

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
---	--

(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
F 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to maintain safe and functioning showers and bathrooms in 8 of 9 hallway bathrooms used by residents and in 2 resident rooms. (Room # 211 and # 321)</p> <p>During the initial tour of the facility on 5/7/12 at 12:30 AM and throughout the survey residents were observed using the hall bathrooms and showers. Each hall had a minimum of two hallway bathrooms or bathrooms and shower combinations.</p> <p>Hallway bathroom #01 was observed on 5/7/12 at 1:55 PM. 10:40 AM. The observation revealed no cover on the wall soap dispenser at the sink. During observations on 5/8/12 at 10:15 AM, and 5/11/12 at 10:40 AM the dispenser cover had not been installed.</p> <p>Hallway bathroom #02 was observed on 5/7/12 at 2:05 PM with no cover observed on the wall soap dispenser at the sink. The light fixture over the toilet was not working. The toilet was not securely attached to the bathroom floor and moved from side to side when a resident or visitor sat on it. During observations on 5/8/12 at 10:20 AM and 5/11/12 at 10:50 AM there was no cover on the soap dispenser, the light over the toilet</p>	F 253	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provision of federal and state law.</p> <p><u>F 253</u></p> <ul style="list-style-type: none"> • Soap Dispenser covers were replaced in hall bathrooms: 01, 02, by 314, back hall. Lights were repaired/replaced in hall bathrooms: 02, 11, 12. Toilet was tightened in hall bathroom 02. Call cords were repaired or properly placed in hall bathrooms by 314, 08. Hot water controller was replaced in hall bathroom 06. Safety rail was tightened in hall bathroom by 211. Items stored were removed in hall bathroom 11. Open soap container was removed from hall bathroom by 314. Bathroom #321 yellow tape removed, frames sealed, drain addressed, call cord in proper placement. 	6/8/12 5-11-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cissy McCoy</i>	TITLE Administrator	(X6) DATE 6/28/12
---	------------------------	----------------------

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER

LUTHERAN HOME - WINSTON SALEM

STREET ADDRESS, CITY, STATE, ZIP CODE

**849 WATER WORKS ROAD
WINSTON-SALEM, NC 27105**

(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
F 253	<p>Continued From page 1</p> <p>would not come on, and the toilet was not stabilized.</p> <p>The 300 hall bathroom and shower located between rooms 314 and 316 was observed on 5/7/12 at 1:00 PM. The observation revealed no cover on the wall soap dispenser at the sink and no cover on the soap dispenser in the shower. A second observation on 5/8/12 at 10:06 AM indicated no repairs had been made to the dispensers. During an observation on 5/11/12 at 10:48 AM the emergency call light cord was found wrapped around the shower curtain rod and was not accessible to any resident on the toilet or in a wheelchair. An opened one quart plastic container of soap was positioned on the floor of the shower stall. The soap dispensers did not have a cover.</p> <p>The #06 hallway bathroom and shower was observed on 5/8/12 at 2:50 PM. The hot water handle in the shower was missing. A rusty pair of vise grip pliers was attached to the shower hot water control. Another observation on 5/11/12 at 10:30 AM indicated the pliers were still present on the hot water control in the shower.</p> <p>The back resident hallway bathroom was observed on 5/8/12 at 2:50 PM. The wall soap dispenser at the sink was noted to have no cover. During a second observation on 5/11/12 at 10:35 AM the dispenser remained without a cover.</p> <p>Hallway bathroom #08 was observed on 5/11/12 at 9:55 AM. The emergency call bell cord beside the toilet was broken and not accessible to a resident seated on the toilet or in a wheelchair.</p>	F 253	<ul style="list-style-type: none"> All hallway bathrooms were checked and repair/replacements were made for soap dispenser covers, light bulbs, secure rails and toilets, call cords, water controllers, and stored items. Staff were re-educated on use of maintenance repair slips. Director of Maintenance will make weekly rounds of hall bathrooms to check: soap dispenser covers, light bulbs, secure rails and toilets, call cords, water controllers, and stored items. Weekly rounds will be done for one month, then monthly rounds will be on a PM schedule. Repair slips will be addressed on an ongoing basis. Maintenance Director will inspect hall bathrooms weekly for one month, then monthly rounds will be done on a PM schedule. All findings will be repaired as found and reported to quarterly QA meeting. 	<p>5-11-12</p> <p>5-28-12</p> <p>6-8-12</p>

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
F 253	<p>Continued From page 2</p> <p>The #11 hallway bathroom and shower was observed on 5/8/12 at 10:15 AM and on 5/11/12 at 9:45 AM. A shower chair and a portable over the toilet chair were stored in the shower stall. The bulbs in the shower light fixture and overhead light fixture in the bathroom were not working. The overhead bathroom light fixture had no cover and the light bulbs were exposed. The light fixture over the sink had only one of two bulbs which worked.</p> <p>Hallway bathroom #12 was observed on 5/8/12 at 10:10 AM and on 5/11/12 at 9:50 AM. There were no working bulbs in the overhead light fixture. The sink light fixture was working.</p> <p>An observation of resident room #211 on 5/7/12 at 2:55 PM revealed a loose safety rail on the left wall beside the toilet. A second observation on 5/11/12 at 9:15 AM noted the rail had not been repaired.</p> <p>An observation of room # 321 on 5/8/12 at 3:25 PM revealed the shower had yellow caution tape secured across the shower and a foul odor was noted from the drain. The bathroom door frames were noted to have holes and sharp edges at the bottom of 2 of the 4 frames. The emergency call bell cord (metal) was noted to be 6 inches long and was positioned 5 feet off the floor. The call bell cord could not be reached by a resident in a wheelchair. This bathroom was shared by 8 male residents. A second observation on 5/9/12 at 2:35 PM and a third observation on 5/11/12 at 9:15 AM indicated no repairs had been made to the bathroom and the yellow caution tape was still in place to indicate the shower was inoperable.</p>	F 253		

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
F 253	<p>Continued From page 3</p> <p>An interview was conducted with the Maintenance Supervisor on 5/9/12 at 10:59 AM. He stated he was not aware of any missing soap dispenser covers, broken light fixtures, pliers used as water control handles, loose safety rails, or burned out light bulbs. He revealed staff have work order request sheets at the 200 hall nursing station. He indicated staff are to fill out the request forms and place them in the maintenance box when they see a need for maintenance services. The Maintenance Supervisor reported he checked the box each morning for any requests. He stated staff often call him or verbally give him information on needed maintenance issues. The Supervisor revealed he had not had any maintenance requests for the hallway bathrooms or resident rooms # 211 or # 321. The Maintenance Supervisor indicated he knew the shower on the 300 hall had been " taken out of commission " but he was not aware why. He revealed he was sure some maintenance repair issues were not being submitted because they were moving to a brand new facility on June 18, 2012.</p> <p>During an interview with Housekeeper #1 she stated residents use the hallway bathrooms to shower because some of the rooms are so small it is difficult to move them into the room bathroom with a mechanical lift. She indicated ambulatory residents and independent wheelchair residents use the hall bathrooms because they were larger and easier to get in and out off.</p> <p>During an interview on 5/11/12 at 11:00 AM the facility Administrator stated some repairs were not being made due to the short time period before they moved into the new building in June. She</p>	F 253		

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
F 253	Continued From page 4 indicated she was not aware of the bathroom and shower room problems. The Administrator revealed it was her expectation all lights would be operational with working light bulbs and broken light fixtures would be repaired. She stated vice grip pliers should not used as hot water control handles in the shower and all emergency call bell cords should be easily reached by residents. The Administrator indicated her expectation was residents should have access to bathrooms and showers that were safe and functional.	F 253		
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to provide and maintain adequate lighting in 4 of 9 hallway bathrooms used by residents. During the initial tour of the facility on 5/7/12 at 12:30 AM and throughout the survey residents were observed using the hall bathrooms and showers. Each hall had a minimum of two hallway bathrooms or bathrooms and shower combinations. 1. Resident # 123 was admitted to the facility on 11/23/11 with diagnoses of heart failure, dementia, neurotic disorders, chronic obstructive pulmonary disease, and rehab services. The resident was assessed on admission as a fall risk. His quarterly Minimum Data Set (MDS) was completed on 4/19/12. The resident was coded	F 256	<u>F 256</u> <ul style="list-style-type: none"> Light was repaired/replaced in hall bathroom 10, 02, 11, 12. All hallway bathrooms were checked and repair/replacements were made for light bulbs. Staff were re-educated on use of maintenance repair slips. Director of Maintenance will make weekly rounds of hall bathrooms to check light bulbs. Weekly rounds will be done for one month, then monthly rounds will be on a PM schedule. Repair slips will be addressed on an ongoing basis. 	6/8/12 5-11-12 5-11-12 5-28-12

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
F 256	<p>Continued From page 5</p> <p>as having decreased range of motion on one lower extremity. The resident required supervision to ambulate, transfer, and toilet. The resident used a walker for locomotion.</p> <p>On 5/10/12 at 9:40 AM resident # 123 was observed coming out of the 200 hallway common bathroom #010. The resident backed out of the bathroom and tried to turn his walker around in the doorway. The resident was observed attempting to hold the bathroom door open, turn around, and move his walker into position. The resident stated he could not use the bathroom because the lights were all out. He indicated he had entered the bathroom and then could not turn on the light. He revealed he had to move around in the dark until he could find and open the door. The resident stated he now had to go all the way to another hall to go to the bathroom.</p> <p>A review of the resident ' s care plan updated on 4/24/12 indicated he was in restorative care for ambulation due to heart failure and generalized weakness. The care plan listed interventions to be sure his walker was clean, working properly, and easily accessible. The resident was care planned to walk 150 feet using the rolling walker.</p> <p>An interview was conducted with the Maintenance Supervisor on 5/9/12 at 10:59 AM. He stated he was not aware of any burned out light bulbs. He revealed staff have work order request sheets at the 200 hall nursing station. He indicated staff are to fill out the request forms and place them in the maintenance box when they see a need for maintenance services. The Maintenance Supervisor reported he checked the box each morning for any requests. He stated staff often</p>	F 256	<ul style="list-style-type: none"> Maintenance Director will inspect hall bathrooms weekly for one month, then monthly rounds will be done on a PM schedule. All findings will be repaired as found and reported to quarterly QA meeting. 	6-8-12

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
F 256	<p>Continued From page 6</p> <p>call him or verbally give him information on needed maintenance issues. The Supervisor revealed he had not had any maintenance requests for the hallway bathrooms. He revealed he was sure some maintenance repair issues were not being submitted because they were moving to a brand new facility on June 18, 2012.</p> <p>During an interview with Housekeeper #1 on 5/11/12 at 11:10 AM she stated residents use the hallway bathrooms. She indicated ambulatory residents and independent wheelchair residents use the hall bathrooms because they were larger and easier to get in and out off.</p> <p>During an interview on 5/11/12 at 11:00 AM the facility Administrator stated some repairs were not being made due to the short time period before they moved into the new building in June. She indicated she was not aware the hallway bathrooms did not have working lights. The Administrator revealed it was her expectation all lights would be operational with working light bulbs. The Administrator indicated her expectation was residents would have access to bathrooms were safe and functional.</p> <p>2. Hallway bathroom #02 was observed on 5/7/12 at 2:05 PM. The light fixture over the toilet was not working. During further observations on 5/8/12 at 10:20 AM and 5/11/12 at 10:50 AM the light over the toilet would not come on.</p> <p>The #11 hallway bathroom and shower was observed on 5/8/12 at 10:15 AM and on 5/11/12 at 9:45 AM. The bulbs in the shower light fixture and overhead light fixture in the bathroom were not working. The overhead bathroom light fixture</p>	F 256		

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
---	--

(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
F 256	<p>Continued From page 7</p> <p>had no cover and the light bulbs were exposed. The light fixture over the sink had only one of two bulbs which worked.</p> <p>Hallway bathroom #12 was observed on 5/8/12 at 10:10 AM and on 5/11/12 at 9:50 AM. There were no working bulbs in the overhead light fixture. The sink light fixture was working.</p> <p>An interview was conducted with the Maintenance Supervisor on 5/9/12 at 10:59 AM. He stated he was not aware of broken light fixtures or burned out light bulbs. He revealed staff have work order request sheets at the 200 hall nursing station. He indicated staff are to fill out the request forms and place them in the maintenance box when they see a need for maintenance services. The Maintenance Supervisor reported he checked the box each morning for any requests. He stated staff often call him or verbally give him information on needed maintenance issues. The Supervisor revealed he had not had any maintenance requests for the hallway bathrooms. He revealed he was sure some maintenance repair issues were not being submitted because they were moving to a brand new facility on June 18, 2012.</p> <p>During an interview with Housekeeper #1 she stated residents use the hallway bathrooms. She indicated ambulatory residents and independent wheelchair residents use the hall bathrooms because they were larger and easier to get in and out off.</p> <p>During an interview on 5/11/12 at 11:00 AM the facility Administrator stated some repairs were not being made due to the short time period before</p>	F 256		

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
--------------------	--	---------------	---	----------------------

F 256 Continued From page 8
they moved into the new building in June. She indicated she was not aware of the hallway bathroom problems. The Administrator revealed it was her expectation all lights would be operational with working light bulbs and broken light fixtures would be repaired. The Administrator indicated her expectation was residents would have access to bathrooms that were safe and functional.

F 256

F 371
SS=D 483.35(i) FOOD PROCURE,
STORE/PREPARE/SERVE - SANITARY

F 371

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

6/8/12

This REQUIREMENT is not met as evidenced by:
Based on observations and interviews the facility failed to store and prepare food under sanitary conditions.

An initial tour of the kitchen was conducted on 5/7/12 at 11:15 AM. The dry storage room was noted to have flies. Brown dried splatters were noted on the wall and a fifty cent size solid brown dried substance was observed on the floor beside the dented can shelving. The can storage rack had 4 individual boxes of cereal and 1 can of soup on the floor under the rack. Flour and thinner dry storage bins were noted to have the

F 371

- Kitchen was treated for flies, fly fan is in place as well as fly light by exterior door. Spot on wall was cleaned. Spot on floor was cleaned. Cereal boxes and soup can were retrieved and placed on appropriate shelf. Flour and thinner bins had

5-7-12

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM			STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105	
(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
F 371	<p>Continued From page 9</p> <p>scoops inside the bins in scoop holders. The dry product came up into the scoop holders and had contact with the scoops. The spice rack in the dry storage area was dusty and had a greasy film that could be felt on contact.</p> <p>Preparation areas were noted to need a general cleaning. All utility carts in the kitchen had a film of grease. Pots and pans were stored to air dry on shelving that had visible dust and a greasy film. Tray racks were observed to have food particles and grease residue.</p> <p>The walk in cooler was noted to have a 4 pound jar of grape jelly that had been opened and was half full. The jar had no date to indicate when it was opened. The green shelving in the cooler was observed to have residue from stored vegetables and produce. A 3 inch area of cooked spaghetti was noted on the side of a hamburger bun box.</p> <p>An interview was conducted with the Kitchen Manager. He indicated the cooler shelves are cleaned monthly and that produce is delivered weekly. The Manager stated the jelly should have had an open date. He revealed the flies had just appeared at the facility and the pest company had come last week to spray. The Manager indicated the pot and storage shelving should not have a grease film or visible dust.</p> <p>An interview was conducted with the Administrator on 5/11/12 at 11:00 AM. She indicated the facility would soon be moving to a new facility with a spacious and clean kitchen area. The Administrator stated the kitchen had just started having a fly problem recently and the</p>	F 371	<p>scoops removed. Cleaning performed on: spice rack, utility carts, pan drying rack, tray rack, green shelving in cooler. Jelly and bun box were discarded.</p> <ul style="list-style-type: none"> • Kitchen sanitation round completed by RD for entire kitchen. • Kitchen staff will be assigned and educated on weekly cleaning and checking tasks and will sign off and report to ASFD. ASFD will make weekly inspections of the kitchen and will make corrections as needed and report results to FSD. RD will make monthly visits and check sanitation for any needed corrections. • FSD will report results quarterly to QA committee for one year. 	<p>5-7-12</p> <p>5-11-12</p> <p>6-8-12</p>

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
F 371	Continued From page 10 pest control people had been out to spray. The Administrator revealed it was her expectation the kitchen would be pest free, all opened food would be dated, and the storage and prep areas would be clean.	F 371		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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 have access to the keys.</p> <p>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</p>	F 431	<p><u>F 431</u></p> <ul style="list-style-type: none"> Expired Novolin R, Promethazine and Hydrocortisone were removed from medication cart and returned to pharmacy. Each expired medication was researched and found that none had been given to any resident since date of expiration. All Medication carts were reviewed for expired medications to be returned to pharmacy. Nurses were educated on returning expired medications to pharmacy. 	<p>5-9-12</p> <p>5-10-12</p> <p>5-10-12</p> <p>5-30-12</p>

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
F 431	<p>Continued From page 11 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to ensure that expired medications were discarded in one of four medication carts observed for medication storage. The finding was:</p> <p>Observation on 5/9/12 at 12:00 PM revealed the medication cart containing medications for rooms 301 through 312 contained the following expired medications:</p> <ol style="list-style-type: none"> One 10 milliliter (ml) vial of Novolin R (regular short acting insulin) 100 u (units)/ml was 1/3 full and dated as opened on 4/4/12. One blister pack of Promethazine 25 milligram (mg) (anti nausea and vomiting medication) containing four tablets. The expiration date on the pharmacy label was 2/8/12. Hydrocortisone acetate AC (Anusol-HC) 25 mg rectal suppositories (hemorrhoid medication). The pharmacy label indicated the medication was dispensed on 4/02/09 and had an expiration date of 10/11. <p>At 12:35 PM on 5/9/12 Registered Nurse (RN) #1 medication nurse stated regular insulin expires 30 days after opening. She further revealed that the expired medications should have been returned to the pharmacy.</p> <p>Review of the facility policy dated 6/29/10 and entitled " Medications with Special storage</p>	F 431	<ul style="list-style-type: none"> Medication carts will be reviewed weekly by the assigned nurse. Any expired medications will be pulled and returned to pharmacy. Nurse Supervisor/ADON will spot check carts every two weeks. Any expired medications will be pulled and returned to pharmacy. Pharmacy Consultant will review carts quarterly for one year and any expired medications will be pulled and returned to pharmacy. All results from Medication cart audits will be reported to Director of Nursing who will review any findings quarterly with QA committee for one year. 	<p>6-4-12</p> <p>6-8-12</p>

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
---	--

(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
F 431	<p>Continued From page 12</p> <p>Requirements " noted open vials of Novolin insulin were to be labeled with the date opened and discarded after 30 days.</p> <p>An interview with the director of nursing at 12:50 PM on 5/9/12 revealed there were two consultants pharmacist that checked the medication carts.</p> <p>Consultant pharmacist #1 was interviewed on 5/10/12 at 8:55 AM and stated that she assisted the other consultant pharmacist who checked the medication carts.</p> <p>At 2:10 PM on 5/10/12 a telephone interview with consultant pharmacist #2 was conducted. She stated that she didn ' t check the medication carts. The service was available at the facility ' s request and it was done by a nurse. The nurse hadn ' t been visited the facility for at least the previous year.</p> <p>A subsequent interview with the DON on 5/11/12 at 10:00 AM revealed all medication administration personnel were responsible for maintaining the medication carts including checking expiration dates.</p>	F 431		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control</p>	F 441		6/8/12

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
F 441	<p>Continued From page 13</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, facility policy and staff interviews the facility staff failed to wash their hands before and after caring for a resident. (Resident #72) The facility failed to prevent contamination to a urinary catheter for 1 of 1 catheter observed. (Resident # 103) . This was evident in 3 of the sampled resident in the survey.</p>	F 441	<p><u>F 441</u></p> <ul style="list-style-type: none"> • NA #1 was educated 1:1 on infection control related to hand washing/sanitizer use before and after entering resident rooms and providing assistance. NA #3 was educated 1:1 on infection control related to hand washing/sanitizer use before and after entering resident rooms and providing assistance. Also about direct patient infection control measures when sneezing/coughing. C.N.A. was educated on proper placement of catheter and infection control. Resident # 72, # 103, # rm 307 were monitored for signs/symptoms of infection. • Education was conducted for all staff on hand washing and infection control with a pre and post test required. 	<p>5-9-12</p> <p>5-9-12</p> <p>5-11-12</p> <p>5-31-12</p>

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM			STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105	
(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
F 441	<p>Continued From page 14</p> <p>Findings include</p> <p>Review of the infection control policy dated 12/21/09 and the hand washing and hand hygiene policy dated 12/21/09 revealed in part explained the importance of hand washing or use of alcohol based hand rubs before and after direct contact with residents, before and after doning gloves.</p> <p>1 Resident # 72 was admitted to the facility on 12/26/12 with cumulative diagnosis of Alzheimer ' s disease. According to the Minimum data set, Resident # 72 was alert and oriented and able to make her needs known. She was dependent on the staff for mobility, transfers and toileting.</p> <p>Review of Resident #72 ' s care plan revealed the resident was dependent on the staff for transfers and toileting.</p> <p>During an observation on 5/7/112 at 12:40 PM; NA #1 entered the room to assist the resident to the bathroom, she immediately doned a pair of gloves without washing her hands, assisted the resident to the bathroom, removed the soiled brief and disposed it in the trash. NA #1 removed her gloves and exited the room and restarted passing the meal trays on the hall.</p> <p>During an interview with NA at 5/7/12 at 12:12 PM she indicated she thought she washed her hands before she removed the gloves left the resident ' s room.</p> <p>During an interview with the director of nursing on</p>	F 441	<ul style="list-style-type: none"> Staff Development Coordinator will continue to monitor hand washing and infection control by weekly rounds. Education and correction will be made "on the spot" and findings reported to Director of Nursing. Facility infections will continue to be tracked and reported by Staff Development Coordinator. Director of Nursing/Staff Development Coordinator will report findings on infection control quarterly to the QA committee for one year. 	<p>5-30-12</p> <p>6-8-12</p>

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
F 441	<p>Continued From page 15</p> <p>5/8/12 @ 2:15 PM she stated her expectations were that all staff were to wash their hands before and after resident care, even if they were wearing gloves.</p> <p>2On 5/8/12 at 10:26 AM during an observation, NA #3 entered resident ' s room 307 to assist the resident to be transferred via mechanical lift. NA#3 was observed to walk into room and began putting the resident's lift pad hooks on the lift. NA #3 did not wash her hands or use disinfecting gel before providing care. The resident was sneezing several times as they transferred him with the lift. She repositioned the resident in the chair, and then left the room without washing her hands and started assisting another resident.</p> <p>During an interview with NA #3; she indicated she realized she forgot to wash her hands. She usually uses the gel in her pocket.</p> <p>During an interview with the infection control nurse, at 10:43 AM on 5/11/12, she indicated the staff were constantly reminded and in-serviced on the importance of hand washing. She indicated she expects the staff to follow the hand washing policy before contact with resident, before and after using the bathroom, between residents after resident, between vital signs, moving equipment. She further indicated she had instructed the staff to wash their hands using the " 15 seconds hand washing rule. " Her expectation was that the staff were to wash their hands before and after providing care. If this resident was sneezing an unable to cover his mouth, her expectation was the staff would do this for the resident and them make sure they washed their hands.</p>	F 441		

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
F 441	<p>Continued From page 16</p> <p>During an interview with the Administrator on 5/11/12 at 9:48 AM she indicated her expectation is that all staff washed their hands before and after resident care and use of the bathroom. She indicated if a resident could not cover their mouth and nose, the staff should do this for the resident and then wash their hands.</p> <p>3. The facility policy on Catheter Care, Urinary was reviewed. The policy had been revised on 4/12/12. The policy stated on page one under Infection Control " the catheter tubing and drainage bag should be kept off the floor " .</p> <p>Resident # 103 was admitted to the facility on 3/12/12. Resident #103 was observed 5/8/12 at 2:35PM on the 200 hall being pushed by a Nursing Assistant (NA) from activities. The urinary catheter bag was observed to be covered by a blue privacy bag and was secured on the back of the wheelchair. The urinary bag and tubing were dragging the floor in the hallway. The NA pushed the resident past the 200 nursing station and down the hall. The urinary bag and tubing continued to drag on the floor.</p> <p>An interview was conducted on 5/9/12 at 4:15 PM with NA #2 who is usually assigned to this resident. She stated all urinary catheters should be hung below the level of the bladder when a resident is being transported in a wheelchair. The NA indicated the catheter and tubing should never touch the floor. She revealed if the tubing</p>	F 441		

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
---	--

(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
F 441	Continued From page 17 or bag touches the floor the nurse should be made aware. An interview was conducted with the First Shift Supervisor on 5/11/12 at 9:25 AM. She stated the urinary catheter should never have come in contact with the floor. She indicated the urinary catheter should have been secured at a level to ensure no contact with the floor. An interview was conducted with the Director of Nursing on 5/11/12 at 11:00 AM. She stated it was her expectation the urinary catheter would be secured to the wheelchair and off the floor while the resident was being transported. She stated the facility policy addressed this area.	F 441		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to provide an effective pest control program for flies in the kitchen, dining, and resident areas. An initial tour of the kitchen was conducted on 5/7/12 at 11:15 AM. Observation of the dry storage area revealed two flies on shelving and canned items. During the initial tour and throughout the survey	F 469	<u>F 469</u> <ul style="list-style-type: none"> Dry Storage area was treated for flies. Main dining area was treated for flies. Room #204 was treated for flies and spiders. Pest Control company was contacted and options were discussed for fly treatment. Extra visits were put in place. Weekly updates will be held with Pest Control for one month then monthly on a PM schedule and as needed. 	6/8/12 5-7-12 5-11-12 6-4-12 5-11-12

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
F 469	<p>Continued From page 18</p> <p>the Minimum Data Set (MDS) office was noted to have a clear plastic zip lock bag full of water suspended over the doorway. Staff stated the MDS coordinator used the bag to keep the flies out of her office.</p> <p>A dining observation was conducted on 5/7/12 from 12:15pm until 12:55 PM in the main dining area of the facility. Multiple flies were noted in the room and around food trays. A fly was observed crawling on a resident ' s roll after she left the table. Her dining companion continuously fanned the air over her plate at lunch to prevent a fly from landing on her food. Flies were observed landing on sherbet and chocolate pudding at another table where residents were eating lunch. Three files were seen crawling on the dining room glass windows while the residents were eating.</p> <p>A second observation of the dining room on 5/8/12 at 12:25 PM revealed three flies in the dining room.</p> <p>Room # 204 was located just across the hall from the dining room. During an observation of room #204 on 5/9/12 at 10:22 AM 2 flies were observed at the residents ' sink. Two fly swatters were seen hanging by the beds in the room. One resident was asleep and the other resident was out of the room during the observation.</p> <p>On 5/10/12 at 8:55 AM a resident was noted up in her wheelchair in room #204. The resident was alert, oriented, and a member of the Resident Council. The resident stated the room often had flies. She reported she used her fly swatter and " swats them down ". A large brown spider the size of a fifty cent coin was observed crawling</p>	F 469	<ul style="list-style-type: none"> • Housekeepers will review for pests on daily rounds, removing any seen pests and keep a log. Environmental Services Director will review logs and report to Maintenance Director as extra pest control treatment is needed. Maintenance Director will schedule any extra pest control treatments with provider. • Maintenance Director will report findings on pest control quarterly to QA committee for one year. 	<p>6-4-12</p> <p>6-8-12</p>

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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
--------------------	--	---------------	---	----------------------

F 469

Continued From page 19
down the window blinds. The resident rolled her wheelchair over to the wall, removed the fly swatter, and swung at the spider.

An interview was conducted with the Maintenance Supervisor on 5/9/12 at 10:59 AM. He revealed he was not aware of a fly problem in the facility. He indicated there had been a few flies in the building this week but he had never seen any before. He stated the facility had a contract with Steriteck who came out monthly to spray for all types of pests. The Supervisor revealed staff, family, and residents could report any pest sightings to a nurse at the nursing station. He indicated a Live Pest Sighting Log was kept at the nursing station on the 200 hall. He reported he checked the log or the nurses informed him about any sightings. The Supervisor revealed he contacted the pest company whenever he was aware of a pest problem and the company sent someone out to the facility immediately.

A review of the Live Pest Sighting Log revealed pests documented for May 2012. Spiders were reported on 5/2 in room #220 and in room #221 on 5/4. A cricket was documented in room #223 on 5/4. On 5/24 a facility employee noted flies and ants in the common area (main dining room) in the Live Pest Sighting Log. A review of the facility Pest Control Policy indicated the facility did have an active contract with Steriteck who came on a monthly and as needed basis.

An interview was conducted with the MDS Coordinator on 5/11/12 at 9:25 AM. She stated she had always had the zip lock bag full of water over her door. She revealed it was an old fashioned country trick to keep out flies. The

F 469

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

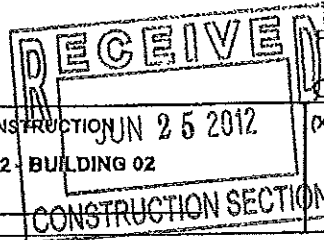
PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105
--	--

(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
F 469	<p>Continued From page 20</p> <p>MDS Coordinator indicated the facility did not usually have flies.</p> <p>An interview was conducted with the Administrator, Director of Nursing, and the Corporate Nurse on 5/11/12 at 11:00 AM. The Administrator reported the facility had sprayed for flies during the week. She indicated the flies had just appeared in the past week or two. She stated damp rainy weather with the facility location next to a goat pasture was probably the trigger for the flies. The Administrator revealed it was her expectation flies would not be in the dining room, kitchen, or resident rooms.</p>	F 469		

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



PRINTED: 06/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2012
--	--	---	--

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 5350 OLD WALKERTOWN ROAD WINSTON-SALEM, NC 27105
---	--

(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	INITIAL COMMENTS Surveyor: 02249 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 II(222) construction, one story, with a complete automatic sprinkler system.	K 000	Please be advised we moved out of this facility on 6-19-12, prior to the due date of this plan of correction. We no longer occupy Lutheran Home Winston Salem on Old Walkertown road.	
K 012 SS=D	The deficiencies determined during the survey are as follows: 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 012	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provision of federal and state law.	6-7-12
K 038 SS=D	This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on June 5, 2012 at approximately 11:00am onward, there are holes in the rated roof/ceiling assembly of the following areas: 1. janitor's closet near room 214 2. electrical switchgear room 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 038	<ul style="list-style-type: none"> Repairs have been made to ceiling tiles in janitor closet near 214 and electrical room. All other janitor closet ceilings were checked to ensure coverage. Maintenance Director/designee will complete a Preventative Maintenance check on all ceilings monthly for one year. Results of any problems with ceilings PM will be discussed at quarterly QA&A meeting for one year. 	
K 038	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cuddy McCoy* TITLE: *NHA* (X6) DATE: *6/22/12*

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: 06/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2012
NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM			STREET ADDRESS, CITY, STATE, ZIP CODE 5350 OLD WALKERTOWN ROAD WINSTON-SALEM, NC 27105		
(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 038	Continued From page 1	K 038	K038 <ul style="list-style-type: none"> Hardware was replaced on janitor closet door near 214. Other janitor closets were checked for appropriate hardware. Maintenance Director will check on janitor doors for appropriate hardware on a PM program monthly. Door hardware PM will be discussed at quarterly QA&A for one year. 	6-8-12	
K 047 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047	K047 <ul style="list-style-type: none"> Exit lights at ramp was repaired for correct direction. All exit lights were checked for proper direction. Exit lights will be checked monthly for one year. Exit sign direction will be discussed quarterly in QA&A for one year. 	6-22-12	
K 051	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on June 5, 2012 at approximately 11:00am onward, exit sign in corridor area directs occupants through unprotected corridor area of unoccupied structure. The unoccupied area contains unprotected storage areas and rooms adjacent to exit path. The unoccupied structure is separated by a two hour fire barrier from the occupied health care section of the facility. The area is located near the staff dining area.	K 051			

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

PRINTED: 06/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2012
NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM			STREET ADDRESS, CITY, STATE, ZIP CODE 5350 OLD WALKERTOWN ROAD WINSTON-SALEM, NC 27105		
(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 051	Continued From page 2 A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on June 5, 2012 at approximately 11:00am onward, the fire alarm system would not function during connection to alternate(batteries) power source.	K 051	K051 <ul style="list-style-type: none">Battery back-up was replaced in alarm panel.Battery was checked for working order by Modern Systems.Battery will be checked for one year as a separate preventative maintenance program.Battery for fire alarm system will be discussed quarterly in QA&A for one year.	6-7-12	
K 147 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 147			

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

PRINTED: 06/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2012
NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME - WINSTON SALEM			STREET ADDRESS, CITY, STATE, ZIP CODE 5350 OLD WALKERTOWN ROAD WINSTON-SALEM, NC 27105		
(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 147	Continued From page 3 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on June 5, 2012 at approximately 11:00am onward, there is a broken receptacle cover in resident room 208. 42 CFR 483.70(a)	K 147	K 147 <ul style="list-style-type: none"> Receptacle cover replaced in room 208. An in-service has been held with the staff to remind them to fill out maintenance requests for any broken items. Maintenance Director will PM receptacle covers. Receptacle covers will be discussed quarterly in QA&A for one year. 	6-6-12	

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26884, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 345088	(Y2) Multiple Construction A. Building 02 - BUILDING 02 B. Wing	(Y3) Date of Revisit 7/16/2012
Name of Facility LUTHERAN HOME - WINSTON SALEM	Street Address, City, State, Zip Code 849 WATER WORKS ROAD WINSTON SALEM, NC 27105	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0012	Correction Completed 06/19/2012	ID Prefix _____ Reg. # NFPA 101 LSC K0038	Correction Completed 06/19/2012	ID Prefix _____ Reg. # NFPA 101 LSC K0047	Correction Completed 06/19/2012
ID Prefix _____ Reg. # NFPA 101 LSC K0051	Correction Completed 06/19/2012	ID Prefix _____ Reg. # NFPA 101 LSC K0147	Correction Completed 06/19/2012	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____ CMS RO	Date: 7/17/12	Signature of Surveyor:	Date: 7/16/12
Followup to Survey Completed on: 6/5/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		