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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345153	345153 B. WING				08/16/2012		
NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME AT TRINITY OAKS					REET ADDRESS, CITY, STATE, ZIP CODE 120 KLUMAC RD 5ALISBURY, NC 28144				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 000	The facility is in compliance wih the requirements			000					
	of 42 CFR Part 483 Care Facilities (Ger	, subpart B for Long Term neral Health Survey)							
.ABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES RE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		abtic (x5Mr		(X3) DATE SI COMPLE		
		345153	BWNG			09/0	5/2012	
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE			
LUTHERAN HOME AT TRINITY OAKS					LISBUKLUMACRO RY, NC 28144			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(x5) COMPLETION DAVE	
K 000	INITIAL COMMENT	TS .	K	000				
K 062 SS≔E	conducted as per T at 42 CFR 483.70(a Health Care section referenced publicat different buildings. I (222) protected con North Carolina Spe The facility is equip sprinkler system. CFR#: 42 CFR 483 NFPA 101 LIFE SA Required automatic continuously mainta condition and are in periodically. 19.7 25, 9.7.5 This STANDARD is Based on the obserduring the tour on Squick response sprinkler system.	FETY CODE STANDARD sprinkler systems are lined in reliable operating	К		The sprinkler head in questi inspected and cleaned. And sprinkle inspections are con and required maintenance is performed. All other sprinkl were checked and meet cod Quarterly inspections are co by the Maintenance Departi ensure compliance.	nual ducted s er heads de. onducted	9/6/12	
K 072 SS=D		i.70 (a) FETY CODE STANDARD e continuously maintained free	K	072				
	of all obstructions o use in the case of fi furnishings, decora	r impediments to full instant re or other emergency. No tions, or other objects obstruct	•				MONDATE	
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVES	SIGNATU	JRE T	Adminstrato	9/1	(XSYDATE	

Any deficiency statement ending with an asterisk (I denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient projection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether of 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: 923318

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPL1ER/CLIA IDENTIFICATION NUMBER:			LIRE CSNSTBURTENLING 01	(X3) DATE SURVEY COMPLETED					
		345153	BWNG			0910	512012				
NAME OF ER	AV FROME YET YET WIT		r 0		REET ADDRESS, CITY, STATE, ZIP CODE SALISBURY, NC 28144						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	8 2 0 K L U M A C ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	R D ID PREFI TAG	X	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE				
K 072	Continued From page 1 exits, access to, egress from, or visibility of exits. 7.1.10				The facility removed the 6 inch handrails beside the janitors closet on the Administration hall and D wing janitor closet door. The doors are able to be opened 180 degree flat.						
	Based on the obser during the tour on 9 that the facility had opened into the corropen 180 degrees fa door closure instandoor closed after better the locations are: \$\frac{1}{2}\$	Service hall janitors closet and nather administration hallway.			On the service hall door, the stop was removed which all 180 degree flat. Monthly safety rounds are conducted by the Safety Co to ensure access to egress compliance and code. Thos findings are reported to the committee and corrective actaken when required.	ilows a ommittee meet se safety					
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PART	TMENT OF HEALTH	I AND HUMAN SERVICES								FOR	09/10/2012 MAPPROVED 0938-0391
STATEMENT DEFICIENCI CORRECTION	ES AND PLAN OF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	day Briding	THE STATE OF THE S	ADKEIN				(X3) DATE S COMPL	GURVEY ETED	
		345153	BWVG.		╫┼	\pm	-			09/0	5/2012
NAME OF P	ROYDER OR SUPPLIER	Υ ΌΔΚΘ		STREET AD	OH:	S	s, c	Υ, ε	TATE, ZIP		
A-111m1			ая	CODE SA	118	ΒŲ	IRY	NC	28144		
/Y4\ Ib	SUMMARY ST	8 2 0 K L U I V I A C ATEMENT OF DEFICIENCIES	ID.	T j	ήφ	VΙÞ	EH	s PL	AN OF CORRE	CTION	COMPLETION (X5)
(X4) ID PREFIX TAG	LEACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	X (EA		CO	ER	NCE DEF	AN OF CORRE VE ACTION SH ID TO THE API ICIENOY)	PROPRIATE	DATE
K 000	INITIAL COMMEN	INITIAL COMMENTS							A transmission of the control of the		
	conducted as per at 42 CFR 483,70(Health Care section referenced publical different buildings, (222) protected conducted conducted North Carolina Spe	ode (LSC) survey was The Code of Federal Register a); using the 2000 Existing n of the LSC and its tions. This facility has two Building number 2 is Type 2 instruction, and is utilizing ectal Locking arrangements. oped with an automatic		and an artist state of the property of the state of the s							
K 018	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD			K 018							
SS=D	Doors protecting or required enclosure hazardous areas a those constructed wood, or capable of minutes. Doors in required to resist the limited minutes of the door closed. Do are permitted. Roller latches are plin all health care face.		AND								
Any deficiency eafegue wing the lays following	y statement ending vith rds provide sufficient pr date of survey who her c g the date these docume	DEFESUPPLIER REPRESENTATIVES SIGN an asterisk (*) denotos a deficiency which of the patients. (See Instruction or not a plan of correction is provided. For the facility. If	trotu	sitution may it for nursing it homes, the es are cited,		xcu es /e		rom Indir is a	correcting proggs stated above ad plans of correction	viding it is dete re are discloss rection are dis is requisite to	rmined that ble 90 days closable 14 continued
rogram parti	араноп. —————					_					So of
ODM ONE O	E87/02-00) Perulare Vareins	c Obsolute Fuent IO: (IVV 121		CISL ID. No.	Illi	Ť		1		antinuation ob	

DEPART	TMENT OF HEALTH	AND HUMAN SERVICES E VI ES								FOR	09/10/2012 MAPPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		DVG CQ	N SA	5Y.	318	02		(X3) DATE SI COMPLE	URVEY TED
		345153	8WN3		#	\dashv	_			09/0	5/2012
NAME OF PE	ROVIDER OR SUPPLIER		ra	REET AD	OR	SS,	CI	/, S1	ATE, ZIP		
LUTHER	IAN HOME AT TRINIT	YOAKS		CODE 820 SALISBU	JΗY	, N	C4	314	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	ID PREFIX TAG	CAC	:ACI	1CX	מחנ	ECTI NO	AN OF CORRECT VE ACTION SHOU D TO THE APPR ICIENCY)	JLD BE	(XS) COMPLETION DATE
K 018	Based on the obser during the tour on 9 was observed as no include: The dutch station was not able sealed with one mo	not met as evidenced by: vations and staff interview /5/2012 the following item oncompliant, specific findings door for the VCC unit nurses to be closed latched and	K 018	mech an as which when	iari itra i ex	isi ga on osi	n v I a nec ng	as n th tec T	led a closin installed when the upper hale to the lower he door is a he motion.	nich is If of the er half	9/10/12
<u>(</u>	they conform to 19. upper leaf and lowe a latching device, a upper and lower lea	3.6.3.6 In addition, both the ir leaf shall be equipped with nd the meeting edges of the eves shall be equipped with et, or a bevel. (NFPA 101		A THE PARTY OF A THE PARTY OF T							
FORM CMS-2	2567(02-99) Previous Versl	ons Obsolete Event ID; UTY	121 F	acility ID 6	9/2 5/3	18			,110	ontinuation sh	eet Page 2 of 2
				:						•	411DS

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 RE & MEDICAID SERVICES (X3) DATE SURVEY **JACLMON** STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA ABLIDIG COMPLETED IDENTIFICATION NUMBER: MATER LDING 01 BWNG. 345153 09/05/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, OFF, STATE, ZIP CODE **LUTHERAN HOME AT TRINITY OAKS** SALIBBUKLU MCHD RY, NO 28144 PROVIDERS PLAN OF CORRECTION
EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFER NOED TO THE APPROPRIATE
DEFICIENCY) COMPLETION DATE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LCC IDENTIFYING INFORMATION) TAG TAG K 000 INITIAL COMMENTS K 000 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 has two different buildings, Building number 1 is Type 2 (222) protected construction, and is utilizing North Carolina Special Locking arrangements. The facility is equipped with an automatic sprinkler system. CFR#; 42 CFR 483.70 (a) K 062 NFPA 101 LIFE SAFETY CODE STANDARD K 062 SSHE 9/6/12 The sprinkler head in question was Required automatic sprinkler systems are inspected and cleaned. Annual continuously maintained in reliable operating sprinkle inspections are conducted condition and are inspected and tested 19.7.6, 4.6.12, NFPA 13, NFPA and required maintenance is periodically. performed. All other sprinkler heads were enecked and meet code. 25, 9.7.5 Quarterly inspections are conducted by the Maintenance Department to This STANDARD is not met as evidenced by: Based on the observations and staff interview ensure compliance. during the tour on 9/5/2012 the facility has a quick response sprinkler head in the soiled utility room on the A-B wing that has paint overspray on the bulb. CFR#: 42 CFR 483.70 (a) K 072 NFPA 101 LIFE SAFETY CODE STANDARD K 072 SS=D Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE (XS) DATE

Any deficiency statement ending with an astorisk (I denotes a deficiency which the institution may be excussed from correcting providing it is determined that visaleguards provide sufficient projection to the patients. (See instructions.) Except for nursing fromes, the findings stated above are disclosable 90 days wing the date of survey whether of 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, are approved plan of correction is requisite to continued program participation.

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

Event ID: UTY121

Facility ID: 9238 8

If continuation sheet Page 1 of 2

PRINTED: 09/10/2012

FORM APPROVED OMB NO 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES CONTINE** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ABILING COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: CBYSTANING OF BWNG 345153 0910512012 STREET ADDRESS, CHIV, STATE, ZIP CODE NAME OF EFFANTED ME AT LEINITY OAKS SALISBURY, NO 28144 820 KLUMAC R D FROY DEAS PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFER NCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (XS) (X4) ID PREFIX ď (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The facility removed the 6 inch 9/6/12 · K 072 handrails beside the janitors closet K 072 Continued From page 1 on the Admin stration hall and D exits, access to, egress from, or visibility of exits, 7,1,10 wing lanitor dioset door. The doors are able to be opened 180 degree flat. On the service hall door, the door This STANDARD is not met as evidenced by: Based on the observations and staff interview stop was fembyed which allows a during the tour on 9/5/2012 it was determined 180 degree flat. that the facility had two janitor closets that opened into the corridor, these doors did not Monthly safely rounds are open 180 degrees flat to the corridor wall nor had conducted by the Safety Committee a door closure installed to automatically keep the door closed after being opened. to ensure actess to egress meet compliance and code. Those The locations are: Service hall janitors closet and findings are apported to the safety the janitors closet on the administration hallway. committee and corrective action is CFR#: 42 CFR 483.70 (a) taken when required. Facility ID: 928318 If continuation sheet Page 2 of 2 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UTY121

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DEPARTMENT OF HEALTH AND HUMAN SERVICES