

MAY 31 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/01/2013
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NAME OF PROVIDER OR SUPPLIER  LUTHERAN HOME-ALBEMARLE	STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001
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F 156 SS-C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (O(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate,</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p><u>Plan of Correction Tag #483.10</u></p> <p><u>F156</u></p> <p><u>For all residents and families affected:</u></p> <p>On 05/06/13 the administrator posted on a bulletin board in the main hallway of the facility the names, phone numbers, and addresses for the following State client advocacy groups: North Carolina Division of Health Service Regulation (DHSR)-Survey/Certification Section; North Carolina DHSR-Nursing Home Licensure Division; North Carolina State Ombudsman; Local Ombudsman; Medicaid Fraud-Program Integrity Division; Division of Aging and Adult Services; and Services for Deaf and Hard of Hearing. In addition, a posting for the Complaint Intake Unit was posted with updated contact information. The administrator completed training for all department heads on 05/07/2013 regarding the change in division names and contact information and directed the department heads to the location where this updated information is posted. The administrator educated all staff and residents that attended the all-staff meeting on 05/15/2013, regarding the posting of the change in contact information for the State advocacy groups. The administrator has instructed all department heads to share with residents where this updated information is located. In addition, an announcement was made during family night on 05/16/13 by the administrator that items on the bulletin board had been updated. An announcement regarding the changes will be made at the next resident council meeting on 05/22/13. A note will be sent to responsible parties with May billing statements (on or around 05/27/13) regarding the change.</p>	

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

TITLE

(X6) DATE

*Courtney Adams*

*Administrator*

*5/28/2013*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions ) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of correction is requisite to continued program participation

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F 156	<p>Continued From page 1</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by</p>	F 156	<p><u>For all residents and families that had the potential to be affected:</u></p> <p>Two postings with the updated contact information and advocacy group name have been posted on the bulletin board in the main hallway on the facility by the administrator. A letter addressing residents and families was posted on the same bulletin board to inform residents, family members and visitors of the changes in the client advocacy groups in North Carolina. A copy of the letter will be distributed to all residents on 05/21/13 by the ward clerk.</p> <p><u>System Changes:</u></p> <p>The administrator posted the names of the State client advocacy groups with their respective phone numbers and addresses on the bulletin board in the main hallway in the facility. The administrator, or Business Office Manager, will check the postings monthly for three months by calling and verifying the information with the appropriate agencies. After three months, the administrator, or Business Office Manager, will check yearly from the date of the last monthly check, with the State client advocacy groups, or when any changes are implemented within the divisions, to ensure the divisions names, phone numbers and addresses are correct .</p> <p>The corrective action will be completed by May 29, 2013.</p>	

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F 156	<p>Continued From page 2 such benefits,</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to accurately post the state nursing home regulatory agency contact information. The findings included:</p> <p>On 4/28/13 at 4:35 pm, during an initial tour of the facility, the main bulletin board, near the A hall had one sign with the Department of Health and Human Services (DHHS) Complaint Branch, listing a hotline number.. On a second sign, it stated that DHHS-Division of Facility Services could be contacted at a number that was no longer in service, and the posting did not include how to reach the state agency by address.</p> <p>On 4/29/13 at 10:19 am, an identical observation was made of the state contact information.</p> <p>Administrative Staff #4 was interviewed on 4/30/13 at 10:47 am.. She stated that she visited the facility at least quarterly and acknowledged that there was a new Administrator in place. She shared that she did not realize that the information that they posted for the state nursing home regulatory agency, lacked an address, current phone number or referred to it by its previous agency name, She gave assurance that it would be corrected.</p> <p>On 5/1/13 at 5:30 pm, the facility was able to post an updated sign with contact information for the state nursing home regulatory agency</p>	F 156			

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F247 SS-B	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by. Based on record review and staff and resident interview, the facility failed to inform 2 (Residents # 106 &amp; #103) of 3 sampled residents prior to receiving a new room mate.. The findings include:</p> <p>1. Resident #106 was admitted to the facility on 6/10/11. The annual Minimum Data Set (MDS) assessment dated 3/27/13 indicated that Resident #106 had no cognitive impairment.</p> <p>On 5/1/13 at 10:05 AM, Resident #106 was interviewed. She stated that she was not informed that she was getting a new room mate.. At 10:10 AM, administrative staff #1 was interviewed,. She stated that she was responsible of informing the residents when ever there was a change of room or new room mate., She acknowledged that she did not document that she had informed Resident #106 when a new room mate was admitted on 4/2/13</p> <p>2. Resident #103 was admitted to the facility on 2/17/11 The annual MDS assessment dated 4/17/13 indicated that Resident #103 had moderate cognitive impairment.</p>	F247	<p><b>PLAN OF CORRECTION TAG 483.15</b></p> <p><b>F247</b></p> <p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated.</p> <p><b>For the residents affected:</b> On 05/21/13, the social worker addressed the lack of communication with resident #103 and resident #106 regarding a change in their roommate. The social worker explained to resident #103 and resident #106 that it was their right to be made aware of any room/roommate change. An apology was extended for lack of communication on the behalf of the facility by the social worker. The social worker was in-serviced by the administrator on the importance of notifying all residents prior to room/roommate changes, as well as the importance of documenting this communication.</p> <p><b>For residents that have the potential to be affected:</b> A review of records of the previous four months was completed by the Medical Records Director and 18 total residents were identified as having had a room change. If not documented, the social worker will provide an explanation to the 18 residents who had a room change, who are still residing in the facility, regarding their room change and/or receiving a new roommate by May 29, 2013. In addition, the resident who was already residing in the room that received a new roommate will also be extended an apology by the social worker if documentation does not prove that the resident was notified of the room/roommate change. It will be explained to the residents by the social worker that they were entitled to be made aware of any changes involving their care including room/roommate changes prior to the occurrence of the event and this will be completed by May 29, 2013.</p> <p><b>System Changes</b> In the electronic medical records under the Departmental Notes tab, in the Social Services visits/notes folder, a blue tab has been added reading "Roommate Issues". This will allow the social worker to document any type of discussion regarding roommate problems, changes, etc. The social worker will discuss potential room/roommate changes with any resident that would be affected by the potential change and document</p>		

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F 247	Continued From page 4 On 5/1/13 at 10:01 AM, Resident #103 was interviewed, He stated that he was not informed that he was getting a new room mate. At 10:10 AM, administrative staff #1 was interviewed. She stated that she was responsible of informing the residents when ever there was a change of room or new room mate. She acknowledged that she did not document that she had informed Resident #103 when a new room mate was admitted on 4/10/13.	F 247	The social worker received in-servicing by the Lutheran Services Carolinas Clinical Informatics Nurse on the addition of the tab in our electronic medical records system, under the Departmental Notes tab, and the importance of discussing a room and/or roommate change prior to the occurrence of the event. Beginning the week 05/20/13, the Medical Records Director will randomly select two charts weekly for one month on residents who have had room/roommate changes, as applicable, to ensure that the resident has been informed by the social worker and that the social worker has documented this, for both residents in the room of the room and/or roommate change. Two charts will be selected monthly for one quarter by the Medical Records Director, then two charts will be selected quarterly for the remainder of the year by the Medical Records Director. <u>Monitoring plan to ensure solutions are sustained</u> The results will be documented using the Quality Improvement Collection Form by the Medical Records Director and will be presented by the Medical Records Director at the quarterly Quality Assurance meeting.	
F 279 SS-B	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by Based on record review and staff interview, the	F 279	<u>PLAN OF CORRECTION TAG # 483.20</u> F279 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.  To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. <u>For residents affected</u> For resident #54, the care plan regarding psychotropic medication use was updated on 04/30/2013 by the MDS nurse. For resident #90, two care plans were updated, including a care plan updated on 05/13/2013 for diuretic medication use, and a care plan updated on 05/21/2013 to reflect the use of psychotropic medication, by the MDS nurse. For resident #34, a care plan was initiated for palliative care by the MDS nurse on 05/06/2013. <u>For residents that have potential to be affected</u> For all residents with the potential to be affected, 100% of the residents' medical records will be audited based on psychotropic and diuretic medication use and palliative care orders by the two MDS nurses. Care plans will be updated by May 29th, 2013 by the two MDS nurses. <u>System Changes</u> On May 7, 2013, in our electronic medical records system, the care plan folder for Hospice was updated from Hospice to Hospice/Palliative Care. This is where all Hospice/Palliative Care care plans will be written.	

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F 279	<p>Continued From page 5</p> <p>facility failed to develop a care plan for the use of the psychotropic and diuretic medications for 2 (Residents # 54 &amp; #90) of 10 sampled residents reviewed for unnecessary medications and failed to develop a care plan for palliative care for one( Resident # 34) of one residents reviewed for palliative care. The findings include:</p> <p>1. Resident #54 was admitted to the facility on 3/20/12 with multiple diagnoses including Dementia with agitated features. The Minimum Data Set (MDS) assessment dated 3/6/13 indicated that Resident #54 had impaired cognition and had received antipsychotic medications.</p> <p>Review of the physician's orders revealed that Resident #54 was on Haldol (antipsychotic medication) for Dementia with agitated features.</p> <p>Review of the care plan revealed that there was no care plan developed for the use of the antipsychotic medication..</p> <p>On 4/30/13 at 10:54 AM, administrative staff #2 was interviewed.. She stated that she failed to care plan the use of the antipsychotic medication and she did not know the reason why.. She further stated that she had updated the care plan to include the use of the antipsychotic medication..</p> <p>2., Resident #90 was admitted to the facility on 2/3/11 with multiple diagnoses including Depressive Disorder and Congestive Heart Failure. The MDS assessment dated 2/8/13</p>	F 279	<p>Beginning May 8, 2013, physicians orders will be copied once a day, Monday through Friday, (a copy of any orders from the weekend are copied Monday), by the Medical Records Director and given to the two MDS nurses to update care plans. This will ensure that care will be individualized to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The two MDS nurses will be responsible for reviewing the orders they receive daily, Monday through Friday.</p> <p>The Medical Records Director will check a sample of physician orders beginning the week of 05/20/13 for charts that were audited according to the plan in the above paragraph to ensure that physician orders pertinent to care were added to the residents plan of care. The sample of physician orders taken by the Medical Records Director will include 6 physician orders weekly for one month, 6 physician orders monthly for one quarter, and 6 physicians orders quarterly for the remainder of the year.</p> <p>The facility's nurse consultant educated the care plan team (care plan team includes the Social Worker, two MDS nurses, Dietary Manager, and the Activities Director) on May 13<sup>th</sup> 2013, to include individualized care plans for each resident, including the development of care plans for residents with psychotropic medications, diuretic medications and palliative care orders.</p> <p>The care plan team was in-serviced by the DON on May 7, 2013 regarding the change in the electronic medical records system on the addition of the Hospice/Palliative Care folder. The care plan team was in-serviced by the DON on May 7, 2013 to inform the MDS nurses that they will receive a copy of all physician orders daily so that care plans can be individualized to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Effective May 13<sup>th</sup>, 2013, a facility nursing consultant or the DON will randomly select five charts weekly from a list of residents generated in our electronic medical records system that are on diuretic medications, psychotropic medications or with palliative care orders to ensure that care plans are completed accurately to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Then, five charts for patients on psychotropic medications, diuretic medications or palliative care will be selected monthly for one quarter, and then five charts will be selected quarterly for the remainder of the year by a facility nursing consultant or the DON. The results will be documented using the Quality Improvement Data Collection Form.</p>	

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F 279	<p>Continued From page 6</p> <p>indicated that Resident #90 had no cognitive impairment and had received antidepressant and diuretic medications,</p> <p>Review of the physician's orders revealed that Resident #90 was on Celexa (antidepressant) for Depression and Lasix (diuretic) for Congestive Heart Failure.,</p> <p>Review of the care plan revealed that there was no care plan developed for the use of the antidepressant and diuretic medications.,</p> <p>On 4/30/13 at 10:54 AM, administrative staff #2 was interviewed, She stated that she did not develop a care plan for the use of the antidepressant and diuretic medications because the medications did not affect the resident's care or were not causing any problems to the resident.</p> <p>3. Resident #34 was admitted to the facility on 11/21/2011. Cumulative diagnoses included Atrial fibrillation, Diabetes, Cerebrovascular accident and long term use of antibiotics.. The Quarterly Minimum Data Set (MDS) dated 3/5/13 indicated Resident #34 was moderately cognitively impaired.</p> <p>A physician's order dated 4/11/2013 stated strict palliative care, No hospital, no IV's (intravenous therapy), no antibiotics after completion of current antibiotic treatment.</p> <p>A review of the care revealed that there was no care plan developed for palliative care.</p>	F 279	<p><u>Monitoring plan to ensure solutions are sustained</u></p> <p>The results of these chart audits will be presented by the facility's nursing consultant or DON at the facility's quarterly quality assurance meetings with changes made as indicated.</p> <p>The corrective action will be completed by May 29, 2013</p>		

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F 279	Continued From page 7 On 5/1/13 at 3:13 PM., Administrative staff #2 stated she was the person responsible for Resident #34's care plan.. She reviewed the care plan and indicated she did not note anything related to palliative care except for pain management, She said she did not initiate a care plan for palliative care because Resident #34 received the same care as prior to the physician order on 4/11/2013 for strict palliative care, no hospital, no IV's and no antibiotic treatment.	F 279		
F 332 SS=D	483,25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by. Based on observation, staff interview, facility policy review, record review and drug manufacturer specifications, the facility failed to ensure a medication error rate of less than 5% due to 4 errors out of 25 opportunities for error resulting in a 16% medication error rate for 1 of 6 residents observed (Resident #147) during medication pass.  The findings included:  A facility policy, last revised 1/17/11, entitled "Enteral Tube Medication Administration" read in part '3, Enteral tubes are flushed before administering medications and after all medications have been administered with at least 30 ml (milliliters) of water. 4 Prior to crushing tablets for	F 332	<u>PLAN OF CORRECTION TAG #483.25</u> <u>F332</u> <u>For the resident affected</u> On April 30, 2013, Resident #147 was monitored closely with no adverse effects noted or observed. A medication error report has been submitted by Nurse #1 following the incident. On April 30, 2013, Nurse #1 was in-serviced by the DON on the facility's Enteral Tube Medication Administration policy, which includes the proper way to administer multiple medications via a gastrostomy tube and appropriate water flushes with medication administration via a gastrostomy tube. On April 30, 2013, Nurse #1 was in-serviced by the DON on appropriate measuring devices for liquid medications that can not be measured accurately using the standard 30ml measuring cup. A syringe with accurate markings was placed with Resident #147's KCL bottle by the DON to ensure accurate measurement. On April 30, 2013, Nurse #1 was in-serviced by the DON on appropriate Advair Diskus administration technique, including rinsing the mouth immediately after administration of the Advair Diskus medication. If unable to rinse due to nil per os (NPO) status the resident's mouth needs to be swabbed immediately after use. On April 30 <sup>th</sup> , 2013 Nurse #1 swabbed Resident #147's mouth immediately following the breathing treatment.	



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F 332	<p>Continued From page 8</p> <p>administration through the enteral tube, the Crushing Guidelines and list are consulted.. Crushed medications are not mixed together.. The powder from each medication is mixed with water or other suitable diluent if water is unacceptable, before administration. Each medication is administered separately to avoid interaction and clumping.."</p> <p>1, (a) Resident #147 was admitted to the facility on 4/22/13.. Diagnoses included status post gastrostomy tube, chronic heart failure, atrial fibrillation and chronic obstructive pulmonary disease .</p> <p>On 4/30/13 at 8:40 AM, Nurse #1 was observed to crush the resident's medications ordered to be given via the gastrostomy tube (G-tube).. The medications included Lasix 40 milligrams (mg), metaprolol 50 mg, amiodorone 200 mg and aspirin 81 mg. The nurse placed the medications in one bag, crushed them, and then emptied the crushed medications into a plastic cup containing approximately 120 milliliters (ml) of a mixture of water and potassium chloride (KCl)</p> <p>On 4/30/13 at 8:45 AM, Nurse #1 was interviewed, She stated she was not aware that medications should be crushed and administered individually through the G-tube.</p> <p>During an interview on 4/30/13 at 5.21 PM, Administrative Staff #3 indicated that medications given via G-tube should be crushed and given individually</p>	F 332	<p><b>For residents that have the potential to be affected</b></p> <p>At the present time, no other residents have naso-gastric or gastrostomy tubes, therefore no other residents have the potential to be affected by enteral tube medication administration at this time. However, all current licensed nurses will be in-serviced by the DON by 05/29/13 on the facility's Enteral Tube Medication Administration policy for any future resident that may have a naso-gastric or gastrostomy. Because all residents with Advair Diskus or with liquid medications have the potential to be affected, all licensed nurses and all medication aides will be in-serviced on the appropriate way to measure liquid medications and appropriate Advair Diskus administration by May 29th, 2013 by the DON. The DON or MDS nurse will complete a medication administration observation of each licensed nurse and each medication aide, for all shifts and the weekend nurses and medication aides, by 05/29/2013 to ensure compliance with the policies, with the exception of nurses and medication aides who do not have a scheduled shift before 05/29/2013, including but not limited to PRN nurses and nurses out on medical leave. The nurses and medication aides who fall into the exception category will be observed completing a medication administration upon their first scheduled shift.</p> <p><b>System Change</b></p> <p>A copy of the Enteral Tube Administration Policy was placed on every medication cart for quick referencing by the DON by 05/02/2013.</p> <p>Syringes were placed by the DON on every cart for accurate measuring of liquid medications by 05/02/2013.</p> <p>Every current Advair Diskus was labeled by the facility supervisor with a bright color sticker that reads, "rinse mouth after use or swab if unable to rinse". Every future Advair Diskus will be labeled by the facility supervisor or the DON with a brightly colored sticker</p> <p>All newly hired nurses will be in-serviced on the Enteral Tube Medication Administration Policy and all newly hired nurses and medication aides will be in-serviced on appropriate measuring devices for liquid medications and proper technique for Advair Diskus administration by the Staff Development Coordinator during new-hire orientation.</p>	

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

PRINTED: 05/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/01/2013
NAME OF PROVIDER OR SUPPLIER  LUTHERAN HOME-ALBEMARLE			STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	I PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332	<p>Continued From page 9</p> <p>1, (b) April 2013 physician orders for Resident #147 included potassium chloride (KCl) 16 milliequivalents (mEq) via gastrostomy tube (G-tube) daily,</p> <p>On 4/30/13 at 8:40 AM, the label on the KCl bottle read in part, 16 mEq = 12 ml (milliliters). Nurse #1 was observed to measure the KCL in a 30 ml medication cup that had markings for 5 ml, 10 ml, 15 ml, 20 ml and 30 ml., The nurse poured the KCl to between the 10 and 15 ml markings..</p> <p>On 4/30/13 at 8:45 AM, Nurse #1 was interviewed, She said the KCl bottle had come with a syringe to measure the 12 ml dose, but the syringe had been lost,. The nurse added she had given the KCl frequently and knew what 12 ml looked like in the medication cup.</p> <p>During an interview on 4/30/13 at 5:21 PM, Administrative Staff #3 acknowledged that 12 ml could not be accurately measured in a 30 ml medication cup and indicated she expected nurses to use a syringe for accurate measurement of the KCl,</p> <p>1 (c) On 4/30/13 at 8:42 AM, Nurse #1 was observed administering medications to Resident #147 via gastrostomy tube (G-tube). The nurse did not flush the tube prior to or after administering the medications.</p> <p>During an interview on 4/30/13 at 8:45 AM, Nurse #1 stated she normally flushed the tube with water before and after administering medications but forgot to do so this time</p>	F 332	<p>The DON or MDS nurse will complete a medication administration observation of each licensed nurse and each medication aide, for all shifts and the weekend nurses and medication aides, by 05/29/2013 to ensure compliance with the policies, with the exception of nurses who do not have a scheduled shift before 05/29/2013, including but not limited to PRN nurses and nurses out on medical leave. The nurses and medication aides who fall into the exception category will be observed completing a medication administration upon their first scheduled shift. Beginning the week 05/20/13, the DON or MDS nurse will complete a medication administration observation on two randomly selected nurses/medication aides weekly for one month, then monthly for one quarter, then quarterly for the remainder of the year to ensure that the licensed nurses are adhering to the policy for Enteral Tube Medication Administration, to ensure that licensed nurses and medication aides are accurately measuring liquid medications, and to ensure that licensed nurses and medication aides are using the appropriate technique for Advair Diskus administration. Any issues will be addressed immediately by the DON or MDS nurse.</p> <p><u>Monitoring plan to ensure solutions are sustained</u></p> <p>The results of these medication administration observations will be presented by the DON or MDS nurse at the facility's nursing meetings as well as the facility's quarterly quality assurance meetings to ensure ongoing compliance.</p> <p>The corrective action will be completed by May 29, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/01/2013
NAME OF PROVIDER OR SUPPLIER  LUTHERAN HOME-ALBEMARLE			STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	n1 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332	<p>Continued From page 10</p> <p>During an interview on 4/30/13 at 5:21 PM, Administrative staff #3 stated G- tubes should be flushed with 30 milliliters (ml) of water before and after medication administration</p> <p>1, (d) A facility policy, last revised 2/17/09, entitled "Oral Inhalation-Metered Dose Inhalers" included the following step after administering the inhaled medication: "11 Have the resident rinse his/her mouth and spit out the rinse water.."</p> <p>Manufacturer specifications on Advair Diskus package insert read in part, "After each dose, rinse your mouth with water and spit the water out. Do not swallow,"</p> <p>On 4/30/13 at 8:44 AM, Nurse #1 was observed administering Advair Diskus inhalation to Resident #147 The nurse did not rinse or swab the resident' s mouth with water following the inhalation but immediately began the resident's scheduled nebulizer treatment of levalbuterol.</p> <p>During an interview on 4/30/13. at 8:45 AM, Nurse #1 stated she normally swabbed the resident's mouth with water after administering the Advair Diskus because the resident was too cognitively impaired to rinse and spit on request. The nurse said she did not see any mouth swabs in the resident's room so she planned to bring some swabs and swab her mouth after the nebulizer treatment was completed .</p> <p>During an interview on 4/30/13 at 5:21 PM, Administrative Staff #3 stated she expected the mouth to be rinsed or swabbed immediately following the administration of Advair Diskus .</p>	F 332			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/01/2013
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NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME-ALBEMARLE	STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	E PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

  
TRINITY  
PLACE

Ms. Noreen Calder, RN, Nurse Consultant  
North Carolina Dept. of Health and Human Services  
Nursing Home Licensure and Certification Section  
2711 Mail Service Center  
Raleigh, NC 27699-2711

May 28, 2013

Dear Ms. Calder,

Enclosed please find the updated Plan of Corrections to address the deficiencies found from the recertification survey conducted on April 28<sup>th</sup>, 2013-May 1<sup>st</sup>, 2013 for Trinity Place in Albemarle, NC.

Please let me know if I can provide you with any more information or documentation.

Thank you,



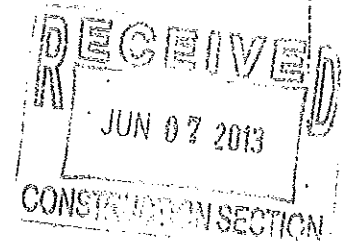
Courtney Adams  
Administrator  
cadams@trinityplacealbemarle.net  
P:704-982-8191

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  05/23/2013
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NAME OF PROVIDER OR SUPPLIER  LUTHERAN HOME-ALBEMARLE	STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 62 ALBEMARLE, NC 28001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS  This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type II protected construction and is not equipped with a complete automatic sprinkler system.  CFR#: 42 CFR 483.70 (a)  The facility is currently undergoing renovation for a complete automatic sprinkler system installation.	K 000	Plan of Correction: CFR#: 42 CFR 483.70 (a) Tag K 045  For residents affected: On 05/28/2013 the Maintenance Director installed a double light fixture outside the exit door from the resident dining room. The light fixture has been wired into the emergency power system.  For residents that have potential to be affected: On 05/28/2013, the Maintenance Director completed an inspection of the rest of the building to ensure that all exits (a total of ten exits) have proper lighting and that the lights are connected to the emergency power system. The Maintenance Director checked to make sure each light at the exits is working properly.	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045	System Changes: Starting the week of 06/10/2013, the Maintenance Director or Maintenance Assistant will check all of the exit doors in the facility to ensure that all required exit discharge lights are working. The Maintenance Director or Maintenance Assistant will check the light(s) at each exit door one time a week for month one to ensure they are working properly, one time a month for a quarter, and quarterly for the remainder of the year. After one year, the maintenance team will continue to check the outside lights at each means of egress once a quarter, or as needed.  The results will be monitored and reported at the quarterly Quality Assurance meeting by the Maintenance Director for one year.  The corrective action will be completed by July 7 <sup>th</sup> , 2013.	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99. Standards for Health Care Facilities.	K 076		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Courtney Adams TITLE: Administrator (X8) DATE: 06/07/2013

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  05/23/2013
NAME OF PROVIDER OR SUPPLIER  LUTHERAN HOME-ALBEMARLE		STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 076	<p>Continued From page 1</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 5/23/2013 the following Life Safety item was observed as noncompliant, specific findings include: The oxygen storage at station 2 had a mixture of full and empty cylinders.</p> <p>CFR#: 42 CFR 483.70 (a)</p>	K 076	<p>Plan of Correction; CFR#: 42 CFR 483.70 (a) Tag K 076</p> <p>For residents affected: On 05/31/2013, Trinity Place received a 12 tank oxygen rack from Specialized Medical Services. The Maintenance Director put the new oxygen tank rack in the oxygen storage room at station 2 (by the E&amp;F hall nurses station). The empty and full oxygen tanks were separated from each other. The Maintenance Director has put three racks in each of the storage rooms, for a total of 6 racks in the entire building. The Administrator re-labeled the oxygen racks on 06/07/2013 so that it is clear which racks are designated for full oxygen tanks and which racks are designated for empty oxygen tanks.</p> <p>For residents that have potential to be affected: The Administrator and Director of Nursing, beginning the week of 06/03/2013, have started in-servicing all nurses and facility supervisors regarding the importance of separating full and empty oxygen tanks. The Administrator or Director of Nursing will in-service all nurses at the next mandatory nursing meeting, before 7/7/2013, regarding the importance of separating full and empty oxygen tanks. Any nurse not in attendance will be in-serviced by the Director of Nursing or the Administrator by July 7<sup>th</sup>, 2013. The Certified Nursing Assistants (CNA's) will be in-serviced by the Director of Nursing or the Administrator at the next mandatory CNA meeting, before 7/7/2013, regarding separation of empty and full oxygen tanks. Any CNA that is not present at the mandatory meeting will be in-serviced by the Director of Nursing or the Administrator by July 7<sup>th</sup>, 2013. Each oxygen tank rack was re-labeled on 06/07/2013 according to it's use, e.g. the rack designated for empty containers has a label that reads "empty oxygen tanks" and the rack designated for full containers has a label that reads "full oxygen tanks".</p> <p>System Change: Starting the week of 06/10/2013, the Administrator or Facility Nursing Supervisor will check both oxygen storage rooms to ensure that oxygen storage tanks are being kept in their respective racks (full oxygen tanks must be kept in a separate rack from empty oxygen tanks). The Administrator or Facility Nursing Supervisor will check both oxygen storage rooms five times a week for one month, five times a month for one quarter and five times a quarter for the remainder of the year.</p> <p>The results will be monitored and reported at the quarterly Quality Assurance meeting by the Director of Nursing or the Administrator for one year.</p> <p>The corrective action will be completed by July 7<sup>th</sup>, 2013.</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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PRINTED: 06/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345109</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - BUILDING 02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/23/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LUTHERAN HOME-ALBEMARLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type II protected construction and is not equipped with a complete automatic sprinkler system.</p> <p>CFR#: 42 CFR 483.70 (a)</p> <p>The facility is currently undergoing renovation for a complete automatic sprinkler system installation.</p> <p>NOTE: There were no life safety code deficiencies noted during the survey in building 2.</p>	K 000		

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

TITLE

(X6) DATE

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.