THE LAURELS OF CHATHAM

F 000 INITIAL COMMENTS
No deficiencies were cited as a result of the complaint investigation survey of 8/18/12. Event ID #JB1L11.

F 371 483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
The facility must:
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based upon observations and staff interview the facility failed to maintain the temperatures of beverages including milk, at or below 41 degrees Fahrenheit at the tray line and for service in the dining room.
The findings included:
At 11:45 AM on 8/15/2012, the lunch food temperatures were checked by the dietary manager with a calibrated thermometer.
Individually poured glasses of lemonade, water and juices had been prepared and were being held in compartmentalized trays stacked on a cart that was in close proximity to a hot oven. Kitchen personnel working in the tray line were taking beverages from the compartmentalized tray of beverages to put on individual trays with resident meals. The temperature of a glass of lemonade was found to be 55 degrees Fahrenheit.

The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is September 11, 2012.

Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.

F 371 Food Procure, Store/Prepare/Serve-Sanitary
Corrective Action
The gallon jug of chocolate milk, when found to be 46 degrees, was replaced with a new one from the refrigerator. Ice was added to the juices.

Corrective Action for those having the potential to be affected
The other milk products were reviewed at the time of the survey, by the dietary manager. No other milk product was found to be above 41 degrees. Ice was added to the bin to further cool the juices.

LAWRTORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

J. L. L. 11

ADMINISTRATIVE DIRECTOR

TIE

SEPT 13TH, 2012

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 discloseable 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 discloseable 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.
F 371  Continued From page 1
from the top tray by the oven registered at 60
degrees.

On 8/15/2012 at 11:53 AM, temperatures were
taken of beverages on a cart in the main dining
room adjacent to the kitchen. A gallon jug of
chocolate milk, sitting in a tray with ice was 48
degrees. The other juices were in pitchers on the
same cart. The regular cranberry juice was 52
degrees, the apple juice was 55 degrees and the
honey-thick cranberry juice was 74 degrees.

During an interview on 8/15/2012 at 11:54 AM,
the dietary manager indicated the milk should be
at or below 41 degrees Fahrenheit.

F 431 483.60(b), (d), (e) DRUG RECORDS,
LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of
a licensed pharmacist who establishes a system
of records of receipt and disposition of all
controlled drugs in sufficient detail to enable an
accurate reconciliation; and determines that drug
records are in order and that an account of all
controlled drugs is maintained and periodically
reconciled.

Drugs and biologicals used in the facility must be
labeled in accordance with currently accepted
professional principles, and include the
appropriate accessory and cautionary
instructions, and the expiration date when
applicable.

In accordance with State and Federal laws, the
facility must store all drugs and biologicals in
locked compartments under proper temperature
controls, and permit only authorized personnel to

Systemic Changes
The dietary employees have been re-
educated on the process of temperature
monitoring. An insulated cooling bin has
been purchased, that is placed in the
freezer to cool, prior to placing ice,
milks, and juices. At the tray line, juices
have been moved away from the oven
area. In addition, ice is being placed into
the juices, as well as around the drinks.

Monitoring
A QA Temperature Monitoring tool, that
includes beverages served in the dining
room, will be reviewed by the Dietary
Manager and/or his designee, daily for 1
month then randomly each week x 2
months, to observe for compliance of
temperature monitoring. Any beverages
found above the required temperatures
will be cooled, and any milk products
will be replaced. Additional education
will be provided as necessary.

The QA committee will review findings
during the monthly QA committee
meeting x 2 months or until resolved to
monitor for on-going compliance with
additional education being provided if
indicated.

Continued compliance will be monitored
through routine temperature monitoring
and through the facility's quality
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 431</td>
<td></td>
<td></td>
<td>Continued From page 2 have access to the keys.</td>
<td>F 431</td>
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<td></td>
<td>assurance program. Additional education and monitoring will be initiated for any identified concerns.</td>
</tr>
</tbody>
</table>

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

- Based on record review, observations and interviews with facility staff, the facility staff failed to lock the medication cart, leaving it unattended for 1 of 7 medication carts.

The findings include:

- Record review of the policy and procedure for "Medication Administration" revised 07/09 revealed, "13. Make sure that the medication cart is locked at all times when it is not in use or not within your constant vision. Store the medication cart in the appropriate storage area between med passes."

- Observations on 8/14/12 at 2:01 PM revealed the medication cart unlocked and parked between rooms 801 and 803. The lock on the medication cart was protruding, indicating the medication cart was unlocked. Two residents were in the hallway and one resident confused was sitting next to the unlocked medication cart, asking for his...
<table>
<thead>
<tr>
<th>F 431</th>
<th>Continued From page 3 medication. (the medications had already been passed) At 2:14 PM the Unit Manager walked by and locked the medication cart.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Interview on 8/14/12 at 2:14 PM with the Unit Manager revealed that her expectation was that nurses never walk away from a medication cart that was not locked.</td>
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<td>Interview on 8/14/12 at 2:20 PM with the medication nurse revealed that she checked her medication cart three times before she left it. She continued that she may have answered an alarm. She did not remember why she left the medication cart.</td>
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<tr>
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<td>Interview on 8/14/12 at 2:25 PM with the DON revealed that the medication carts must be locked at all times.</td>
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<tr>
<td>F 431</td>
<td>medication carts locked and stored off of the hall when not in use.</td>
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</tbody>
</table>

**Monitoring**

The Director of Nurses and/or her designee will randomly check medication carts to ensure the carts are securely locked daily for three weeks, and then weekly for one quarter, utilizing a monitoring tool. Nurses will be re-educated as necessary.

The QA committee will review findings during the monthly QA committee meeting x 2 months or until resolved to monitor for on-going compliance with additional education being provided if indicated.

Continued compliance will be monitored through routine medication cart observations and through the facility’s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.
### INITIAL COMMENTS

The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is September 19th, 2012.

Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.

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#### NFPA 101 LIFE SAFETY CODE STANDARD

Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1

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#### Corrective Action

**K 012 Life Safety Code Standard**

Corrective Action for those having the potential to be affected.

All other areas of possible penetration have been checked by the Director of Maintenance. No other areas have been identified to require sealant.

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**Systemic Changes**

The Director of Maintenance will inspect areas that have been serviced by outside vendors, as they complete their work, to determine if all penetrations have been...
## Initial Comments

This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system.

The deficiencies determined during the survey are as follows:

**K 012**

NFPA 101 LIFE SAFETY CODE STANDARD

Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1

**K 038**

NFPA 101 LIFE SAFETY CODE STANDARD

Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1

## Preventive Action

In addition, the Director of Maintenance will on a semi-annual basis, review all areas of penetration, for proper sealant.

Monitoring

The Director of Maintenance will check the areas of penetration, monthly times three months, and then semi-annually thereafter, to confirm compliance. Continued compliance will be monitored through the facility's preventative maintenance and quality assurance programs. The Administrator will be responsible to act upon any recommendations coming from the committee.

**K 038**

Life Safety Code Standard

Corrective Action

The throw bolts were removed at the time of survey.

Corrective Action for those having the potential to be affected

All other doors were checked by the Director of Maintenance and Administrator. No other doors were found to have throw bolts on them.

Systemic Changes

The Director of Maintenance has been re-educated regarding allowable locking mechanisms. As this door was the only door with throw bolts, this door has had...
**THE LAURELS OF CHATHAM**

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>K 038</td>
<td>Continued From page 1 42 CFR 483.70(a) By observation on 9/8/12 at approximately noon the following exit access was non-compliant, specific findings include; throw bolts on the exit- egress door from the Alzheimer's courtyard into the building. The courtyard area requires two means of egress. This item was removed during the survey.</td>
<td>K 038</td>
<td>a special lock system installed, to conform to all other doors in the facility. Monitoring The Director of Maintenance will check all doors monthly, for two months, to confirm compliance. Continued compliance will be monitored through the facility's preventative maintenance and quality assurance programs. The Administrator will be responsible to act upon any recommendations coming from the committee.</td>
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<tr>
<td>K 052</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD SS=F A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.8.1.4</td>
<td>K 052</td>
<td>K 052 Life Safety Code Standard Corrective Action The fire alarm panel is in the process of being replaced. The duct detectors noted in item 4 have been repaired. The other 5 items on the list will be addressed with the new alarm panel. Corrective Action for those having the potential to be affected. The fire alarm panel is in the process of being replaced. The duct detectors noted in item 4 have been repaired. The other 5 items on the list will be addressed with the new alarm panel. Systemic Changes Once the fire alarm panel is replaced, the remaining items on the list will have been corrected. The fire alarm company will continue to make quarterly visits</td>
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This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/8/12 at approximately noon the following fire alarm system was non-compliant, specific findings include; report from 8/7/12 from Eagle Fire indicated six (6) items that have not been corrected.
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<td>K 052</td>
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| K 052         | NFPA 101 LIFE SAFETY CODE STANDARD  
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Monitoring
The Director of Maintenance will test the alarm system weekly for one month and monthly for two months to confirm compliance of new system, when in place. The alarm company will review system as scheduled and at least quarterly. Continued compliance will be monitored through the facility's preventative maintenance and quality assurance programs. The Administrator will be responsible to act upon any recommendations coming from the committee.