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 _____	C 09/10/2015

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #VYL111.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the	F 278	Preparation and/or execution of this plan	10/14/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/01/2015

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F 278	Continued From page 1 facility failed to accurately code the following areas on the Minimum Data Set (MDS): level 2 Preadmission Screening Resident Review (PASRR) for 1 of 1 residents (Resident #86) sampled for level 2 PASRR, medications for 1 of 5 residents (Resident #62) sampled for unnecessary medications, and pressure ulcers for 1 of 3 residents (Resident #101) sampled for pressure ulcers. The findings included: 1. Resident #86 was initially admitted to the facility on 12/4/12 and readmitted to the facility on 8/5/14 with multiple diagnoses that included Down ' s syndrome and dementia. The annual MDS dated 11/4/14 indicated a "No" to question A1500 which asked if Resident #86 had been evaluated by a level 2 PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. An interview was conducted on 9/10/15 at 12:20PM with MDS Coordinator #1. She stated that the information used to answer the MDS question A1500 for Resident #86 was obtained from the facility's demographic information sheet for Resident #86. She stated that the demographic information sheet for Resident #86 did not indicate that she was a level 2 PASSR. MDS Coordinator #1 revealed that administrative staff #4 maintained all resident demographic information sheets. An interview was conducted on 9/10/15 at 1:15PM with administrative staff #4. She stated that Resident #86 received PASRR Level 2 status on 2/22/13. Administrative staff #4 stated that Resident #86 continued to be a level 2 PASRR, but the information was mistakenly left off of	F 278	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 278=D Assessment Accuracy/ Coordination/Certified Trinity Glen will continue to conduct assessments that accurately reflect the resident¿s status. *For resident #86, #62 and #101, corrected MDS assessments were being transmitted during the survey and it was reported to survey team. The transmissions resulted in no change to the RUG scores. The MDS¿s were transmitted on 9/10/15 and 9/11/15. *All residents in the facility were audited by Admissions Director on 9/10/15 to ensure PASRR number is identified and correct on the demographic sheet, 100% were in compliance. MDS Coordinator was provided a list of all residents with a PASRR level II in the facility and reviewed the list in case mix meeting on 10-15-15 with Interdisciplinary Team to make sure they are marked appropriately. An audit was conducted by Interdisciplinary Team on 9/17/15 of all residents with Pressure areas and any corrections were made. LSC¿s corporate Director of Clinical Services will conduct an in-service training of MDS Coordinators and care plan team on 10/7/15.	

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F 278	Continued From page 2 Resident #86's demographic information sheet. She revealed that was the reason Resident #86's MDS did not indicate that she was a level 2 PASRR. 2. Resident #62 was admitted to the facility 8/17/15. Cumulative diagnoses included, in part, diabetes, depression, anxiety and long term use of insulin. An Admission/ 5 day Minimum Data set (MDS) dated 8/24/15 indicated Resident #62 had received injections four days and diuretic medication one day during the observation period. The MDS indicated she did not receive any antipsychotic medication during the observation period. Physician orders dated 8/17/15 were reviewed and revealed Resident #62 had an order for Haldol (antipsychotic medication) 5 milligrams (mg) by mouth every six hours as needed for hyperactivity. Resident #62 did not have an order for diuretic medication. The Medication Administration Record (MAR) for Resident #62 was reviewed and revealed Resident #62 did not receive any diuretic medication during the observation period. She had received five injections during the observation period and one antipsychotic medication. On 09/10/2015 at 8:11AM, an interview was conducted with MDS coordinator #1. She stated she reviewed the MAR and physician orders to get the information needed to complete a resident ' s MDS. She reviewed Resident #62 ' s MAR and Admission MDS and stated she should have	F 278	*PASRR numbers will be entered on the demographic information sheet upon admission. This information will be included in the 5-day post-admission audit completed by medical records. Upon completion of an MDS, the MDS Coordinator will begin utilizing the electronic medical record program that does an audit comparison of the chart to identify any inaccuracies related to coding of medications on the MDS, and will make any needed corrections prior to transmission. Residents with pressure ulcers will be reviewed weekly by the interdisciplinary team in the weekly TREK meeting. Each of the two MDS coordinators will audit the other MDS coordinator's MDS assessments for accuracy and have any corrections made prior to transmission weekly. *Each MDS Coordinator will audit MDS¿s of the other MDS coordinator each month for accurate coding of PASRR, medications and pressure audits weekly for three months, then monthly for one quarter then quarterly for the remainder of the year and report results to QAPI committee with any changes made to the plan as needed.	

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included the PPD and Haldol. MDS coordinator stated she did not know why she documented that Resident #62 received diuretic medication and accidently put 1 for the diuretic and it should have been for the antipsychotic.

3. Resident # 101 was admitted to the facility on 3/30/2015 with the diagnosis of chronic kidney disease, steroid induced hyperglycemia, chronic Steroid use, vitamin D deficiency, debility, and pressure ulcer.
A comprehensive Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/06/2015 revealed that Resident #101 was cognitively intact and required extensive assistance with activity of daily living (ADLs). The MDS further indicated that Resident # 101 was at risk for pressure ulcers and had one stage 2 pressure ulcer on admission with granulation tissue (pink or red tissue with shiny, moist, granular appearance).
The weekly wound summary dated 04/16/2015 revealed resident had an unstageable pressure ulcer to the right heel noted on admission 3/30/2015. Measurements of 2.0 cm in length, 2.0 cm wide and no depth, tissue type was necrotic.
The weekly wound nurse summary dated 4/16/2015 interventions were to apply bilateral heel protectors when in bed.
The weekly wound summary dated 04/23/2015 revealed a stage 2 pressure ulcer to resident #101 ' s right mid buttock noted on 03/31/2015. Measurements were 0.3 cm in length, 0.3 cm wide with granulation tissue; a pressure area to right heel was also noted on admission 03/30/2015 as an unstageable suspected deep tissue injury pressure ulcer measuring 1.0 cm in length and 2.0 cm wide with necrotic tissue. The

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weekly wound nurse summary dated 4/16/2015 interventions were to apply bilateral heel protectors when in bed.
A Review of the Treatment Administration Record (TAR) dated 3/31/2015 and the physician orders dated 3/31/2015 note that a pressure relief device was to be maintained on resident #101 ' s bed at all times, to apply skin prep to the right ankle and cover with a hydrocolloid dressing and to apply skin prep to the left heel blisters and skin prep to the right heel blisters. The stage 2 pressure ulcer of the sacrum was to have skin prep applied to it and then to cover with a hydrocolloid dressing.
During an interview with the two MDS coordinators and the Wound nurse on 9/10/2015 at 09: 25 AM it was revealed that the MDS nurses had not reviewed the Wound care summaries that were dated 4/16/2015 and 4/23/2015 after the completion of the comprehensive assessment with ARD date of 4/06/2015 because they were not aware that the information contained documentation that pertained to the assessment look back time frame. MDS nurse #2 stated that the documentation was confusing to follow and that they needed to communicate with the Wound nurse to be certain that they had current information for MDS completion and the Wound Nurse agreed that she needed to be certain to have current information available to prevent miscoding in the future. The MDS nurses stated that they were going to make corrections to the previous comprehensive MDS with the ARD of 4/06/2015 and also review all current wound reports, physician orders and Wound Nurse Practitioner consults to assess the need for a significant change in status assessment or the need for modification of any MDS assessments, Care Area Assessment Summaries and care plans that have already been completed.

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on a closed record review and staff interview the facility failed to update the care plan and add interventions to relieve pressure and prevent a blister on the right heel that progressed to an unstageable pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. Resident # 101. Findings included: Resident # 101 was admitted to the facility on 3/30/2015 with the diagnoses of chronic kidney disease, steroid induced hyperglycemia, chronic Steroid use, vitamin D deficiency, debility, and pressure ulcer.	F 280	F 280=D Right to Participate Planning Care-Revise CP Trinity Glen will continue to develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident¿s needs, and,	10/12/15

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F 280	Continued From page 6 The resident had physician orders dated 3/31/2015 for pressure reduction mattress when in bed and skin prep to right ankle then cover with hydrocolloid, to apply skin prep to blisters on both heels and to apply to the sacrum then cover with hydrocolloid. A comprehensive Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/06/2015 revealed that Resident #101 was cognitively intact and required extensive assistance with activity of daily living (ADLs). The MDS further indicated that Resident # 101 was at risk for pressure ulcers and had one stage 2 pressure ulcer on admission with granulation tissue (pink or red tissue with shiny, moist, granular appearance). The care plan initiated on 4/07/2015 indicated the resident had a stage 2 pressure ulcer to the sacrum, closed blisters to the left and right heels and an abrasion to the right ankle present on admission related to reduced physical mobility, urine and bowel incontinence. The approaches included to follow the medical plan for treatment, measure area weekly and as needed, monitor diet intake, ensure adequate hydration, the use of pressure relieving device for bed, application of ointments and medications for skin integrity concerns, record intake every shift, cleanse peri-area and apply barrier cream after incontinent episodes and as needed. The weekly wound nurse summary dated 4/16/2015 interventions to apply bilateral heel protectors when in bed. On 5/13/2015, the resident had a physician order to bear weight as tolerated when ambulating wearing shoes from 9:00 AM to 11:00 AM only and then to remove shoes. The weekly wound summary dated 5/14/2015 revealed the stage 2 pressure ulcer to the right	F 280	to the extent practicable, the participation of the resident, the resident¿s family of the resident¿s legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. *Resident #101 was discharged from the facility on 6-26-15. *Each resident with a pressure area has had a care plan review by the IDT (including the Treatment Nurse)on 9-17-15 to ensure treatment interventions are updated by the Care Plan Coordinators. *The care plan for any resident with a pressure area will be reviewed weekly in the interdisciplinary care plan team trek meeting to ensure any updates are reflected on the care plan. The treatment nurse will begin attending the weekly trek meetings to discuss new interventions, and any changes will be made to the care plan at that time. LSC¿s corporate Director of Clinical Services will conduct an in-service training of MDS Coordinators on 10/7/15 to discuss updating care plan interventions timely. *The DON or ADON will audit all pressure ulcer care plans, to ensure interventions are updated, weekly for 3 months, then audit monthly for the remainder of the year. The DON or ADON will report quarterly for one year to the QAPI committee with any changes made to the plan as needed.	

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mid buttock was healed and orders were discontinued. The right heel pressure was a suspected deep tissue injury that which had worsened and was becoming larger measuring 2.0 cm in length, 3.5 cm wide with necrotic tissue. Also to continue heel protectors to bilateral heels when in bed and to use positioning pillows when resident is in bed.
There was a physician order dated 5/15/2015 to place a bed cradle to the foot of the bed for pressure relief.
The Wound Nurse Practitioner consult dated 5/19/2015 for care transition and foot problems indicated the right heel had an opened unstageable pressure ulcer measuring 2.0 cm x 3.6 cm x 2.0 cm, with 100% slough. The base was unseen, with moderate drainage, no odor, slight tenderness at the edges and no erythema. The right lateral ankle pressure ulcer was open, measuring 0.5 cm x 1 cm x 0.5 cm, dry slough. The base was unseen, no odor, no tenderness, no erythema. Two plus edema was present to bilateral lower extremities.
The weekly wound summary dated 6/11/2015 revealed an unstageable suspected deep tissue injury pressure ulcer of the right heel measuring 1.0 cm in length, 2.0 cm wide with necrotic tissue. The right posterior ankle had an unstageable pressure ulcer improving with granulation occurring, measuring 1.0 cm in length, 1.0 cm wide with slough tissue. Intervention to continue to use pressure relief device in resident #101 ' s in the wheel chair.
On 9/10/2015, the resident ' s closed record care plans dated 4/07/2015 and 4/08/2015 were reviewed and did not have the bilateral heel protectors when in bed on the care plan. These had been ordered on 4/16/2015. A physician order on 5/13/2015 for resident ' s shoes to be

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F 280	Continued From page 8 worn from 9:00 AM until 11:00 AM daily and the use of positioning pillows which had been ordered on 5/14/2015 and the bed cradle which had been ordered on 5/15/2015 had not been placed on the care plan. There were no updates to the care plan since 4/08/2015. On 9/10/2015, an interview was conducted with the wound care nurse and two MDS coordinators. They stated the care plans were initiated within 7 days after completion of the admission MDS and updated as needed to reflect current care concerns and to maintain updated interventions. The Wound nurse was responsible for keeping the nurses updated of skin integrity concerns, treatment changes as well as proactive and preventive approaches so care plans could be updated to reflect the resident ' s current status. The MDS coordinators completed a medical record review with each MDS and made changes based on medical record documentation. The MDS coordinators stated that they did not always have timely information to keep the care plans current and that sometimes the documentation was confusing to follow. The MDS coordinators did state that they understood that they needed to ask questions and investigate confusing documentation so that all care plans were updated to meet each resident ' s care needs and to be as accurate as possible for providing care.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		10/14/15

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F 281	Continued From page 9 Based on medical record review and staff interview, the facility failed to follow the physician ' s orders to obtain vital signs every shift for one of five residents reviewed for unnecessary medications (Resident #62). The findings included: Resident #62 was admitted to the facility 8/17/15. Cumulative diagnoses included diabetes, chronic obstructive pulmonary disease (COPD), coronary artery disease, depression, anxiety, long term use of insulin, anemia and renal dialysis. An Admission/ 5 day MDS dated 8/24/15 indicated Resident #62 was cognitively intact. She required extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene and total assistance with bathing. A physician progress note dated 9/1/15 stated Resident #62 was noted to have altered mental status and hypotension low blood pressure) while at dialysis. Her systolic blood pressure had been running 170-190 at the facility but decreased when she received dialysis. Blood pressure medications had been adjusted and Resident #62 was feeling much better and more alert. Norvasc (blood pressure medication) would be added back at night to get slightly better blood pressure control. Physician orders were reviewed and revealed an order dated 9/1/15 to check vital signs every shift. The Medication Administration Record for September 2015 was reviewed and revealed vital signs were documented on day shift 9/2/15 and evening shift 9/3, 9/4, 9/6, 9/7 and 9/9/15.	F 281	F281 = D Services Provided Meet Professional Standards Trinity Glen services provided or arranged for by the facility will continue to meet professional standards of quality. *Resident #62 has been evaluated by Physician Services and no adverse effects were found. Resident #62 was discharged to home on 9/15/15. *An audit was done on 9/10/15 by ADON for any residents having an order for q shift vital signs. There were no residents in the facility with q shift vital signs ordered at the time of the audit. *ADON or RN Supervisor will audit all units in the entire facility weekly for any q shift vital signs orders, and will check for compliance and report results to DON. By 10/2/15, all Nurses and MAAs will be re-educated by the ADON on the importance of obtaining and charting q shift vital signs when ordered by the physician. *A report will be presented quarterly by DON in QAPI for one year with any changes made to the plan as needed.	

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F 281	Continued From page 10 Nursing notes from 9/1/15 through 9/9/15 were reviewed and no vital signs were documented during that time. A review of the nursing assistant vital sign book revealed vital signs done but not documented in Resident #62 ' s medical record: 9/2-night and day shift; 9/3-night and evening shift; 9/4-day shift; 9/5-night shift; 9/6-night shift; 9/7-evening shift; 9/8-night, day and evening shift; 9/9-night shift. On 09/10/2015 at 9:05AM, Administrative staff #2 stated she expected nursing staff to follow the physician orders and obtain and document the vital signs in the medical record every shift for Resident #62.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow the care plan and assess the dialysis site for one of one residents (Resident #62). The findings included: Resident #62 was admitted to the facility 8/17/15. Cumulative diagnoses included renal dialysis. An Admission/5 day Minimum Data Set (MDS) dated 8/24/15 indicated resident #62 was cognitively intact. Dialysis was checked as	F 282	F282=D Services by Qualified Persons/Per Care Plan Trinity Glen will continue to provide or arrange services by qualified persons in accordance with each resident¿s plan of care. *Resident #62 was discharged home on	10/14/15

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F 282	Continued From page 11 resident receiving dialysis during the assessment period. A care plan dated 9/8/15 stated Resident #62 had renal failure related to diabetes. Approaches included, in part, assess vascular access site for complications; report my thrill prior to and after dialysis. Resident #62 was interviewed during stage 1 on 9/8/15. She stated she had a shunt in her left upper arm and received dialysis three times a week. Resident #62 said they checked her shunt at dialysis and that the nursing staff at the facility did not check her shunt site daily for thrill and/ or bruit. Dialysis treatment communication sheets that were filled out by the facility prior to and after dialysis and information filled out by the dialysis staff on 8/19/15, 8/24/15, 8/26/15, 8/28/15 and 8/31/15 were reviewed and there was no documentation that the thrill and/or bruit were checked at any time. Physician orders were reviewed and revealed no orders related to checking the thrill and/or bruit of the dialysis shunt site. The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August 2015 and September 2015 were reviewed. No documentation was noted regarding assessment of the thrill/ bruit of the dialysis shunt site. Nursing Notes from 8/17/15 through 9/10/15 were reviewed. There was no documentation noted regarding assessment of the dialysis shunt site	F 282	9/15/15. *An audit was conducted by the ADON on 9/10/15 for all residents that receive dialysis to ensure AVF checks were documented on the TAR and Care Plans. *Nurses, including Nurse #1, will be educated by the ADON by 10/2/15 on checking AVF for thrill/bruit and upon the order that shall be obtained by physician services for any resident that receives dialysis services. AVF orders and checks will be reviewed weekly for compliance by the ADON or RN Supervisor who will report to the DON monthly. *DON or ADON will report on Dialysis AVF checks to the QAPI committee quarterly for one year, and changes will be made to the plan as needed.	

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F 282	Continued From page 12 for thrill and/or bruit. On 09/09/2015 at 5:18PM, Nurse #1 was interviewed. She stated she had provided care for Resident #62 for two to three days. She stated Resident #62 had a shunt in her left upper arm for dialysis and had checked the shunt site for bleeding and infection but had not checked the dialysis shunt site for thrill and/or bruit. She stated, if the shunt site was checked for thrill/ bruit, it would have been documented in the nurse charting section. On 09/10/2015 at 8:56AM, Administrative staff #2 stated she had reviewed Resident #62 ' s medical record and did not find any documentation regarding the thrill and bruit assessment. She stated she expected nursing staff to assess the dialysis shunt site for thrill and bruit every shift and to document the results.	F 282		
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, staff interviews, and psychologist interviews, the facility failed to obtain a psychiatric consult as ordered by the physician for one of one residents (Resident #84) sampled.	F 309	F309=D Provide Care/Services for Highest Well Being	10/9/15

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F 309	Continued From page 13 The findings included: Resident #84 was admitted to the facility on 4/27/15 with multiple diagnoses that included cardiac failure, coronary artery disease and dementia. The admission Minimum Data Set (MDS) assessment dated 5/4/15 indicated Resident #84 had severe cognitive impairment and displayed physical behavioral symptoms toward others 1-3 days per week. The quarterly MDS assessment dated 7/23/15 indicated the resident ' s physical behavioral symptoms directed toward others increased to daily occurrences. The initial care plan dated 4/30/15 for Resident #84 indicated a problem area of behaviors. Resident #84 was noted to have altered behavior patterns, pacing, and agitation. The care plan update on 7/23/15 and 9/10/15 indicated an ongoing need for this care area. The care plan dated 9/10/15 indicated that the resident had a tendency to show combative behaviors such as hitting, kicking, shoving and scratching staff. The physician ' s orders were reviewed. On 4/28/15 there was a physician ' s order for a psychiatric consult. On 5/19/15 there was a physician ' s order for a psychiatric consult. A social service quarterly note dated 7/23/15 indicated that Resident #84 was noted to be combative by kicking, scratching, hitting and being verbally abusive during care. A review of the medical record revealed no documentation that Resident #84 received a psychiatric consult as ordered. A review of Nursing Assistant (NA) behavioral charting from 4/27/15 to 9/10/15 indicated Resident #84 had displayed physical behaviors such as hitting, shoving, scratching and kicking staff or others regularly since the time of	F 309	Trinity Glen will continue to ensure each resident receives and facility provides 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. *Resident #84 has had a psychiatric consult on 9/10/15. *The ADON completed audit on 9/10/15 for any orders for psych services to ensure the orders were fulfilled. The audit showed that all residents who had orders had been seen by Psych services upon completion of Psych Services visit to Resident #84. *On 9/10/15, the Administrator re-educated the Social Worker on the need to follow-up on all psych orders to ensure the visit occurred. The Social Worker has developed a log for psych services. The log contains: date of new orders for psych services, when the service was contacted, when the visit was completed, and when the note is placed in the chart. The log is given to the Administrator monthly. The ADON will audit for psych orders weekly and will reconcile the log to ensure all orders are fulfilled. *The Social Worker will report on completion of psych services consultations, per orders, on a quarterly basis for one year in QAPI, and changes will be made to plan as needed.	

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F 309	Continued From page 14 admission. An interview was conducted on 9/9/15 at 4:30PM with NA #3. She revealed that Resident #84 displayed agitated behaviors when care was provided. These behaviors included physically hitting and swinging at staff. NA #3 indicated that this behavior continued since Resident #84 ' s admission. NA #3 stated that she completed behavioral charting daily for Resident #84. An interview was conducted pm 9/10/15 at 10:30AM with NA #4. She revealed that Resident #84 regularly hit, kicked and pushed staff on most days. NA #4 indicated that these behaviors had continued since Resident #84 ' s admission. NA #4 stated that she completed behavioral charting daily for Resident #84. An interview was conducted on 9/9/15 at 4:45PM with the Social Worker (SW). She stated that she emailed the referral for a psychiatric consult on 4/29/15. The SW revealed that she did not follow up on this referral and she was not aware the consult did not occur. She stated she emailed a second referral for a psychiatric consult on 5/21/15 and said that she did not follow up on this referral and she was not aware the consult did not occur. An interview was conducted on 9/10/15 at 12:30pm with the SW and the psychologist whom the psychiatric consult referral was made for Resident #84. The psychologist revealed that she had not conducted a psychiatric consult for Resident #84. The psychologist stated that she did not understand why she was not contacted for a psychiatric consult for a resident (Resident #84) who continued to have physical behaviors for 4 months.	F 309		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		10/11/15

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F 371	Continued From page 15 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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to label and date opened food items in the kitchen freezer and in the refrigerator on one of four pods (pod#4). The findings included: On 9/8/15 at 10:55AM, an initial tour of the kitchen was conducted with the dietary manager. An observation of the freezer area revealed 21 beef patties in an opened bag with white edges observed on the beef patties. The opened bag was not sealed, labeled or dated. On 9/10/15 at 10:25AM, a tour of the kitchen freezer and pod areas was conducted with the dietary manager. An observation of the kitchen freezer revealed an opened bag of broccoli wrapped in plastic not labeled or dated. An observation of the refrigerator on pod 4 revealed the following: a hot dog wrapped in tin foil and placed in a bag. The item was not labeled or dated. There were two meat containers that had cucumbers in one and peppers in another. Both were not labeled or dated and were in a grocery bag.	F 371	F371=D Food Procure, Store/Prepare/Serve ¿ Sanitary Trinity Glen will continue to: 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. *Food not labeled and dated in the kitchen freezer and the refrigerator on Pod #4 was discarded in surveyor¿s presence on 9/8/15 and 9/10/15. All refrigerators and freezers were checked for properly labeled and dated food products on 9/10/15. *All dietary staff were issued a permanent marker and tape for labeling that will now be considered a part of the uniform. A root cause analysis survey was conducted with each dining services staff member to determine the contributing factors of the failure to label/date items. This	

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F 371	Continued From page 16 On 9/10/15 at 11:05AM, Nurse #2 stated nursing staff were supposed to store their food items in the break room refrigerator and the residents' foods should be stored in the nourishment room. All items should be labeled and dated. On 9/10/15 at 11:05AM, the dietary manager stated all items in the kitchen freezer and refrigerators should be labeled and dated. She said there should not be any resident/ staff food items in the pod 4 refrigerator.	F 371	information will be utilized to make ensure compliance with sanitary regulations. Dining staff were re-educated on the importance of labeling and dating all opened food items by the Certified Dietary Manager (CDM) on 9/28/15. The ADON/SDC re-educated all facility staff on appropriate storage, labeling, and dating of staff and resident personal foods, this was completed 10-8-15. Dietary staff will inspect refrigerators and freezers for labels and dates each shift and will sign off on label/date checklist. Assistant Food Service Director will check labels and dates no less than five times per week and report to CDM. The Administrator will hold weekly meetings for four weeks, then monthly meetings for one year, with the dining services management team. A Registered Dietician will conduct a directed in-service related to Kitchen Sanitation with Dining Staff on 10-5-15. The Administrator has requested an additional directed in-service by Alliant Quality, North Carolina's Quality Improvement Organization to occur no later than 10-11-15. The QIO will re-educate the Dining Services staff on the elements of F371.Administrator has made changes to Dining Services Team to include a serve-safecertified instructor as Dining Services Director to continue the education on kitchen sanitation on an on-going basis. *CDM will report on compliance with labeling and dating quarterly to QAPI, and any changes will be made to the plan as needed.	

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F 372	Continued From page 17	F 372		
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to keep the area around the dumpster clean and failed to keep the dumpster door closed for two of three dumpsters. The findings included: On 9/8/15 at 11:00AM, an initial tour of the dumpster area was conducted with the dietary manager. A total of six (6) clear surgical gloves was noted on the ground at the side of the center dumpster and on either side at the back of the dumpster. A second tour of the dumpster area was conducted with the dietary manager on 9/10/15 at 10:05AM. The following was noted: The side door of the center dumpster was open approximately two inches. There was a clear garbage bag hanging out of the dumpster. Around the dumpster was three straws, an empty fruit snack box, an empty bag of potato chips, a water bottle, clear plastic wrap, a milk carton and approximately twelve (12) clear surgical gloves. Many insects (hornets) were observed around the center dumpster. Also, the second dumpster that contained garbage had a black garbage bag hanging out the side door and the side door was open approximately two inches On 9/10/15 at 10:05AM, the dietary manager	F 372	F372 = E Dispose Garbage & Refuse Properly Trinity Glen will continue to dispose of garbage and refuse properly. *The dumpster area and the surrounding areas were cleaned on 9/10/15. *Each dumpster was checked for refuse on all four sides and for closed doors on 9-10-15. *Dietary and environmental services staff will be re-educated on 10/5/15 by the dietary manager and the housekeeping director to ensure all waste gets inside the dumpster and that the doors are closed upon each trip to the dumpster. A schedule was made up for daily dumpster checks by dietary and environmental services staff. CDM and Environmental Services Director will monitor these checks for completion each week and turn in to Administrator monthly. *CDM and Environmental Services Director will report on dumpster checks quarterly to QAPI, and any changes will be made to plan as needed.	10/12/15

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F 372	Continued From page 18 stated it was the responsibility of the dietary staff/ housekeeping staff to keep the dumpster area clean. She stated she expected dietary and housekeeping staff to keep the area clean. On 9/10/15 at 10:10AM, an interview was conducted with the housekeeping supervisor. She stated it was the responsibility of housekeeping/ dietary staff to keep the dumpster area clean. One of the housekeeping staff usually checked the trash area around 7:30AM each day and kept a check on it throughout the day. She stated housekeeping did not check it this morning. The housekeeping supervisor stated she expected housekeeping and dietary staff to keep the area clean and free from debris.	F 372		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520		10/11/15

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F 520	Continued From page 19 requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility ' s Quality Assessment and Assurance committee failed to implement, monitor and revise as needed the action plan developed for the 10/9/14, 7/25/13, and 5/11/12 recertification surveys in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies on proper labeling and dating of food items (F371) on the 10/9/14, 7/25/13, and 5/11/12 recertification surveys. The findings included: This tag is cross referenced to F 371. Based on observation and staff interview, the facility failed to handle foods in a sanitary manner by touching nonfood items, then using gloved hands to touch the bread and place on residents ' plates on two of four dining areas (pod #1 and pod #4) and failed to label and date opened food items in the kitchen freezer and in the refrigerator on one of four pods (pod #4). An interview was conducted with Administrative Staff #1 on 9/10/15 at 2:30 PM. Administrative Staff #1 stated concerns regarding the improper labeling and dating of food items had been corrected through the quality assurance process in the past years. She stated a new assistant dietary manager was recently hired and dietary management was expected to identify and correct concerns in the kitchen.	F 520	F520 = E QAA Committee- Members/Meet Quarterly/Plans Trinity Glen will continue to maintain a QAA committee with correct members that meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develop and implement appropriate plans of action to correct identified quality deficiencies. A state or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. *Trinity Glen has developed a QAPI plan for correction, monitoring and compliance of F371. *The administrator contacted Casey Conner, Quality Advisor with Alliant Quality QIO to review and suggest any needed changes with the QAPI process for F371. Ms. Conner visited the facility on 9/25/15 to review and make recommendations	

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F 520	Continued From page 20	F 520	regarding implementation of the QAPI Process for the F371 and survey issues. *The Registered Dietician will train all Dining Services staff on serve-safe elements related to kitchen sanitation by 10/11/15. We believe that as a just culture facility, educating our staff further on why this matters will enable and empower them to strive to do better and to make any needed changes. The Administrator has requested an additional directed in-service by Alliant Quality, North Carolina's current Quality Improvement Organization to occur no later than 10-11-15. The QIO will re-educate the Department Managers and Supervisors on the QAPI program. The QIO will also re-educate all Dining Services staff on the elements of F371. The Administrator has made changes to staffing to include a certified serve-safe trainer as Dining Services Director to continue the education on an on-going basis. The corporate Director of Quality Improvement will re-educate the department managers on properly identifying and correcting quality concerns by 10/11/15. A root cause analysis survey was conducted with each dining services staff member to determine the contributing factors of the failure to label/date items. This information will be utilized to ensure compliance with sanitary regulations. The Administrator will hold weekly meetings for four weeks, then monthly meetings for one year, with the dining services management team. *CDM will report on compliance with labeling and dating quarterly to QAPI, and	

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F 520	Continued From page 21	F 520	any changes will be made to the plan as needed. The QIO will be invited in to review the plan quarterly as an enhancement.	