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

PRINTED: 08/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/28/2011	
	345153						
	ROVIDER OR SUPPLIER	Y OAKS		82	ET ADDRESS, CITY, STATE, ZIP CODE O KLUMAC RD ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	There were no de the recertification so OODU11. The fact requirements of 42	ficiencies cited as a result of survey on 7/28/11, Event ID# sility is in compliance with the CFR Part 483, Subpart B for acilities (General Health	F	000			
	ODECTORIS OF BROW	DER/SUPPLIER REPRESENTATIVE'S SIG	MTHRE		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 CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345153	B. WING			07/28/2011	
	ROVIDER OR SUPPLIER AN HOME AT TRINIT	Y OAKS		82	EET ADDRESS, CITY, STATE, ZIP CODE 20 KLUMAC RD ALISBURY, NC 28144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF ÓEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULI. REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		IOULD BE	(X5) COMPLETION DATE	
F 000	the recertification s OODU11. The faci requirements of 42	iciencies cited as a result of urvey on 7/28/11, Event ID# lity is in compliance with the CFR Part 483, Subpart B for acilities (General Health	F	000	DEFICIENCY		
I ADOC ATT			BEATT LOW				(VG) DATE
PAROKATOK,	T DIKEGTOKS OK PROVIL	DER/SUPPLIER REPRESENTATIVE'S SIG	NALUKE		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 CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/06/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B, WING 345153 08/31/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SET 9. 0 2011 820 KLUMAC RD **LUTHERAN HOME AT TRINITY OAKS** SALISBURY, NC 28144 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 SS=F The facility checked all exit doors One hour fire rated construction (with 1/4 hour and verified all were working as fire-rated doors) or an approved automatic fire required. The door in on A wing extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When was adjusted and is working properly. the approved automatic fire extinguishing system It will continue to be audited on a option is used, the areas are separated from monthly basis by the Maintenance other spaces by smoke resisting partitions and Department. Maintenance and the doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed Administrator will be responsible for 48 inches from the bottom of the door are oversight. permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 8/31/2011 it was determined that the facility dust and lint in the combustion chamber of the gas fired dryers in the laundry. CFR#: 42 CFR 483.70 (a) K 038 NFPA 101 LIFE SAFETY CODE STANDARD K 038 SS≒E Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 8/31/2011 it was determined that the required exit door leading from the "A" wing was dragging on the bottom of the frame, LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE Administrator

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 o rogram participation.

Event ID: 00DU21

If continuation sheet Page 1 of 2

Dunsy

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

PRINTED: 09/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
	345153		B. WING		08/31/2011	
	PROVIDER OR SUPPLIER AN HOME AT TRINIT	Y OAKS	8	REET ADDRESS, CITY, STATE, ZIP COD 120 KLUMAC RD 5ALISBURY, NC 28144	Ę	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 038	'	opened for egress from that	K 038			

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

Event ID:00DU21

Facility ID: 923318

If continuation sheet Page 2 of 2



THATH THE HOUSE

PRINTED: 09/08/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (XI) DAYE SURVEY COMPLEYED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 02 - BUILDING 02 A BUILDING 2011 B. WING 08/31/2011 345153 STREET ADDRESS, CITY, STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 820 KLUMAC RD LUTHERAN HOME AT TRINITY OAKS SALISBURY, NG 28144 BUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X6) Completion Date (X4) ID PREFIX PREFIX TAG YAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 There were no Life Safely Code Deficiencies noted in this building at time of survey. CFR#: 42 CFR 483.70 (b) LABORATOR DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (XS) 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 aufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 80 days following the date of subject 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 and made available to the facility. If delicioncies are alled, an approved plan of correction is requisite to continued program participation.

FORM CM5-2557(62-98) Previous Versions Obsoldte

Event ID:00DU21

Facility ID: 923318

If continuation sheat Page 1 of 1