STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345088	A. BUILDING _____ B. WING _____	07/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GLEN	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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain stool specimens for hemocult test x 3 per physician ' s order for 1 of 1 resident (Resident #86) with orders for hemocult test. Findings included: Resident #86 was admitted to facility on 6/28/13 with diagnosis of pneumonia, thrombophlebitis, leukocytosis, depression, urinary tract infection, anxiety, gastroesophogeal reflux disease, dysphagia, generalized weakness, hypertension and chronic pain syndrome. The Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/12/12 revealed that Resident #86 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting and bathing. Labatory values on 7/8/13 revealed Red Blood Count was 3.08 normal range (4.22-5.81), Hemoglobin 9.0 normal range (13.0-17.0) and Hematocrit 27.2 normal range (39-52). On 7/8/13 a telephone physicians order was	F 309	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. F 309 • Resident #86 had hemocult stools x3 and results were negative. There was no negative outcome for resident #86. Results were reviewed by surveyor during the visit. • Each resident was reviewed and there were found to be no other residents with an order for Hemocult stool at the time of survey. • Director of Nursing met with physician and obtained his expectations for any orders for hemocult stools. A procedure was updated as to include informing staff in the daily huddle of any hemocult stools needed. Staff were re-educated regarding procedure for hemocult stools. DON	7-24-13 7-25-13 8-14-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cissy McCoy | TITLE: NHA | (X6) DATE: 8/15/13

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.

P.B Judy B M-J G-M D.R

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345088	A. BUILDING _____ B. WING _____	07/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GLEN	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 309	Continued From page 1 received to obtain hemocult stools x3 and recheck Complete Blood Count (CBC) on 7/14/13. Lab values on 7/15/13 revealed Red Blood Count was 3.05, Hemoglobin 9.1 and Hematocrit was 27.6. The physician was notified of values on 7/15/13 with no new orders received as documented on the lab sheet. The physicians order dated 7/8/13 was not transcribed to the Treatment sheet until 7/11/13. Resident # 86 had bowel movements documented on Nursing Assistant flow sheet 7/8/13, 7/9/13, 7/10/13, 7/11/13, 7/15/13, 7/18/13, 7/19/13, 7/20/13, 7/23/13 and 7/24/13. Interview with Nurse #2 on 7/24/13 at 2:00 PM revealed that documentation on the treatment sheet on 7/15/13 and 7/18/13 noted that Resident #86 had a BM, but it was not checked by hemocult because NA ' s did not know a stool specimen was needed. Interview with NA #1 on 7/25/13 at 9:10 AM who was assigned to Resident #86 revealed that she was not aware to notify the nurse about stools. She indicated that she was aware of Resident #86 needs by looking at the care plan. During an interview with the Director of Nurses (DON) on 7/25/13 at 8:30 AM she indicated that her expectations regarding checking stools for hemocult would be that the resident would allow a digital specimen and a specimen would be obtained each day. If the resident was noncompliant, the nurse would alert the Nursing Assistant (NA) that a specimen was needed. The DON further indicated that the need for a stool	F 309	created a task on the electronic charting system to let her know when any orders were given for hemocult stools so that she would receive a message from the computer in order to follow up with staff. NHA and DON met with Medical Director to devise new system for placement of new orders for transcription and double check. Staff and physician extenders were educated on new procedure. Each nurse received their own personal copy of policy and procedure via US mail 8-14-13. • Director of Nursing will monitor any orders for Hemocult stools and will keep a log of findings. Staff Development Coordinator will do "on-the-spot" education for any areas needing correction. DON will report progress in quarterly QAPI meeting for one year, which will evaluate effectiveness and update plan if needed.	8-12-13

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F 309	Continued From page 2 specimen would be communicated to the NA by the nurse in the huddle meeting at each shift. The huddle meeting communicates any resident changes in condition, appointment schedules, specimens, etc. The DON indicated that the BM ' s are documented by the NA on the Kiosk (computer documentation on the wall).	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that – (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to check for proper placement of the gastrostomy tube (G-tube). The facility failed to check for tube feeding residual.	F 322	F 322 • Resident #106 was checked by Physician to ensure there were no adverse reactions. Meds were reviewed at that time. Orders were obtained to review vital signs x3 shifts. Vital signs were obtained with no adverse reactions noted. Physician followed up with resident the next week to further ensure there were no adverse reactions. Order was on the chart dated 6-4-13 to cocktail medications for administration via g-tube. Care plan has been updated to reflect cocktail meds. Order was obtained 7/24/13 to replace G-tube and this was carried out on 7-24-13 by the treatment nurse and new dressing was applied. • All residents were reviewed and no other residents had tube feeding at time of survey.	7-24-13 7-25-13

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F 322	Continued From page 3 The facility continued to administer medications through the gastromy tube when the liquid would not flow freely. This was evident in 1 of 1 resident observed during the medication pass. (Residents #106). Findings include: Facility Policy titled " Enteral Tube Medication Administration revised 01/17/11 from the contracted Pharmacy revealed in part: To check Placement of the enteral tube " 5: Assist the resident to a semi-fowler ' s to High Fowler ' s position (30*-50*), if tolerated by resident physical or medical condition. 6: Check placement: To confirm placement of feeding tube: a) Attach 50 cc [cubic centimeters] syringe with a 10 cc of air to the end of the tube. If tube is clamped, unclamp the tube. b) Place stethoscope 2-3 inches below the xyphoid process [sternum or breastbone]. c) Forcefully inject 10 cc of air into tube while listening to abdomen with stethoscope to abdomen for a " whooshing " sound. Verification of placement of tube is complete when " whooshing " sound is heard. Administering Medication: 7) Dilute the crushed or split medication with 30 ml [milliliters] water (or prescribed amount). 8) Reattach syringe (without plunger) to the end of the tubing. 9) Administer medication by gravity flow. Pour diluted medication into the barrel of the syringe while holding the tube slightly above the level of insertion. Open the clamp and deliver the	F 322	• Nurse #1 was immediately educated and relieved of duty. Employees were re-educated regarding the "Enteral Tube Medication Administration" policy. Each nurse received their own personal copy of the policy via US Mail 8-14-13. • Staff Development Coordinator will observe Medication Administration via G-tube weekly for one month then monthly for one year and report results to the QAPI committee for one year. Results will be discussed and plan updated if needed.	8-14-13 8-12-13

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F 322	Continued From page 4 medication slowly. Clamp tubing (or begin flush) before the tubing drains completely. 10) If administering more than one medication, flush with 5 to 10 ml (or prescribed amount) warm water between medications. 11) When the last of the medication begins to drain from the tubing, flush the tubing with 30 to 50 ml of warm water (or prescribed amount). 12) Quickly clamp the tubing when the flush is complete. Remove the syringe. Have the resident maintain the semi-fowler ' s position for at least 30 minutes, if tolerated by the resident ' s physical or medical condition. Alternatively, place the resident on right side with the head of the bed partially elevated. " Resident # 106 was admitted to the facility with hemiplegia due to CVA (cerebral vascular accident), dysphagia, and gastrostomy tube (G-tube) for feeding. According to the 07/04/13 minimum data set (MDS) indicated Resident # 106 was severely impaired for cognition and daily decision making. The resident was also assessed as dependent on the staff for all activities of daily living. Review of the monthly physician orders dated 07/01/13 revealed the following medications to crushed and administered via the G-tube: Metropolol Tartrate for hypertension, Albuterol for dyspnea, Clonidine for hypertension, Norvasc for hypertension, Miralax for constipation, Oxycodoen for chronic pain, Cozaar for hypertension, Ativan for Anxiety, Vitamin C for supplement, Children ' s Aspirin for coronary artery disease, Lactulose for constipation, Lisinopril for hypertension, Baclofen for muscle spasms, Prilosec for prevention of gastric reflux.	F 322		

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F 322	Continued From page 5 Flush gastrostomy tube with 75 cc of water before and after medication administration. During an observation of the medication pass for Resident # 106 on 07/24/13 at 12:34 PM, Nurse #1 poured Metroprolol Tartrate and Ativan. These medications were crushed. Nurse# 1 filled a 120 cc cup with cold water from the water pitcher that contained ice. Resident # 106 was lying on his left side with the head of the bed in at approximately *30 angle. Nurse #1 did not adjust the resident ' s position before beginning to administer the medication via the G- tube. Nurse #1 turned off the feeding pump and disconnected the tube feeding adaptor from the G-tube. Nurse #1 bent G-tube in half and placed the syringe into the end of the gtube. As Nurse #1 unfolded the G-tube, a liquid substance that resembled tube feeding, approximately 20 cc in the tube began to creep up into the syringe. Nurse #1 took the plunger of the syringe and forcefully pushed the contents down into the G-tube. Nurse #1 re-folded the G-tube with the syringe attached and tilted the syringe upright and held it in place. Continued observation revealed Nurse #1 poured the crushed medications into the cup of 120 cc of water, and slowly poured half of the medication mixture into the syringe. The mixture would not flow freely into the G-tube. Nurse #1 then forcefully pushed the medication mixture into the G-tube. The Nurse removed the plunger and the medication mixture began to leak out of the G-tube into the syringe. The medication mixture was then noted leaking around the abdominal dressing covering the gtube insertion site. Nurse #1 stated " I will change the dressing when I am finished giving these medications. " Nurse #1 refolded the G-tube and finished pouring the rest	F 322		

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F 322	Continued From page 6 of the medication mixture into the syringe, again using the plunger to forcefully pushed the medication mixture down into the G-tube. Nurse #1 removed the syringe and reconnected the feeding tube for infusing and turned back on the pump. During the observation Nurse#1 did not check the placement of the G-tube. During an interview with the DON (director of nursing) on 07/24/13 at 2:35 PM she revealed her expectation was the nurse was to follow the physician ' s orders to flush the g tube with 75cc of fluid before and after the medication was administered. She further indicated if the nurse had a problem getting the fluid to flow into the gtube she should stopped administration, changed the resident ' s position or gotten assistance. The nurse should have not used the plunger to forcefully push the backflow or medication mixture into the gtube. The DON indicated she should have not used the plunger to force the fluid into the gtube. The DON finally stated " I am going to have the physician evaluate the resident and make sure there is no blockage or problem with the gastrostomy tube. " Interview with DON on 7/25/13 at 2:00 PM revealed the attending physician evaluated the resident and ordered the G-tube to be reinserted.	F 322		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 • Each item was removed by FSD at the time of inspection for items stacked wet or with particles, items not at temp and for items not dated and chipped dishes. • Entire kitchen checked for labeling and dates on all	7-24-13 7-29-13

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F 371	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store plates in a sanitary manner, failed to date stored open foods and failed to maintain cold foods at or below 41 degrees on the serving line. The findings include: 1. Observations on 7/22/13 at 4:22 PM in the clean dish area revealed eleven stacked dessert plates were wet and one plate had dried egg on the surface. Interview on 7/22/13 at 3:24 PM with the Dietary Manager revealed the plates should not be stacked wet or with dried food ready for service. The plates were removed from the shelf by the dietary manager. Observations on 7/25/13 at 11:25 AM revealed four of the 32 plates stacked for use on the serving line were chipped at the rims and one plate had dried food particles on the surface. These were removed from the serving line by the dietary aide. Interview on 7/25/13 at 12:30 PM with the dietary manager revealed the plates would be checked each Tuesday when he reorders supplies. The staff should have checked the plates and removed the ones that had the chipped rims. The plate that had dried food would be checked	F 371	food products. Dish inventory checked for chips. Temp logs placed on each POD. • Kitchen staff was re-educated on labeling and dating of food for storage, how to check for cleanliness, chipping, and dryness of dishes prior to stacking and taking temperatures on the PODs and will sign off daily and report to ASFD. ASFD will conduct inspections of the kitchen for dating of products, dryness, cleanliness and chipping of dishes prior to stacking. AFSD will conduct inspections of the PODs for temps and dish condition and will make corrections and do additional training as needed and report results to FSD. ASFD and FSD will review inspection and temp logs from PODs and kitchen weekly. RD will make monthly visits and check labels/dates and temps for any needed corrections. • FSD will report results quarterly to QAPI committee for one year.	8-14-13 8-12-13

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F 371	Continued From page 8 when stacked or before using it by the dietary aide plating the food. 2. During an observation on 7/22/13 at 4:10 PM of the reach in refrigerator, the following items were opened and not dated: a green bell pepper, a head of lettuce, container of garlic butter, container of chicken salad, and a package of cheese. Observations on 7/22/13 at 4:13 PM of the walk in refrigerator revealed a bag of shredded cheese and a bag of carrots were open and not dated. Observations on 7/22/13 at 4:15 PM of the walk in freezer revealed two packages of lima beans were open and not dated. Interview on 7/22/13 at 4:18 PM with the dietary manager revealed the staff were supposed to date any opened food stored for later use. 3. Observations on 7/24/13 at 12:20 PM revealed a tray of sandwiches in the refrigerator. The temperature of the egg salad, chicken salad and pimiento cheese sandwiches were not checked prior to service. After the serving line had started, the temperature of an egg salad sandwich was checked using the calibrated thermometer used by the dietary aide. The temperature of the egg salad was checked by the Dietary manager. The sandwich temperature was 45.5 degrees. The egg salad sandwiches were removed from the service line by the Dietary Manager. Observations on 7/24/13 at 12:24 PM revealed four dishes of pudding. The pudding was placed on a tray with cakes for service by the aides. The	F 371	Results will be reviewed and plans updated if needed.	

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F 371	Continued From page 9 pudding was not refrigerated or kept cold. The temperature of the pudding was checked using the calibrated thermometer used by the dietary aide. The temperature of the pudding was checked by the Dietary Manager and found to be 46.5 degrees. The pudding was removed from the counter by the Dietary manager. Interview on 7/24/13 at 12:26 PM with the Dietary Manager revealed the temperature of the pudding should have been checked prior to service and kept refrigerated. The egg salad sandwiches were not checked prior to leaving the kitchen. The sandwiches were kept in the refrigerator and should have been at or below 41 degrees prior to service. An interview was conducted on 7/24/13 at 12:30 PM with the dietary aide who brought the tray of sandwiches from the kitchen. The dietary aide explained she removed the sandwiches from the refrigerator in the kitchen, but left them on a cart before putting them in the refrigerator. She explained she had not checked the temperature of the sandwiches prior to starting the service line in the dining room.	F 371		

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

PRINTED: 08/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345088	A. BUILDING 03 - NEW REPLACEMENT FACILITY B. WING _____	08/13/2013

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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 New Health Care section of the LSC and its referenced publications. This facility is Type III (211) protected construction utilizing North Carolina Special locking arrangements, and is equipped with a complete automatic sprinkler system.	K 000	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.	
K 147 SS=D	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 8/13/2013 the following Life Safety item was observed as noncompliant, specific findings include: 1. The Internet cafe' is considered a place of refuge but does not have a unitary light on the emergency circuit that is not able to be switched off. 2. The generator annunciator panel is not in a regularly manned area. The generator annunciator is currently located in the vestibule of the front entrance. CFR#: 42 CFR 483.70 (a)	K 147	K147 • 1. A Unitary light on the emergency circuit has been added in the Internet Café. 2. The generator annunciator has been relocated to the nursing station. • All resident places of refuge have been evaluated for unitary lights on the emergency circuit. All alternate placements were considered for generator annunciator. • Maintenance Director has added a preventative maintenance schedule for the unitary light on the emergency circuit and for the generator annunciator. • Results of monthly preventative maintenance program for the unitary light and generator annunciator will be discussed at quarterly QAPI meeting. Any issues will be followed up and updated as needed.	9-27-2013

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Cindy McCoy, NHA

(X6) DATE
8/27/13

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.