medication administered as ordered physician. No negative resulted from this observation with paramadministration will be residents	desident #101's physician was otified of the HR's less than 60. No ew orders were received. The esident's medication is being dministered as ordered by the hysician. No negative outcome esulted from this observation. Current residents receiving nedications with parameters for dministration will be reviewed by the Unit Managers to ensure vita	

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.

Facility ID: 923173 If continuation sheet Page 1 of 20

	OT ON MEDIOTINE O		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL			COMPLETED	
		345389	B. WIN	G		10/06	5/2011
	ROVIDER OR SUPPLIER RELS OF FOREST GLEI	NN		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529			
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F 281	Continued From page 1 9/15, 9/16, 9/17, 9/18, 9/26/11) of twenty three HR recorded were below 60 (between 58-59). The MAR for October, 2011 was reviewed on 10/5/11. The HR on 10/02/11 was 58 and on 10/03/11, the HR was 59. The boxes on the MAR for October 2 and 3 had nurse's initials indicating that the Lopressor was administered to the resident. On 10/05/11 at 5:22 PM, Nurse #1 was interviewed. She stated that she was scheduled to work 7-3 shift and she acknowledged that she had administered the Lopressor with the HR of less than 60. She stated that she was not aware of the order to hold it if below 60.			281	signs are documented as and medications are admir ordered. Variances will be to the physician if indicated. Nurse #1 received one counseling/education regard policy on following physician regards to holding bloomedications by the 11/01/2011. Nurse #3 received one counseling/education regard procedure for admirations and the counseling/education regards procedure.	nistered ase reported. to one rding our cian orders d pressure DON or content or conten	r s e
	2. Review of the facility policy titled "Restoring Patency of Feeding Tube" (dated 11/02) revealed "Policy: Clogged feeding tubes are restored to patency as soon as clog is noted. Clogged tubes are replaced if attempts to unclog are unsuccessful." The procedure read, in part, "Warm Water Method a) draw up 30 ml (millilliters) warm water in syringe b) attach syringe to tube c) gently push in fluid and pull back fluid, alternating positive and negative pressure. Avoid continued excessive pressure. "Alternate Warm Water Method a) draw up 5 ml of warm water in syringe, attach syringe to tube. Inject warm water into tube and clamp for 5 minutes c) flush with water until clear. " Review of the facility policy titled "Administration of Medication via Feeding Tube" (dated 11/02)				medications via gastrostor flushing the tube, procedunclogging a gastrostomy ensuring the syringe, and place of debris before place syringe back in the protection the DON on 11/02/2011. Licensed nursing staff with additional education DON/designee on the policies and procedured medication administration, physicians' orders in resholding medications per designee.	dures for tube and lunger are acing the ve bag by Il receive by the facility's res for following gards to	

<u> </u>	O I OIT MEDIOF IT IS IS						
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUF COMPLET		
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	ROVIDER OR SUPPLIER RELS OF FOREST GLEN	N		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	:		
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F 281	revealed in part " por capsule contents sho ml of water. All partic to administering the me the Procedure for Adivia Feeding Tube realiquefied medication in flow by gravity into the tube. " Resident #44 was addiagnoses including in gastritis, gallstones, or gastric esophageal resident was moderated by the most report of the Physic 10/1/11 through 10/3 order " Tums Regulation order " Tums Regulation medication pass for Fourse #3 dispensed medication in separated a spoon to mix them ml of water from the juthese medications water was medications water as the process of the particular of water from the juthese medications water from the juthese medications water from the juthese medications water	wder from crushed tablets or uld be dispersed well in 30 cles must be in solution prior medication. "Step #13 of ministration of Medications d, in part, "Pour the nto the syringe and allow to e tube; never force fluid into mitted on 10/25/10 with history of dysphasia, chronic kidney disease, and afflux disease. Decent Quarterly Minimum delay cognitively impaired and dians Order Summary for 20/11 revealed the following or Cal-Gest CHW (chewable) as 600 mg via tube once blement. " The observation of a Resident #44 revealed that decrushed and one liquid the medication cups and used with approximately 20 - 30 ug on her med cart. One of as 3 tablets of Tums 500 mg		medications via gastrate flushing the tube, punclogging a gastroste ensuring the syringe, are free of debris before syringe back in the punclogging was 10/19/2011, 10/20/10/21/2011 by Adminit Unit Managers/designed a medication pass utilizing a med pass of with varying license various shifts on various shifts on various times a week for the weeks to ensure vidocumented where medications are ad	rostomy tube, rocedures for omy tube and and plunger ore placing the protective bag. held on /2011, and strative nurse. The will conduct observation tool ed nurses on ous days of the rends (3) three next (4) four tal signs are no required ministered as dications via administered as dications via administered inges stored tions will be		
	the gastrostomy feed placement. After this	ing tube (g-tube) for Nurse #3 attached the					

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F 281	added some water the administered the residindividually with a sm between each dose. Into the syringe it faile gravity. Nurse #3 ren clamping the tubing with other hand to dislode stuck. She then reatt added more water bu a clamp the medicatiogravity. Nurse #3 the syringe and shook the attached to the g-tube place. She then push crushed Tums via the cup that the Tums hait. She added more with substance up off the bustance with one hand. She removed the syringe with one hand. She removed the syringe and reattang-tube. She poured the syringe and pushed the solution. During the medication 10/5/11 at 4:15 PM, North Tums typically did not	dunger to the g-tube and at infused by gravity. She dent's medications all amount of water in When she poured the Tums od to flow into the g-tube via moved the syringe while with one hand and tapped the the gloved finger of her eanything that might be ached the syringe and tafter releasing her hand as on still did not flow via in placed the plunger in the easyringe while it was by while holding the g-tube in the getube. The medication is deen in still had residue in vater and stirred the pottom of the medication	F	281	the next (4) four weeks and will be reported to the Assurance committee du monthly meeting. Continued compliance monitored through routine observations, routine re MARs, and review of ne during the morning clinica and through the facility'	veekly for concerns Quality ring the will be med pass view of worders I meeting s quality additional will be	

•	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 281	During an interview w 4:30 PM, she indicate not infuse via gravity	e 4 with Nurse #3 on 10/5/11 at the ed that when medications will the accepted practice at the esyringe plunger to push	F 28	31		
F 309 SS≖D	revealed that medica were to be infused via 483.25 PROVIDE CA HIGHEST WELL BEI Each resident must reprovide the necessar or maintain the highemental, and psychosometric provided the necessar or maintain the highemental, and psychosometric provided the necessar or maintain the highemental, and psychosometric provided that medical provided the necessar or maintain the highemental provided that medical provided that medical provided the necessar or maintain the highemental provided that medical provided that medical provided the necessar or maintain the highemental provided that medical provided the necessar or maintain the higher medical provided that medical provided the necessar or maintain the higher medical provided that medical provided that medical provided the necessar or maintain the higher medical provided that medical provided the necessar or maintain the higher medical provided that medical provided the necessar or maintain the higher medical provided that medical provided the necessar or medical provided that medical provided that medical provided the necessar or maintain the higher medical provided that medical provided the necessar or maintain the higher medical provided that medical provided the necessar or maintain the higher medical provided that medical provided the necessar or maintain the higher medical provided that medical provided the necessar or maintain the higher medical provided the necessar or maintain the necessar or medical provided the necessar or medical provided the necessar or medical provided the necessar or medica	RE/SERVICES FOR NG eceive and the facility must y care and services to attain st practicable physical,	F 30	Resident #115's physic notified. The resident's care plan and dietary card l	are card, have been he fluid	11/3/11
	by: Based on record rev			Current residents with o fluid restrictions have been by the Unit Manager and Manager to ensure the restriction is identified in the care, on the nursing care can	reviewed l Dietary ne fluid ne plan of	
	04/10 was reviewed. guests with a nutrition restriction shall receivas prescribed by the of fluids shall be docuprogress notes, care Administration Record	on fluid restriction dated The policy read in part "all n prescription for a fluid ve only the amount of fluids physician. 4. The distribution umented on the dietary plan and the Medication d or Treatment d. 7. The diet card/cardex				

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F 309	restriction. 8. The die preferences and brea 9. Water pitchers sha 's room". Resident #115 was a 01/19/11 with multiple (End Stage Renal Dis assessment dated 08 Resident #115 had m problems and was or indicated that the reshemo dialysis 3 times Wednesday and Frid On 02/15/11, there w 1200 ml (milliliter) flui recommended by the The dietary notes rev 200 ml of fluid every	de changed to reflect the fluid to card shall denote the fluid kdowns allocated to dietary. Il not be placed in the guest dmitted to the facility on ediagnoses including ESRD sease). The quarterly MDS (707/11 indicated that semory and decision making a dialysis. The care plan ident was scheduled for a week on Monday, ay. as a doctor 's order for d restriction as dialysis clinic. ealed that dietary to provide meal and nursing to provide hours to include the water	F 30	removerooms The magnetic provider relation for Admir Mana, 10/26. The Mana educate fluid	ng to communication fluid restrictions nistrative nurse an ger. In-Servicing way /2011 and 10/27/201 Licensed Nurses an ger will be provided the tion relating to increstrictions in the place nursing care card at The Licensed Nurses and the water pitchers are identified resident relations.	aff will be education of orders and Dietary and Dietary additional clusion of an of care and dietary arses will eremoved	
	was interviewed. Sh (Registered Dietician out how much fluid th provide in 24 hours. and output was not n restriction. On 10/05/11 at 5:48 observed eating dinn had 3 glasses of fluic him. His dietary card	AM, administrative nurse #2 e stated that the RD) was responsible in figuring he dietary and nursing would She also stated that intake hecessary for resident on fluid PM, Resident #115 was her in the dining room. He he (480 ml total) in front of he did not reflect the fluid heakdowns allocated for		any n are in the r alloca MAR Dieta Mana restric	Unit Managers will a new orders for fluid acluded in the plan and care card, and communicatery department. The ager will ensure the communicater will ensure the card. Care plans	restriction of care, or the flui- ent in th ed to th ae Dietar re flui- ted on th	s n d e e y d

	OF DECICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
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F 309	Continued From page dietary. On 10/06/11 at 9:15 / observed in his room of him. There were 2 on the tray. There was water observed at the diet card did not indic breakdown allocated On 10/06/11 at 9:16 / She went to observe with his breakfast tray 2 cups of coffee and that the resident should not he bedside and his diet restriction and the bre stated that she had e computer and did not On 10/06/11 at 9:24 / NA #1 was assigned stated that she was restriction on water restriction on 10/06/11 at 9:45 /	AM, Resident #115 was with breakfast tray in front cups (240 ml cup) of coffee as a water pitcher full of e resident 's bedside. The sate fluid restriction and the for the dietary. AM, the RD was interviewed. Resident #115 in his room y in front of him. She saw the the diet card. She stated uld only get 200 ml of fluid on s to provide 280 ml with s. She also stated that the ave a water pitcher at card should reflect the fluid eakdown for dietary. She intered this information in the t know why they were gone. AM, NA #1 was interviewed. to Resident #115. She not aware that the resident	i.	309	cards are reviewed w physician's orders and quarterly. The Dietary Manager will methe allocation of fluids during for identified residents (3) the times a week at varying times a week at varying times (2) two weeks then we times (2) two weeks then rathereafter to ensure accurace Variances will be corrected time of observation. The Unit Managers/designed monitor that fluid allocation are present with the MAR of identified residents and wat pitchers removed from identified residents and wat pitchers removed from identified resident rooms (3) three times week for the next (2) two weekly for (2) weeks then in the time of observation of observation.	ng meals hree es for the ekly ndomly y, at the es will a sheets of ter atified aes a veeks then randomly e ervation.	·
	was on 1200 fluid res a water pitcher at bed NAs were informed of the care guide. Whe care guide did not ha Resident #115.	striction and should not have dside. She also stated that if the fluid restriction through n checked, the resident's ave fluid restriction written for	were the confirmation of t		Monitoring results will be to the Director of Nursing the next (4) four weeks and will be reported to the qual assurance committee during monthly meeting.	weekly for l concerns lity	
	On 10/06/11 at 9:50	AM, the dietary staff was					ŧ

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F 314 SS=D	any resident on fifurther stated that indicated that the fluid restriction. 483.25(c) TREAT PREVENT/HEAL Based on the conresident, the facili who enters the fadoes not develop individual's clinicathey were unavoipressure sores reservices to promo	stated that they did not have uid restriction at this time. She the dietary manager also re was no resident currently on	F 30	new admissions and r during the morning cl routine meal and rout	utine review of new orders inical meeting, nd observations, rough the rance program. and monitoring	
	by: Based on observinterview and me failed to provide the wheelchair, a pressure ulcer for residents (Resident #210 with diagnoses includivascular disease, arthritis and hyper Review of the Nudated 9/14/11 reviadmitted with an	ration, resident and staff dical record review the facility he pressure relieving cushion on a care planned for the care of rone (1) of three (3) sampled ant #210). Findings include: as admitted on 9/14/11 with ng hyperglycemia, peripheral renal insufficiency, rheumatoid rtension. rsing Admission Assessment realed that Resident #210 was unstageable pressure ulcer on neasured 3.5 cm (centimeters) x		F314 Resident #210 has be from the facility to he Current residents whether development of and/or present with will be reviewed Managers and design pressure relieving identified and Variances will be identified.	o are at risk for pressure ulcers pressure ulcers by the Unit mees to ensure devices are implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		NN TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREF	11 G.	EET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET ARNER, NC 27529 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	CORRECTION (X5)	
TAG		LSC IDENTIFYING INFORMATION)	DAT		CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE	DATE
F 309 F 314 SS=D	interviewed. She stany resident on fluid further stated that the Indicated that there fluid restriction. 483.25(c) TREATMI PREVENT/HEAL PREVENT/HEA	restriction at this time. She e dietary manager also was no resident currently on ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores essure sores unless the condition demonstrates that ble; and a resident having lives necessary treatment and healing, prevent infection and		314	Continued compliance will monitored through routine new admissions and new of during the morning clinical routine meal and round obtainity's quality assurance Additional education and will be initiated for any ideconcerns.	review of orders all meeting, servations, the program.	
	by: Based on observat interview and medic failed to provide the the wheelchair, as o pressure ulcer for o residents (Resident Resident #210 was diagnoses including vascular disease, re arthritis and hyperte Review of the Nursi dated 9/14/11 revea	ion, resident and staff cal record review the facility pressure relieving cushion on care planned for the care of ne (1) of three (3) sampled #210). Findings include: admitted on 9/14/11 with phyperglycemia, peripheral enal insufficiency, rheumatoid ension. Ing Admission Assessment aled that Resident #210 was estageable pressure ulcer on assured 3.5 cm (centimeters) x			identified and im	e at risk for sure ulcers sure ulcers the Uni	r s s t

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F 314	Review of the Admiss (MDS) assessment d resident was cognitive having one (1) unstage slough (yellow or white ulcer bed) and as have device for his bed. He pressure relieving detection of the weekly revealed the wound very and on 9/29/11 the Perm x 0.8 cm. Review of the Plan of dated 9/30/11 revealed breakdown will be he interventions for achite Pressure reduction so the pressure ulcer mand had 100 percent. During the dressing of AM the resident state can be painful particularly and the resident state can be painful particularly and the resident that was comfort when he sat that the cushion had mentioned it to some seemed to know any state of the pressure of the particularly and the cushion had mentioned it to some seemed to know any state of the president was composed to the painful particularly and the	sion Minimum Data Set ated 9/21/11 revealed the ely intact and was coded as geable pressure ulcer with the tissue that adheres to the ving a pressure relieving e was not coded as having a vice for his wheel chair. Pressure Ulcer Record was improving with treatment ressure ulcer measured 1.2 f Care for Resident #210 ed the following goal "skin aled within 90 days." eving the goal included: "urface to chair at all times." AM the dressing change for ure ulcer was observed. Leasured 1.0 cm x 0.5 cm yellow slough. Change on 10/6/11 at 11:15 ed that the pressure ulcer alarly when he sits down. That for the first couple of the staff but no one	F3	314	The nursing staff was re-ed the DON/designee on relating to the implement pressure reducing devices procedures for obtaining when needed. The Unit Managers/desig conduct pressure relieving observations (3) three times for (2) two weeks then we (2) two weeks to ensure doint place. All variances corrected at the time of observations results will be to the Director of Nursing with the next (4) four weeks and will be reported to the Assurance committee domonthly meeting. All residents are assessed prevention of pressure ulces IDT upon admission, with in condition, at least quarter needed to ensure risks are and interventions implement indicated.	nees will be ervation. reported veekly for l concerns e Quality aring the a change of the a c	

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	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
F 314	10/6/11 at 11:20 AM pressure reliving cust Interview with Nurse revealed that she rec cushion on his wheel never mentioned to halso indicated that re on the buttocks area pressure relieving de seat. On 10/6/11 at 3 PM ff #210 told her that his missing. She said the closet and told him the further said that she cushion on his wheel facility and she though the hospital before he that it was not sent wheel facility. 483.25(i) DRUG REC UNNECESSARY DREC UNNECESSAR	reveled there was not a nion on the wheelchair seat. #4 on 10/6/11 at 11:25 AM alled the resident having a chair previously but that he residents with pressure ufcers would typically have a vice for their wheel chair WA #2 stated that Resident wheel chair cushion was at she looked for it in his nat she could not find it. She did not recall him having a chair during his stay at the part that perhaps he had it at a was transferred here, but with him when he came to the side was transferred dere, but with him when he came to the side was transferred here, but with him when he came to the side was transferred here, but with him when he came to the side was transferred here, but with him when he came to the side was transferred here, but with him when he came to the side was transferred here, but with him when he came to the side was transferred here, but with him when he came to the side was transferred here, but with him when he came to the side of the same was transferred here. The side of the same was transferred here, but with him when he came to the side of the same was transferred here, but with him when he came to the side of the same was transferred here, but with him when he came to the side of the same was transferred here, but with him when he came to the side of the same was transferred here, but with him when he came to the same was transferred here, but with him when he came to the same was transferred here, but with him when he came to the same was transferred here, but with him when he came to the same was transferred here, but with him when he came to the same was transferred here, but with him when he came to the same was transferred here.	F 31	monitored through assessments, routing observations and the facility's quality assurant Additional education and will be initiated for an concerns.	routine e round hrough the hice program. d monitoring hy identified sician was sures being medication ordered by d panel for btained. No		
	who have not used a	ntipsychotic drugs are not					

		VIEDIOAID OLIVVIOLO	1405 111	u zini	LE CONSTRUCTION	(X3) DATE SURVEY	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII			COMPLETED	
		345389	8. WN	G		10/00	3/2011
NAME OF PR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF FOREST GLEN	N		1 1	101 HARTWELL STREET ARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329 SS=D	10/6/11 at 11:20 AM pressure reliving cus interview with Nurse revealed that she recushion on his wheel never mentioned to halso indicated that reconthe buttocks area pressure relieving deseat. On 10/6/11 at 3 PM #210 told her that his missing. She said the closet and told him tour further said that she cushion on his wheel facility and she though the hospital before his tat it was not sent of facility. 483.25(I) DRUG RECUNNECESSARY DRECESSARY D	reveled there was not a hion on the wheelchair seat. #4 on 10/6/11 at 11:25 AM salled the resident having a lichair previously but that he her that it was missing. She sidents with pressure ulcers would typically have a livice for their wheel chair NA #2 stated that Resident as wheel chair cushion was leat she looked for it in his heat she could not find it. She did not recall him having a lichair during his stay at the ght that perhaps he had it at e was transferred here, but with him when he came to the GIMEN IS FREE FROM RUGS I regimen must be free from An unnecessary drug is any xcessive dose (including in for excessive duration; or conitoring; or without adequate ea; or in the presence of the ces which indicate the dose in discontinued; or any		314	Continued compliance monitored through assessments, routine observations and the facility's quality assurant Additional education and will be initiated for an concerns.	routing round rough the ce program I monitoring y identified medication ordered by panel for btained. No	e d d e e e e e e e e e e e e e e e e e
	resident, the facility	nensive assessment of a must ensure that residents antipsychotic drugs are not				• •	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				(X3) DATE SUR	1
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			/EY D	
		345389	B. WIN	G		10/08	/2011
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 329	therapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral interventic contraindicated, in an drugs. This REQUIREMENT	less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic I dose reductions, and	L	329	Current residents medications with parame administration will be revi the Unit Managers to ens signs are documented as and medications are admin ordered. Current residents with order testing will be reviewed by Managers and designees t labs have been completed a and results are retained medical record. Variances	sure vital specified istered as rs for lab the Unit o ensure s ordered in the	
	facility failed to monit the Lipid panel for 1 sampled residents. T 1 a. Resident #155 w facility on 11/29/10 w including Hypertensidated 09/08/11 indicated 09/08/1	vas originally admitted to the vith multiple diagnoses on. The MDS assessment ated that Resident #155 had			Nurse #2 has received on counseling/education on the for following physician's of to take and document blood pressures before adminedications if ordered physician by the D 11/02/2011. Licensed Nursing Staff educated on 10/27/11 DON/designee relating to physician's orders, monited documenting vital sign	dentified. e to one ne policy rders and residents' inistering by the ON on was re- by the following oring and as when labs are results are	

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THE LAUF	RELS OF FOREST GLEN	И		1101 HARTWELL STREET GARNER, NC 27529		
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F 329	administered as order pressure recorded programmer of the MA were all blank. On 10/05/11 at 3:20 interviewed. She stat to work 7-3 shift. She not checking the resi administering the me On 10/5/11 at 5:18 P was interviewed. Shordered parameters nurses were expected.	red but there were no blood for to giving the medications. AR for the blood pressure PM, Nurse #2 was seed that she was scheduled a acknowledged that she was dent's blood pressure before dication. M, administrative nurse #1 e stated that if the doctor had to hold the medications, the	F3	identified. Continued compliance monitored through revorders during the monitored through the monitored throu	I for tracking labs) utilizing three times a then weekly en randomly labs are lical record. corrected as the wiew of new rning clinical	
F 371 SS=E	facility on 11/29/10 wincluding Hyperlipide dated 09/08/11 indice memory and decision. Review of the doctor Resident #155 was addited at the decision of the doctor Resident #155 was addited at the decision of the decision of the recording panel every 6 month Review of the recording panel result in the 483.35(i) FOOD PROSTORE/PREPARE/STORE/STORE/PREPARE/STORE/STORE/PREPARE/STORE/STORE/PREPARE/STORE/STORE/PREPARE/STOR	's orders revealed that on Lipitor 80 mgs via tube 9/10 for Hyperlipidemia. On ian had ordered for lipid s (June - December). Is revealed that there was no ne chart.	F	meeting, routine review and lab tracking logs, a reviews, during the change over process an facility's quality assura Additional education a will be initiated for concerns. F371 The identified lunch discarded.	routine record month end ad through the ance program and monitoring	11/3/1/

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CENTER	OT ON WEDIOANE &					(X3) DATE SUR	VEY
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	OVIDER OR SUPPLIER RELS OF FOREST GLEN	N		110	ET ADDRESS, CITY, STATE, ZIP CODE 01 HARTWELL STREET ARNER, NG 27629		
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F 329	administered as order pressure recorded programmer on the MA were all blank. On 10/05/11 at 3:20 interviewed. She statto work 7-3 shift. She not checking the residential administering the medium on 10/5/11 at 5:18 P was interviewed. She	red but there were no blood ior to giving the medications. R for the blood pressure PM, Nurse #2 was ed that she was scheduled acknowledged that she was dent's blood pressure before dication. M, administrative nurse #1 e stated that if the doctor had	F	329	The Unit Managers will relab tracking log, (a tool feats and completion of lab a monitoring tool (3) through the completed as ordered and present in the medic Variances will be condentified.	or tracking os) utilizing ee times a nen weekly randomly labs are results are al record.	
	nurses were expected pressure before admit 1b. Resident #155 we facility on 11/29/10 wincluding Hyperlipide dated 09/08/11 indicated memory and decision Review of the doctor Resident #155 was adaily started on 11/2 04/28/11, the physic panel every 6 month	as originally admitted to the vith multiple diagnoses smia. The MDS assessment ated that Resident #155 had a making problems. 's orders revealed that on Lipitor 80 mgs via tube 9/10 for Hyperlipidemia. On ian had ordered for lipid s (June - December).			Continued compliance monitored through review orders during the morn meeting, routine review of and lab tracking logs, rowreviews, during the change over process and facility's quality assurant Additional education and will be initiated for an concerns.	ow of newing clinical factorial fact	
F 371 SS=E	483.35(i) FOOD PROSTORE/PREPARE/S The facility must - (1) Procure food from		F	371	F371 The identified lunch discarded.	meat was	11/3/1/ s

OLHILLI	OT ON MEDICANTE &		1000.11	al vibi	C CONSTRUCTION	(X3) DATE SUR	VFY
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1'	(X2) MULTIPLE CONSTRUCTION A BUILDING		COMPLETED	
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	OVIDER OR SUPPLIER RELS OF FOREST GLEN	IN		11	EET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET ARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	•	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 371		stribute and serve food	F	371	An additional temperature reach in refrigerator #2 posted to document temperatures.	has been	
	by: Based on observation policy and temperature failed to (1) discard of temperature of 1 of 2 (refrigerator #1), and dry prior to use. The findings include 1. A facility policy en revised on 4/11 read opening" (can be kepton opening (can be kepton o	titled "Storage of Food" in part, "Lunchmeats, after ot) "refrigerated 3-5 days". PM, an unsealed container of 19/11, was observed in the on 10/3/11 at 3:32 PM, the of the other of the o			All walk-in coolers, refrige freezers were checked for food items. No other variation identified. The Dietary Manager and received one to counseling/education on for the "Storage of F"Refrigeration/Freezer Terescords." The Dietary staff was instended in Food", in "Refrigeration/Freezer Terescords" and ensuring the are dried properly before to the Dietary Manager on 10 foods.	r outdated ances were cook have one the policy food" and emperature erviced one "Storage naintaining emperature dome lids tray line by	
	refrigeration and free	ezer equipment to ensure that proper temperatures."					

F 371 Continued From page 13 During the initial tour of the kitchen on 10/3/11 at 3:32 PM, 2 reach-in refrigerators were observed side by side. The refrigerators were independent of each other, and each had its own interior and exterior thermometers. Review of the "Refrigerator/Freezer Temperature Record" log used by the facility to record temperatures revealed only one column designated "Reach-in Refrigerator". During an interview of 10/6/11 at 3:45 PM, the cook stated that the log did not have an area to record temperatures of both reach-in refrigerator and freezer temperatures on the log. The cook stated that the log did not have an area to record temperatures of the refrigerator on the right (refrigerator #1). The cook indicated that she expected readings between 39 - 40 degrees Fahrenheit (F) and had not seen any problems. During an interview on 10/6/11 at 3:45 PM, the dietary manager acknowledged that due to an	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				1	2000 011
THE LAURELS OF FOREST GLENN STREET ADDRESS, CITY, STATE, 2IP CODE 1101 HARTWELL STREET GARNER, NO 27529 PREFIX TAG F 371 Continued From page 13 During the initial tour of the kitchen on 10/3/11 at 3.32 PM, 2 reach-in refrigerators were independent of each other, and each had its own interior and exterior thermometers. Review of the "Refrigerator/Freezer Temperature Record" log used by the facility to record temperatures revealed only one column designated "Reach-in Refrigerator". During an interview of 10/6/11 at 3.45 PM, the cook sald it was her responsibility to record refrigerator and freezer temperatures on the log. The cook stated that the log did not have an area to record temperatures of the refrigerator on the right (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the right (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #3). The cook indicated that she expected readings between 39 - 40 degrees Fahrenheit (F) and had not seen any problems. During an interview on 10/6/11 at 3:45 PM, the dietary manager acknowledged that due to an and to record temperature of the refrigerator on the left (refrigerator #2) and just looked at the outside immediately upon identification.								
THE LAURELS OF FOREST GLENN 1101 HARTWELL STREET GARNER, NC 27829 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE CORDSTANCE, CATION SHOULD BE (EACH CORRECTIVE ACT			345389	B. WIN	IG		10/06	/2011
CASIDE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY TAG) (EACH DEFICIENCY THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIENCY TAG) (EACH DEFICIENCY TO THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIENCY TAG) (EACH DEFICIENCY TO THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIENCY TAG) (EACH DEFICIENCY TO THE APPROPRIATE DEFICIENCY TAG) (EACH DEFICIENCY TO THE APPROPRIATE DEFICIENCY TAG) (EACH DEFICIENCY TO THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIENCY TAG) (EACH DEFICIENCY TO THE APPROPRIATE DEFICIENCY TAG) (EACH DEFICIENCY TO THE APPROPRIATE DEFICIENCY TAGO CONTACTORY	NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
F 371 Continued From page 13 F 371 Continued From page 13 During the initial tour of the kitchen on 10/3/11 at 3:32 PM, 2 reach-in refrigerators were observed side by side. The refrigerators were independent of each other, and each had its own interior and exterior thermometers. PROVIDE TREE PROPERTY Provided the properties of the refrigerator. PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY). The Dietary Manager/designee will conduct audits utilizing the Dietary Sanitation Audit tool (which includes monitoring that utensils and dishware (Dome lids) are air dried) weekly for the next (4) four weeks to ensure food is labeled, identified and within the guidelines of our policy for "Storage of food" daily. Unidentified and/or outdated food items will be discarded at the time of observation. Unidentified and/or outdated food items will be discarded at the time of observation. The Dietary Manager/designee will monitor the temperature of the refrigerator on the left (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #1). The cook indicated that she expected readings between 39 - 40 degrees Fahrenheit (F) and had not seen any problems. During an interview on 10/6/11 at 3:45 PM, the dietary manager acknowledged that due to an Monitoring results will be reported to the Administrator weekly for the	THELAUS	IFI S OF FOREST GLEN	N					
F 371 Continued From page 13 During the initial tour of the kitchen on 10/3/11 at 3:32 PM, 2 reach-in refrigerators were observed side by side. The refrigerators were independent of each other, and each had its own interior and exterior thermometers. Review of the "Refrigerator/Freezer Temperature Record" log used by the facility to record temperatures revealed only one column designated "Reach-in Refrigerator." During an Interview of 10/6/11 at 3:45 PM, the cook staled that the log did not have an area to record temperature of the refrigerator on the right (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #1). The cook indicated that she expected readings between 39 - 40 degrees Fahrenheit (F) and had not seen any problems. During an interview on 10/6/11 at 3:45 PM, the dietary manager acknowledged that due to an	1712 27(0)				G		<u>1</u>	
During the initial tour of the kitchen on 10/3/11 at 3:32 PM, 2 reach-in refrigerators were observed side by side. The refrigerators were independent of each other, and each had its own interior and exterior thermometers. Review of the "Refrigerator/Freezer Temperature Record" log used by the facility to record temperatures revealed only one column designated "Reach-In Refrigerator". During an interview of 10/6/11 at 3:45 PM, the cook said it was her responsibility to record refrigerator and freezer temperatures on the log. The cook stated that the log did not have an area to record temperatures of both reach-in refrigerator #2) and just looked at the outside thermometer for the refrigerator on the left (refrigerator #2) and just looked at the outside expected readings between 39 - 40 degrees Fahrenheit (F) and had not seen any problems. During an interview on 10/6/11 at 3:45 PM, the dielary manager acknowledged that due to an	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
oversight on the temperature log, there was no record that temperatures of both reach-in refrigerators were being monitored. 3. A facility policy entitled "Dish Machine Practices" dated 4/10 read in part, "Employees shall follow standards of practice to ensure that all utensils and dishes are sanitized." "Dishes shall be air-dried, and never stored wet."	F 371	During the initial tour 3:32 PM, 2 reach-in reside by side. The refrof each other, and each exterior thermometer. Review of the "Refrig Record" log used by temperatures revealed designated "Reach-lumburing an interview of cook said it was her refrigerator and freez. The cook stated that to record temperature refrigerators. She said temperature of the refrigerator #1). The expected readings by Fahrenheit (F) and houring an interview of dietary manager ack oversight on the tem record that temperat refrigerators were best of the shall follow standard all utensils and disher exterior temperature of the temperature of	of the kitchen on 10/3/11 at efrigerators were observed igerators were independent ich had its own interior and is. erator/Freezer Temperature the facility to record ad only one column in Refrigerator". of 10/6/11 at 3:45 PM, the responsibility to record are temperatures on the log. The log did not have an area as of both reach-in id that she recorded the efrigerator on the right just looked at the outside refrigerator on the left is cook indicated that she etween 39 - 40 degrees ad not seen any problems. on 10/6/11 at 3:45 PM, the nowledged that due to an inperature log, there was no ures of both reach-in ling monitored. Intitled "Dish Machine or read in part, "Employees is of practice to ensure that its are sanitized." "Dishes	F	371	conduct audits utilizing the Sanitation Audit tool (which monitoring that utens dishware (Dome lids) are weekly for the next (4) four ensure food is labeled, iden within the guidelines of for "Storage of food Unidentified and/or outdatens will be discarded at the observation. The Dietary Manager/desimonitor the temperature logensure temperatures are reall refrigerators and free policy. Corrections will immediately upon identification Monitoring results will be to the Administrator week next (4) four weeks and will be reported to the assurance committee dispersion of the discarded to the assurance committee dispersions.	e Dietary i includes ils and air dried) weeks to tified and our policy daily. ted food he time of gnee will s daily to corded on exers per be made ation. e reported ly for the concerns e quality	

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THE LAURELS OF FOREST GLENN CAN ID			345389	8. WING				3/2011
F 371 Continued From page 14 A kitchen observation on 10/6/11 at 11:34 AM revealed staff preparing the tray line for lunch. Twenty (20) of the hirty-three (33) dome lids, stacked on a serving cart at the end of the tray line, were wet. During an interview on 10/6/11 at 11:34 AM, the dictary manager (DM) stated that were pulled by the staff member responsible for placing the lids on the plates. The DM then removed the wet lids and put them on the drying cart. The drying cart was observed to have rows divided into slots by thin metal separators. Most of the slots contained 2 dome lids neather were exposed to all were wet. On 10/6/11 at 12:14 PM, the dictary staff (DS#2) who was responsible for placing the dome lids during the tray line was observed. DS#2 repeatedly took a dome lid off the serving cart and placed it on a plate without visualizing the inside of dome lid that was just placed, DS#2 aknowledged it was wet and removed it. DS#2 then inspected the remaining 6 dome lids on the serving cart and found them all wet. DS#2 placed those 6 on the drying rack, each in individual slots. DS#2 then searched for additional dry dome lids on the were dry. During an interview on 10/6/11 at 2:50 PM, the			N		1	101 HARTWELL STREET		
A kitchen observation on 10/6/11 at 11:34 AM revealed staff preparing the tray line for lunch. Twenty (20) of the thirty-three (33) dome lids, stacked on a serving cart at the end of the tray line, were wet. During an interview on 10/6/11 at 11:34 AM, the dietary manager (DM) stated that wet lids were pulled by the staff member responsible for placing the lids on the plates. The DM then removed the wet lids and put them on the drying cart. The drying cart was observed to have rows divided into slots by thin metal separators. Most of the slote contained 2 dome lids nestled together. The surfacess of the dome lids that were exposed to air were dry. The surfaces that were nestled were wet. On 10/6/11 at 12:14 PM, the dietary staff (DS#2) who was responsible for placing the dome lids during the tray line was observed. DS#2 repeatedly took a dome lid off the serving cart and placed it on a plate without visualizing the inside of the dome lid. When asked to look at the inside of dome lid that was just placed, DS#2 acknowledged it was wet and removed it. DS#2 then inspected the remaining 6 dome lids on the serving cart and found them all wet. DS#2 placed those 6 on the drying rack, each in individual slots. DS#2 then searched for additional dry dome lids on the rack, inspecting each lid and removing only those that were dry. During an interview on 10/6/11 at 11:33 DPM, the	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
drying cart for the dome lids. F 431 483.60(b), (d), (e) DRUG RECORDS, SS=E LABEL/STORE DRUGS & BIOLOGICALS	F 431	A kitchen observation revealed staff prepar Twenty (20) of the th stacked on a serving line, were wet. During an interview of dietary manager (DM pulled by the staff me placing the lids on the removed the wet lids cart. The drying card divided into slots by of the slots contained together. The surface were exposed to air were nestled were were nestled were were exposed to air were nestled were were nestled were were exposed to air were nestled were were exposed to air were nestled were were nestled were were exposed to air were nestled were were exposed to air were nestled were were nestled were were exposed to air were nestled were were exposed to air were nestled were were nestled were were exposed to air were nestled were were exposed to air were nestled were were nestled were were exposed to air were nestled were were nestled were were exposed to air were nestled were were nestled were we	in on 10/6/11 at 11:34 AM ing the tray line for lunch. irry-three (33) dome lids, cart at the end of the tray on 10/6/11 at 11:34 AM, the stated that wet lids were ember responsible for e plates. The DM then and put them on the drying twas observed to have rows thin metal separators. Most d 2 dome lids nestled ess of the dome lids that were dry. The surfaces that set. PM, the dietary staff (DS#2) of for placing the dome lids was observed. DS#2 me lid off the serving cart ate without visualizing the d. When asked to took at the at was just placed, DS#2 emaining 6 dome lids on the not them all wet. DS#2 e drying rack, each in 2 then searched for lids on the rack, inspecting ng only those that were dry. on 10/6/11 at 3:50 PM, the e facility needed an additional ome lids. RUG RECORDS,			monitored through daily observations and through acility's quality assurance Additional education and m will be initiated for any concerns.	kitchen igh the program. ionitoring	

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		345389	B. WIN	G		10/06	3/2011	
	OVIDER OR SUPPLIER	N		11	EET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET ARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(XS) COMPLETION DATE	
F 431	a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliation records are in order a controlled drugs is more conciled. Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. In accordance with Stacility must store all locked compartments controls, and permit have access to the k. The facility must propermanently affixed controlled drugs listed comprehensive Drug Control Act of 1976 abuse, except when package drug distrib	sloy or obtain the services of at who establishes a system and disposition of all afficient detail to enable an an; and determines that drug and that an account of all aintained and periodically sused in the facility must be with currently accepted as, and include the ry and cautionary expiration date when state and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to	F	431	educated relating to the s medications and check expiration dates b	ns and were re- torage of the holds were re-		
	by:	T is not met as evidenced on and staff interview the			observation.		No. Control of the Co	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1' '	ULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345389	B. WNG			10/06/2011	
NAME OF PR	OVIDER OR SUPPLIER						
THE LAUF	ELS OF FOREST GLEN	N		1101 HARTWELL STREET GARNER, NC 27529			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LOBE	(X5) COMPLETION DATE		
F 431	facility failed to discar one (1) of two (2) me include: On 10/6/11 at 2:30 P 100 hall was observe cupboard the followir medications were ob (milligrams) in an und (expiration date 9/11 (vitamin B Complex vin an unopened cont In the medication rocepired medications procrit 10,000 units/r 9/16/11 expiration date	rd expired medications from dication rooms. Findings M the medication room on the stock medication	F	431	monitored through routine is of the medication refrigerators and med controlled through the facility's	will be nspection rooms, arts, and quality Additional will be	
F 441 SS=D	revealed that the phachecking for expired medication rooms m stated that she chec placing a new stock cart. Nurse #5 also medications should placing them in the back to pharmacy. 483.65 INFECTION SPREAD, LINENS The facility must est Infection Control Prosafe, sanitary and co	#5 on 10/6/11 at 3 PM armacy was responsible for medications in the onthly. In addition, she ks the expiration date before medication in her medication indicated that the expired have been discarded by box of medications to be sent CONTROL, PREVENT ablish and maintain an ogram designed to provide a omfortable environment and development and transmission tion.	-	- 441	F441 Resident #44's tube feed sybeen replaced. No negative were identified from observation.	outcomes	

STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRU		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	IDENTIFICATION NUMBER: A. BUILDING				
345389			B. WING 10/06/2				/2011
	OVIDER OR SUPPLIER	N		1	EET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET FARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE
F 431	Continued From page 16 facility failed to discard expired medications from one (1) of two (2) medication rooms. Findings include: On 10/6/11 at 2:30 PM the medication room on 100 hall was observed. In the stock medication cupboard the following stored expired medications were observed: Oyst-Cal C 250 mg (milligrams) in an unopened 100 tablet container (expiration date 9/11), and Rena-vite 100 mg (vitamin B Complex with vitamin C and folic acid) in an unopened container (expiration date 11/10). In the medications were observed: two vials of procrit 10,000 units/ml (milliliter) both with a 9/16/11 expiration date, and two open boxes of		monthly meeting. Continued compliance monitored through routine is of the medication refrigerators and med cathrough the facility's	urses weekly for eks and concerns to the quality tee during the lance will be outine inspection cation rooms, med carts, and cility's quality m. Additional nitoring will be			
	revealed that the phachecking for expired medication rooms medication and stated that she check placing a new stock in cart. Nurse #5 also is medications should in placing them in the block to pharmacy. 483.65 INFECTION SPREAD, LINENS The facility must estainfection Control Prosafe, sanitary and control control prosafe, sanitary and control control prosafe, sanitary and control prosafe, sanitary and control prosafe, sanitary and control prosafe.	onthly. In addition, she as the expiration date before medication in her medication indicated that the expired have been discarded by fox of medications to be sent CONTROL, PREVENT ablish and maintain an gram designed to provide a infortable environment and evelopment and transmission	F	· 441	Resident #44's tube feed sy been replaced. No negative were identified from observation.	outcomes	11/3/11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
71010101	001112011011		A BUILDING				
		345389	B. WN	G		10/06	/2011
	ROVIDER OR SUPPLIER RELS OF FOREST GLEN	N		11	EET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET ARNER, NC 27529		19
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	(a) Infection Control I The facility must esta Program under which (1) Investigates, cont in the facility; (2) Decides what pro should be applied to (3) Maintains a recoractions related to infe (b) Preventing Sprea (1) When the Infection determines that a respreyent the spread of isolate the resident. (2) The facility must promunicable disease from direct contact will train (3) The facility must in hands after each direct hand washing is indicented in the professional practice (c) Linens Personnel must hand transport linens so as infection. This REQUIREMENT by: Based on observation	Program Iblish an Infection Control In it - Irols, and prevents infections It - Irols and corrective Irols and Irols and Irols	F	441	Current residents receiving will be reviewed by the Managers to ensure that synfree of debris and appropriately. Corrections made immediately identification. Licensed Nurses were insected the DON/designee or requirement for rinsing gastrostomy administration after all feedings and/or madministration and that the sfree of debris before storing protective bag on the 10/10/20/2011 and 10/21/2011. Unit Manager/designees will the administration syning residents with gastrostomy utilizing an audit tool week four weeks to ensure the cloof supplies and proper story variances will be corrected time of observation. More sults will be reported Director of Nursing weeklinext (4) four weeks and	the Uniteringes are stored will be upon a stored will be upon the ng the syringe is ng in the 19/2011, all observe nges of tubes by ly for (4) leanliness orage. All ed at the lonitoring to the y for the concerns	
	feeding / enteral med	ed to clean an enteral dication administration one (1) of two (2) residents dings include:	- The state of the		will be reported to the Assurance committee du monthly meeting.	Quality	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED			
		345389	B. WN	IG		10/06/2011	
	ROVIDER OR SUPPLIER	IN	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529		101 HARTWELL STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	Feeding Tube " (dat intermittent and bolustube should be flusher #11 of the procedure store in protective coname and date." Review of the facility of Medication via Ferrevealed, in part, tha #20 was " clean syriremoved and store in with guest's name and diagnoses including gastritis, gallstones, gastric esophageal resident was moderated a feeding tube. Review of the Physical 10/1/11 - 10/31/11 reorder for " glucerna which was administed g-tube. On 10/5/11 at 4:10 Ferredication pass and #44 revealed that No five medications per feeding tube (g-tube)	policy titled "Flushing of ed 11/02) indicated that after is feedings that the feeding ed with water and then step was "clean syringe and intainer labeled with guest's policy titled "Administration eding Tube" (dated 11/02) it during this procedure step inge until all residue is a protective container labled and date. " Imitted on 10/25/10 with history of dysphasia, chronic kidney disease, and eflux disease. ecent Quarterly Minimum and 8/30/11 revealed the stely cognitively impaired and clean 's order Summary for evealed the resident had an 1.5 1 can every 4 hours ", ared via the resident 's	F.	441	Continued compliance monitored through routin observations and through facility's quality assurance Additional education and mill be initiated for any concerns.	e round agh the program. conitoring	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED	
		345389	B. WNG		/06/2011	
	ROVIDER OR SUPPLIER	ENN	110	ET ADDRESS, CITY, STATE, ZIP COD DI HARTWELL STREET ARNER, NC 27529	E	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 441	Infuse 1 can of glu 175 ml of water w between each me the bolus tube fee water and formula syringe and its plu obtained them frod droplets of formula the syringe or plus On 10/5/11 at 4:30 had never cleaned if I dropped it I wo on to explain that by third shift with a there was no need In an interview wit 10/5/11 at 5 PM, s syringe was used there was no need	e also used this syringe to acerna 1.5 formula as well as hich was used as a flush dication and before and after ding. After the medications, were infused Nurse #3 put the linger back in the bag she had m. The syringe still had visible a on it. Nurse #3 did not clean	F 441			

CHITTE	IND ON MEDION	H AND HUMAN SERVICES E & MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·		PRINTE FOR OMB NO	M APPR
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSYRUCTION NO 01 - MAIN BUILDING 01	(XI) DATE	
		345389	B, WING_		·	
	PROVIDER OR SUPPLIER	ILENN	1	REET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET SARNER, NC 27529	11/	02/201
(X4) IO PREFIX (AG	EACH DEFICIENC	AYEMENY OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CHOSS-REFERENCED TO THE APP DEFICIENCY)	វារ៉ា ៣ ៥៩	COMP D)
	Doors protecting corequired enclosures hazardous areas ar those constructed o wood, or capable of minutes. Doors in sequired to resist the no impediment to the are provided with a sequired to closed. Duare permitted, 19, Roller latches are facinall health care fac	pridor openings in other than of vertical openings, exits, or e substantial doors, such as if 1% inch solid-bonded core resisting fire for at least 20 upinklered buildings are only a passage of smoke. There is e closing of the doors. Doors means suitable for keeping litch doors meeting 19,3.6,3.6.3.6.3.6.3.6.3.6.3.6.3.6.3.6.3.6		***	y	12-17-
	- 45-24 V			Ad ministrates		DATE LI

Any deficiency statement anding will an asteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the polients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to confinued program participation.

OP

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	A, BUI		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	COMP	
		345389	B. WI	√G		11/	02/2011
	PROVIDER OR SUPPLIER JRELS OF FOREST G	LENN	•	1'	EET ADDRESS, CITY, STATE, ZIF CODE 101 HARTWELL STREET PARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	COMPLETION DATE
K 018 SS=E	Doors protecting corequired enclosures hazardous areas are those constructed of wood, or capable of minutes. Doors in required to resist the no impediment to the are provided with a the door closed. Do are permitted.	FETY CODE STANDARD orridor openings in other than sof vertical openings, exits, or e substantial doors, such as of 1% inch solld-bonded core fresisting fire for at least 20 sprinklered buildings are only e passage of smoke. There is ne closing of the doors. Doors means suitable for keeping atch doors meeting 19.3,6,3,6.3.6.3. rohibited by CMS regulations cilities.	K	018	The Director of Maintenance will check all corridor doors weekly to ensure compliance with the regulation. All variances will be corrected at the time of observati Monitoring results will be reporte the Administrator and to the Qua Assurance committee during the monthly meeting. Continued compliance will be monitored through the facility's preventative maintenance, fire sat and quality assurance programs.	on. od to	
SS≃F	Based on observat approximately 8:30 noted: 1) The corridor door 206, 215, 228, 234 close, latch and sea 42 CFR 483,70(a) NFPA 101 LIFE SAI One hour fire rated fire-rated doors) or a extinguishing system and/or 19.3,5,4 protests.	FETY CODE STANDARD construction (with % hour an approved automatic fire n in accordance with 8.4.1 ects hazardous areas. When	K 0	29	K 029 The laundry room corridor door the door separating the soiled he room and laundry foom have bee adjusted to close, latch and seal.	lding	18-117-11
ABORATORY	DIRECTOR'S OR PROVID	er/Supplier representative's sign/	YURE -		TITLE		(XB) DATE

Any deficiency statement equity with no 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.

FORM CM9-2587(02-99) Previous Versions Obsolete

Event ID: I0KR21

Facility ID: 923173

If continuation sheet Page 2, of 15

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDENCIA DEPOCIES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(XX) MU A. BUIL		PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE COMP	
		345389	B. WIN	G 🚛		11/	02/2011
	PROVIDER OR SUPPLIER URELS OF FOREST G	LENN		11	EET ADDRESS, CITY, STATE, ZIP GOOF 01 HARTWELL STREET ARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INPORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
K 029	option is used, the a other spaces by sm doors. Doors are so field-applied protect	natic fire extinguishing system areas are separated from oke resisting partitions and elf-closing and non-rated or live plates that do not exceed pottom of the door are	K 02	29	The tape has been removed from kitchen's front dry storage door the rear door has been adjusted doors now close. latch and seal. The Dietary Staff will be provided additional education by the Maintenance Director/designee relating to not taping doors that required to close, latch and seal.	and Both	
T contract v	Based on observation approximately 8:30 Anoted: 1) The Laundry room latch and seal and tholding room and lateth. 2) The dry storage redoors, one towards to the rear door was and the rear door was indicated and the sealing defficient a) Fire dampers close due to condition the following defficient a) Fire dampers close due to condition the required rating of the required rating of c) There are hole walls and ceiling that	g closet on 100 Hall corridor ch and seal, cated on the service hall had noies were tripped and did not not units and/or foregnated around the units and the combustion air inlets at sealed in order to maintain			The corridor door to the housekeeping closet on 100 Hal been adjusted to close, seal and. The fire dampers will be cleaned and/or repaired to allow closing tripped. The area around the combustion inlets, and the penetrations in the walls and ceiling will be filled any sealed with approved fire rated material. The Director of Maintenance has received one to one counseling/education by the Administrator on 11/15/2011 related to the requirements of the regulat	latch, when air air ad/or	

	T OF DEFICIENCIES OF CORRECTION	(X1) FROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:	ENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		345389	B. VV.	,		11	/02/2011
l	PROVIDER OR SUPPLIER JRELS OF FOREST G	LENN		11	REET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET FARNER, NG 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		. PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO GROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 029	Continued From page 42 CFR 483.70(a)	ge 2	K	029	The Director of Maintenance we monitor weekly all corridor and doors to ensure proper closure, latching and seal and ensure the dampers are free of debris and evaluation when tripped. Adjustments will made as identified, '('he Mainten Director will monitor all outside contractors to ensure any penetrin the fire walls are sealed upon completion of any work. Conce will be reported to the Administrand to the quality assurance committee during the monthly meeting. Continued compilance will be monitored through the facility's preventative maintenance, fire sand quality assurance programs,	d fire close l be nance e rations tris trator	
And the state of t		į					
·							

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	of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	V Man Editable	(X3) DATE	SURVEY LETED
		345389	B. WING		11	/02/2011
	Provider or supplier URELS OF FOREST (SLENN		reet address, city, state, zip code 1101 hartwell street Garner, NC 27528		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP OEFICIENCY)	HOULD BE	COMPLETION DATE
	A fire alarm system installed, tested, ar with NFPA 70 Natio 72. The system has and testing progran	age 2 AFETY CODE STANDARD If required for life safety is not maintained in accordance conal Electrical Code and NFPA is an approved maintenance in complying with applicable EPA 70 and 72. 9.6,1,4	K 029	K 052 The fire alarm system was service by Engle Fire Inc. to allow the magnetic locks for the exit doors remain disengaged when the fire alarm notification devices were silenced. The fire alarm system will continue inspected through routine scheduled maintenance checks by outside fire system contractor. To Director of Maintenance or design will monitor the magnetic locks in the exit doors to disengage when fire alarm notification devices are	to y the he nec or the	12-17-11
K 056 SS=F	Based on observat approximately 8:30 noted: 1) When testing the magnetic holders for doors and the magnetic holders for engage who the first and the magnetic holders and the magnetic holders and the first and automated in accordance with NFI accordance with NFI accordance with NFI	s not met as evidenced by: lon on Wednesday 11/2/11 at AM onward the following was fire alarm system the r the cross corridor smoke letic locks for the exit doors ten when the fire alarm were silenced. FETY CODE STANDARD atic sprinkler system, it is lice with NFPA 13, Standard is Sprinkler Systems, to verage for all portions of the in is properly maintained in PA 25, Standard for the and Maintenance of	K 056	silenced during the monthly fire drills. The Administrator and the system contractor will be notified any variances and repairs will be promptly made. Continued compliance will be monitored through the facility's preventative maintenance, fire sat and quality assurance programs. K 056 The yellow sprinkler heads in the Laundry room (Soiled side and cl side), soiled holding room, kitche HVAC room (100 hall), housekeeping closet (100 hall), an maintenance office by laundry havbeen replaced with the red sprinkleheads by Eagle Fire.	fety can	1-17-12

	IENT OF DEFIDIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 MAIN BUILDING 01		(X3) DATE	SURVEY LETEO			
		345389	B, WIN	IG		44	inninnaa
	PROVIDER OR SUPPLIER URELS OF FOREST G	LENN		110	ST ADDRESS, CITY, STATE, ZIP GODE 1 HARTWELL STREET RNER, NC 27529	1 17	/02/2011
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE
K 056	Water-Based Fire F supervised. There supply for the system systems are equipp switches, which are	Intervised From page 3 Intervised From Protection Systems. It is fully upervised. There is a reliable, adequate water upply for the system. Required sprinkler stems are equipped with water flow and tamper witches, which are electrically connected to the utiliding fire alarm system. 19.3.5 K 056 No other sprinkler head bulbs needing replacement were identified. The Director of Maintenance has received one to one education on the requirements by the Administrator.					
K 061 SS=D	Based on observati approximately 8:30 / noted: 1) There are sprinkle for Intermediate Ten Glass Bulb Color of (175°F) in place of C Classification, Glass Areas were the Yello in the following; a) Laundry Roof b) Soiled holding c) Kitchen, d) HVAC room, e) House keeping f) maintenance of 42 CFR 483.70(a) NFPA 101 LIFE SAF	100 Hail g closet 100 Hall office by laundry ETY CODE STANDARD sprinkler systems have that at least a local alarm	K 06	1 2 2	The Director of Maintenance we ensure that any new installation replacements of sprinkler heads equipped with the correct temper classification bulb colors. Continued compliance will be monitored through the facility's preventative maintenance, fire stand quality assurance programs. K 061 The accelerator line to the dry side the sprinkler riser has two valves t	s or arc trature of nat	7£~ }~\(

PRINTED: 11/07/20 FORM APPROVI OMB NO. 0938-03!

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 345389 11/02/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET THE LAURELS OF FOREST GLENN GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION ID COMPLETION DATE PHÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG YAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The accelerator line will be monitored-K 081 Continued From page 4 K 061 through routine scheduled maintenance checks by the outside This STANDARD is not met as evidenced by: contractor and the Maintenance Based on observation on Wednesday 11/2/11 at Director to ensure the system remains approximately 8:30 AM doward the following was functional when the valves are closed. noted: Any variances will be corrected. 1) The accelerator line to the dry side of the Concerns will be reported to the sprinkler riser has two valves (one on both sides Administrator and to the quality of the accelerator) that when closed will affect the assurance committee during the operation of the system and are not equipped monthly meeting. with an electronically supervised tamper alarm. Continued compliance will be monitored through the facility's preventative maintenance, five safety and quality assurance programs,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/STRIBLE (EDICAL)

PRINTED: 11/07/201' FORM APPROVE(OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(XI) DATE SURVEY GOMPLETED	
···		345389	B. WING		11/	02/2011
	PROVIDER OR SUPPLIER URELS OF FOREST G			REET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529		<i>0.0,0011</i>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
K 081	Continued From pa		K 061			
	Based on observati approximately 8:30 noted: 1) The accelerator li sprinkler riser has ty of the accelerator) it operation of the syst	on on met as evidenced by; on on Wednesday 11/2/11 at AM onward the following was ne to the dry side of the vo valves (one on both sides nat when closed will affect the em and are not equipped v supervised tamper alarm.			1	
K 067 SS=F	Heating, ventilating, with the provisions on the decordance with t	ETY CODE STANDARD and air conditioning comply f section 9.2 and are installed the manufacturer's 5.2.1, 9.2, NFPA 90A,	K 067	K 067 The radiation dampers in resident bathrooms have been cleaned and free from lint and dust. The fire dampers in then rehab off and ceiling in the corridor outside resident room 208 have had the fusible linkage replaced and are properly shutting.	‡	12-17-1/
a r 1 b n w a 2 to	Based on observation approximately 8:30 Amoted; i) Throughout the fact the ceiling maintained clean and was an excessive amocumulated on the unit of the processive that the process in the process and the process in the process and the process in the process and the pro	radiation dampers were not in good condition. There ount of lint and dust nits. following areas were found and failed to close. office for outside resident room		All fire dampers in the facility have had the fusible links removed and have been tested to show that they properly close. The Director of Maintenance has received one to one education by the Administrator on the Preventative Maintenance Policies and the requirements.	;	

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(XI) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

B, WING

(X3) DATE SURVEY COMPLETED

345389

A. BUILDING 01 - MAIN BUILDING 01

11/02/2011

NAME OF PROVIDER OR SUPPLIER

THE LAURELS OF FOREST GLENN

STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET

(XA) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	PROVIDER'S PLAN OF CORRECTION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLE DATE
Continued From page 5 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. 42 CFR 483.70(a)	The Director of Maintenance will ensure the ceiling radiation dampers in the resident's bathrooms are free of lint and dust weekly. Any variances will be corrected, Monitoring results will be reported to the Administrator weekly for the next (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting. The Director of Maintenance will ensure the fusible links in he fire dampers are removed, and all fire dampers are removed, and all fire dampers tested to ensure they close, latch and are lubricated every (4) four years. Records of maintenance for the fire dampers will be retained by the Maintenance Director. Continued compliance will be monitored through the fheility's preventative maintenance, fire safety and quality assurance programs.	

FORM CMS-2587(02-99) Provious Varsions Obsolete

Event ID; (0XR21

Facility ID: 923173

Perse 9 of 15

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/07// FORM APPRO CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO, 0938-0</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 345389 11/02/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET THE LAURELS OF FOREST GLENN GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES (X4) 10 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (8K) IYƏJAMOD PREFIX . JEACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) ΊΛG YAG CROSS REFERENCED TO THE APPROPRIATE DAYE DEFICIENCY K 007 Continued From page 5 K 067 Maintenance, At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. 42 CFR 483,70(a) K 075 NFPA 101 LIFE SAFETY CODE STANDARD K 075 K 075 12-17-() SS≍D The laundry aides, housekeepers and Soiled linen or trash collection receptacles do not nursing assistants will be reeducated exceed 32 gal (121 L) in capacity. The average by the Director of Nurses/designee density of container capacity in a room or space relating to not leaving a solled linen does not exceed .5 gal/sq ft (20.4 L/sq m). A cart of 32 gallons or more unattended capacity of 32 gal (121 L) is not exceeded within in the corridors. any 84 sq ft (5.9-sq m) area. Mobile solled linen or trash collection receptacles with capacities The Housekeeping/Laundry greater than 32 gal (121 L) are located in a room Supervisor will monitor the location protected as a hazardous area when not of the soiled linen containers in the attended. 19,7,5,5 corridors (3) three times a week for (4) four weeks then randomly thereafter to ensure on-going compliance. Variances will be corrected at the time of observation. Monitoring results will be reported to This STANDARD is not met as evidenced by: the Director of Nurses weekly for the Based on observation on Wednesday 11/2/11 at next (4) four weeks and concerns will approximately 8:30 AM onward the following was be reported to the quality assurance noted: committee during the monthly 1) A solled linen tub/cart with a capacity greater meeting. than 32 gallons was left unattended in the corridor outside resident room 122, Continued compliance will be 42 CFR 483.70(a) monitored through routine facility round observations and through the facility's quality assurance program.

FORM CMS-2687(02-89) Previous Versions Obsolute

Event ID: (0KR2)

Facility ID: 923173

concerns.

Additional education and monitoring will be initiated for any identified

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If continuation sheet Page 10 of [5

PRINTED: 11/07/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 01 - MAIN BUILDING 01 B. WING 345389 11/02/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 1101 HARTWELL STREET THE LAURELS OF FOREST GLENN GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION lo Prefix (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL LEACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCEO TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) K 076 **ブー**ソカーリ The identified oxygen cylinder was K 076 Continued From page 6 K 076 secured, Appropriate signage (a) Oxygen storage locations of greater than designating full and empty cylinders 3,000 cu,ft, are enclosed by a one-hour has been placed in the oxygen storage. separation. room. (b) Locations for supply systems of greater than All nursing and therapy staff will be 3,000 cu,ft, are vented to the outside. NFPA 99 re-educated by the Director of 4,3.1.1,2, 19.3,2,4 Nurses/designee on the need to secure oxygen cylinders at all times, the requirement for storing full and empty cylinders in their designated areas, and marking empty cylinders with an "empty" tag identification. This STANDARD Is not met as evidenced by: Based on observation on Wednesday 11/2/11 at The Director of Nursing and approximately 8:30 AM onward the following was designees will monitor the oxygen noted: storage rooms (5) five times a week 1) The oxygen storage room located at the 200 for the next (2) two weeks then (3) Hall nurse station had the following: three times a week for (2) two weeks a) An unsecured oxygen cylinder. then randomly thereafter to ensure b) Full and empty oxygen cylinders were compliance. Variances will be stored together. If stored within the same enclosure, empty cylinders shall be segregated corrected at the time of observation. and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid Monitoring results will be reported to confusion and delay if a full cylinder is needed the Administrator weekly for the next (4) four weeks and concerns will be hurriedly, [NFPA 99 4- 3,5,2,2b(2)] (oxygen storage near the nurses station) reported to the quality assurance committee during the monthly 42 CFR 483,70(a) meeting, Continued compliance will be monitored through routine observations of the oxygen storage rooms and through the facility's preventative maintenance and quality assurance programs, Additional education/administrative action and or monitoring will be initiated for any identified concerns.

	Y of deficiencies of correction	(X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIA	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DAYE COMPI	SURVEY LETEU
		345389	B. WING_	· ·	11/	02/2011
	PROVIDER OR SUPPLIER URELS OF FOREST G	GLENN	1	REET ADDRESS. CITY, STAYE, ZIP COU 101 HARTWELL STREET GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL ,SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 076	(a) Oxygen storage 3,000 cu.ft. are end separation. (b) Locations for su	age 6 I locations of greater than closed by a one-hour lipply systems of greater than lited to the outside. NFPA 99	K 076	K 076 The identified oxygen cylinder secured, Appropriate signage designating full and empty cylin has been placed in the oxygen s room. All nursing and therapy staff where educated by the Director of Nurses/designee on the need to oxygen cylinders at all times, the requirement for storing full and	torage	32-17-11
	Based on observat approximately 8;30 noted: 1) The oxygen stora Hall nurse station has An unsecure b) Full and emp stored together. If senclosure, empty and designated (with Empty cylinders confusion and delay	d oxygen cylinder, by oxygen cylinders were stored within the same cylinders shall be segregated h signage) from full cylinders. shall be marked to avoid v if a full cylinder is needed 4- 3.5.2.2b(2)) (oxygen		empty cylinders in their designal areas, and marking empty cylind with an "empty" tag identification with an "empty" tag identification with an "empty" tag identification designees will monitor the oxyg storage rooms (5) five times a we for the next (2) two weeks then three times a week for (2) two withen randomly thereafter to ensure compliance. Variances will be corrected at the time of observation designees will be corrected at the time of observations will be reported. (4) four weeks and concerns will reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through routine observations of the oxygen storal rooms and through the facility's preventative maintenance and quassurance programs. Additional education/administrative action to monitoring will be initiated for monitoring will be initiated for	clers on. con reek (3) reeks ore fon. ted to c next I be	

PRINTED: 11/07/20-FORM APPROVE OMB NO. 0938-035

	it of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	A. BUILDIN	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DATE :	
		345389	B, WING _		11/	02/2011
	PROVIDER OR SUPPLIER URELS OF FOREST G	LENN] 1	reet address, city, state, zip coi 101 Hartwell Street Barner, nc 27529	១៩	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACYION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETIO (XS)
K 078	3,000 cu.ft. are end separation. (b) Locations for su	ge 6 locations of greater than losed by a one-hour pply systems of greater than ted to the outside. NFPA 99	K 078			
K 144 SS=0	Based on observat approximately 8:30 noted: 1) The oxygen stora Hall nurse station has a) An unsecured b) Full and empstored together. If senciosure, empty and designated (with Empty cylinders confusion and delay hurriedly. [NFPA 99 storage near the nur. 42 CFR 483,70(a) NFPA 101 LIFE SAF	d oxygen cylinder, by oxygen cylinders were stored within the same cylinders shall be segregated a signage) from full cylinders, shall be marked to avoid if a full cylinder is needed 4- 3.5,2.2b(2)) (oxygen sees station) FETY CODE STANDARD ecled weekly and exercised nutes per month in	K 144	K 144 A load bank test has been comp The monthly load test will be conducted for 30 minutes under of the EPS nameplate rating or minimum exhaust gas temperaturecommended by the manufactt and documented on the monthly	30% the ure as urer	12-17-11

STATEMENT	TOF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER: 345389	A. 8U	ILDIN	PLE CONSTRUCTION G 81 - MAIN BUILDING 81	(X3) DATE COMPI	
	PROVIDER OR SUPPLIER	GLENN		1	REET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET GARNER, NC 27529		
(X4) ID PREFIX YAG	(FACH DEFICIENC	AYEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	i)X	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	ついしか BE	COMPLETION (XE)
K 144	Continued From page 7			144	The Director of Maintenance has received one on one counseling/education on the required documentation by the Administra		erie i de la companya de la company
	Based on observa approximately 8:30 noted: 1) Documentation conducted without temperature rise, completed within the second of inspection period, and repairs and available for inhaving jurisdiction. NFPA 110 6-4.2 (1) Level 1 and Level least once monthly using one of the foliable for inhot less than 30 perating (b) Loading that may be temperatures manufacturer. NFPA 110 6-4.2.2 EPS installations the equirements of 6-with the available fannually with suppname plate rating for the second process.	Record keeping. A written in, performance, exercising is shall be regularly maintained inspection by the authority. 1999 edition) generator sets in 2 service shall be exercised at the formal of 30 minutes,			The Administrator will review the generator log monthly for the new three months to ensure appropriate documentation. Variances will be corrected as identified and conce will be reported to the quality assurance committee. Continued compliance will be monitored through random reviet the generator log by the administ and through the facility's prevent maintenance and quality assurance programs. Additional education a monitoring will be initiated for a Identified concerns.	et (3) te crns v of rator ative ce and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING OF MAIN BUILDING			(X3) DATE SURVEY COMPLETED			
j			1	or many policonto ve		
		345389	B. WING		11/	02/2011
	PROVIDER OR SUPPLIER URELS OF FOREST G	LENN		REET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET JARNER, NC 27529		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
K 147 SS=D	minutes, for a total bank testing) 42 CFR 483,70(a) NFPA 101 LIFE SAI Electrical wiring and with NFPA 70, National Section 1 Based on observation approximately 8:30 noted: 1) Broken receptack areas; a) Laundry room b) Resident roowall. c) The electrical half nurse station was	ge 8 ent of nameplate rating for 60 of 2 continuous hours. (load FETY CODE STANDARD I equipment is in accordance onal Electrical Code, 9,1.2 I not met as evidenced by: on on Wednesday 11/2/11 at AM onward the following was as were found in the following in both clean and solled side, ms 134, 237 along corridor I panel located by the 200 s blocked with a cart. (Three front of panel was not	K 144	•	m m	12-17-((

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/07/2 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROV STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER: OMB NO. 0938-0. AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 01 - MAIN BUILDING 01 B, WING 345389 NAME OF PROVIDER OR SUPPLIER 11/02/2011 STREET ADDRESS, CITY, STATE, ZIP CODE THE LAURELS OF FOREST GLENN 1101 HARTWELL STREET GARNER, NC 27529 (X4) IO PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL IO PREFIX TAG PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE (X5) GOMPLETK CROSS-REFERENCED TO THE APPROPRIATE OATE DEFICIENCY Repairs will be monitored through review of the facility maintenance requests and routine facility round observations. Concerns will be reported to the Administrator and to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through the facility's preventative maintenance and quality assurance programs. Additional education and monitoring will be initiated for any identified concerns. FORM CMS-2587(02-89) Previous Versions Obsolete

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Facility ID: 923173

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