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	345554	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	**631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412**

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #YUG111.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a	F 278		10/20/17

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

Electronically Signed | 10/20/2017

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 residents (Resident # 90) identified as a Level II PASRR resident. Findings included: Review of Resident # 90's PASRR Level II letter dated 05/04/15 revealed the resident had a permanent number. Review of the Annual MDS dated 06/27/17 indicated resident #90 was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review were used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. In an interview on 10/11/17 at 11:52 AM the MDS Coordinator stated she was informed of a resident's Level II PASRR status by the Admissions Coordinator. On review of the MDS, the MDS Coordinator stated that Resident #90 was not listed as being a Level II PASRR. She stated if no one told her a resident was a Level II PASRR she would assume they were not and would code them accordingly on the MDS. In an interview on 10/11/17 at 3:06 PM the Admissions Coordinator verified that Resident #90 was not listed as a Level II PASRR on the	F 278	MDS Nurse modified previously submitted assessments for Resident #90 to reflect Level 2 PASRR. Corrected MDS assessments were submitted on 10/11/17. Administrator educated both MDS nurses on how to locate PASRR evaluations in the chart on 10/11/17. Administrator created "PASRR group" within the facility that includes: Social Worker, Admissions, Medical Records, MDS Nurse(s) and Administrator. The group will have written communication related to any residents admitted with a level 2 PASRR and/or any residents who are screened after admission and receive a Level 2 PASRR during the course of their care. "PASRR group" completed in-service on purpose and process of PASRR determination on 10/20/17. PASRR for all residents will be reviewed no less than once per month for three months then quarterly for three quarters. Administrator will observe if correct PASRR status has been communicated effectively with all members of the "PASRR group" and that the correct status has been recorded in the MDS assessment. These findings will be documented on QA Log. This log will be included in quarterly QAPI meeting for review. First three entries will be	

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F 278	Continued From page 2 Annual MDS. She indicated she would have informed the Social Worker or the Health Information Management Coordinator when the Level II PASRR was received but she would not have notified the MDS Coordinator of Resident #90's Level II PASRR status. In an interview on 10/11/17 at 3:21 PM the Health Information Management Coordinator stated she performed audits to verify if residents had a PASRR number on admission. She indicated she did not audit the MDS of each resident to make sure the correct information was entered. In an interview on 10/11/17 at 4:48 PM the Administrator stated it was her expectation that the MDS Coordinator obtain the PASRR information from a resident's medical record and enter the correct information on the MDS.	F 278	completed by 1/19/18 and the final entries by 10/20/18. If it is determined that a member of the "PASRR group" is not following correct procedure, he/she will repeat in-service. If same member fails to follow correct procedure again, disciplinary action will be taken.	
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers	F 314		10/20/17

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F 314	Continued From page 3 from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to assess the nutritional status and put nutrition interventions in place to promote wound healing when an unstageable pressure ulcer was discovered for 1 of 1 residents (Resident #109) reviewed for pressure ulcers. The facility also failed to assess the wound bed, measurements, drainage, and surrounding tissue of this wound for three weeks after its discovery. Findings included: Record review revealed Resident #109 was admitted to the facility on 02/08/16 and was discharged to a freestanding hospice center on 10/09/17. The resident's documented diagnoses included pressure ulcers to the right heel and sacrum, iron deficiency anemia, chronic kidney disease (CKD) stage II, congestive heart failure (CHF), and dementia without behavioral disturbances. Resident #109's 09/01/16 comprehensive metabolic panel (CMP) documented her total protein was low at 5.2 grams per deciliter (g/dL) with normal being 6.1 - 8.1 g/dL and her albumin was low at 3.3 g/dL with normal being 3.6 - 5.1 g/dL. (These were the most recent labs indicative of the resident's protein status). On 02/08/17 Resident #109's care plan identified "I have impairment of skin integrity" as a problem. Interventions to this problem included assess the resident's nutritional status, refer to the dietitian, and monitor the resident's diet intake. On 04/21/17 the facility's registered dietitian (RD)	F 314	Director of Nursing and/or Assistant Director of Nursing will review Nurse documentation entered since last review during the AM clinical meeting that occurs Monday through Friday - monitoring for new entries related to pressure ulcers. Complete assessment of all pressure wounds will be completed no later than three days after discovery. This assessment will be documented in the Nursing Notes of the medical record. If new pressure ulcers are found, the resident will immediately be added to list for review in weekly TREK meeting. Residents who are admitted with pressure ulcers will be added to list for review in weekly TREK meeting upon admission. All residents with pressure ulcers will be referred to RD by Dietary Manager or Assistant Manager, in writing, no later than one week after discovery. During the weekly TREK meetings, residents with pressure ulcers will be reviewed to assess nutritional status and to determine if additional nutritional interventions are needed. All residents with pressure ulcers will be recorded on monthly QA log that includes date pressure ulcer was discovered, date of assessment and date of first review in TREK meeting. Administrator will review	

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F 314	Continued From page 4 documented in Resident #109's nutrition assessment, "04/20/17 147.4 lbs (pounds)--weight has been at 144 - 147 lbs for the last month, has had a 11.6% weight loss since Nov (November) 2015, and 2.6% weight loss in the last 6 months. The resident's weight is still above the upper IBW (ideal body weight) range, and with her history of CHF--this overall weight loss has been a beneficial weight loss. She continues on a regular diet and is eating well. Currently with average of 84% meal intake." (There was no further RD assessment of Resident #109 until 09/13/17). A 04/26/17 quarterly minimum data set (MDS) documented Resident #109's cognition was severely impaired, she had disorganized thinking, felt tired, had no psychosis, had no behaviors, required extensive assist from staff to being dependent on staff for all activities of daily living except for eating for which she only required set-up assistance with meals, she was 66 inches tall and weighed 147 pounds, her weight was stable, and she had no unhealed ulcers. During the month of May 2017, based on meal intake records, Resident #109's average meal intake was 74%. A 06/26/17 Weekly Skin Evaluation documented, "Area to right heel, skin prep applied, feet elevated on pillow while in bed." A 06/29/17 physician order documented polymem was to be applied to the resident's unstageable ulcer on the right heel twice weekly on shower days. During the month of June 2017, based on meal	F 314	log of all pressure ulcers no less than once per month for three months then quarterly for three quarters. This log will be included in quarterly QAPI meeting for review. First three entries to be completed by 1/19/18 and the final entries by 10/20/18. In-service reviewing outlining expectations and process related to treatment of pressure ulcers was completed with DON, ADON, Dietary Manager and Assistant Dietary Manager on 10/20/17. If it is determined that a team member is not following correct procedure, he/she will repeat in-service. If same team member fails to follow correct procedure again, disciplinary action will be taken.	

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intake records, Resident #109's average meal intake was 72%.

07/03/17 and 07/10/17 skin evaluations documented Resident #109 had an "open area" on the right heel with "dressing clean, dry, and intact."

A 07/17/17 assessment by the facility's treatment nurse documented, "Right heel unable to stage, granulation (tissue) 75% and slough-firmly attached 25%." The treatment nurse also documented the wound tissue was pink/yellow, there was light serosanguineous drainage, the surrounding tissue was macerated, the wound measured 1 x 0.8 x 0.2 centimeters (cm), and polymem was being applied twice weekly after showers and the area was wrapped with kerlix.

During the months of July 2017 and August 2017, based on meal intake records, Resident #109's average meal intake was 65% for both months.

On 09/13/17 the RD's nutrition assessment for Resident #109 documented, "Unstageable skin area. 09/11/17 - 137 lbs - noted with 8.4% weight loss in 6 months, and 4.9% weight loss in the last month. Current weight is at IBW range - need to maintain resident's current weight within IBW range. Unstageable skin area. (Resident #109) is on regular diet with average of 50% intake - declines at the supper meal. The resident does have history of CHF...Due to the resident's weight decline - will add 60 cc (cubic centimeters) med pass at HS (night)." A 09/13/17 physician order put this supplement into place. (This was the first time a nutrition assessment was completed and a nutrition intervention was put in place for Resident #109 since the resident's right heel ulcer was

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noted on 06/26/17).

Review of resident's hospice care plan revealed the resident was admitted to hospice on 09/15/17.

The treatment nurse's 09/18/17 assessment documented Resident #109's right heel ulcer was unstageable with 100% eschar, had no drainage, measured 1.5 x 1.8 x 0.1 cm, and had polymem applied twice weekly and secured with cosmopor or dermadress.

A 09/18/17 Weekly Skin Evaluation documented the resident had a sacral pressure wound which reopened and measured approximately 1 x 1 cm.

The treatment nurse's 09/20/17 assessment documented Resident #109 had reopened ulcers to her right and left buttocks, both ulcers measuring 1.5 x 1.5 x 0.1 cm, both with 100% eschar, and endit cream applied twice daily.

A 9/20/17 physician order initiated a supplemental milkshake at each supper meal for Resident #109.

The resident's 09/22/17 significant change MDS documented Resident #109 had short and long term memory impairment, was moderately impaired in decision making, exhibited disorganized thinking, had no mood issues, exhibited no psychosis and no behaviors, required extensive assist from staff to being dependent on staff for all activities of daily living except for eating for which she only required supervision by a staff member, she weighed 148 pounds, and she had three unstageable pressure ulcers.

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The treatment nurse's 10/03/17 assessments documented Resident #109's right heel pressure ulcer still measured 1.5 x 1.5 x 0.1 cm with the wound bed being 100% eschar. She also documented the resident's sacral pressure ulcer (combining the ulcers to the right and left buttocks) was a stage III wound measuring 5.5 x 8 x 0.1 cm with the wound bed being 10% eschar, 10% granulation tissue, and 80% epithelial tissue.

Nursing notes documented Resident #109 was discharged from the facility on 10/09/17 to a hospice center.

On 10/11/17 at 3:25 PM the certified dietary manager (CDM) stated the consultant RD visited the facility once monthly. She reported she provided the RD with a list of residents that needed to be assessed based on discussion during weekly TREK meetings in which residents with wounds and weight loss were reviewed. She commented the RD was supposed to assess tubefeeding residents, residents with significant weight loss or weight gain, and residents with pressure ulcers to see if they might need extra protein or supplements to promote wound healing. According to the DM, she could call or e-mail the RD with any questions between her monthly visits. She explained the treatment nurse was usually at the TREK meetings, and provided attendees with a list of current residents with pressure ulcers. The DM provided the lists of residents that she gave to the RD in her visits on 07/13/17 and 08/11/17, and Resident #109 was on neither list.

On 10/11/17 at 4:05 PM, during a telephone interview with the RD, she stated she received a list monthly from the CDM (the RD referral list)

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which included residents she was supposed to assess. She reported this list included residents that were at high risk due to significant weight loss, wounds, and tubefeeding. She commented if residents were identified at high risk between her monthly visits during TREK meetings, the facility could send her a referral and she would complete the assessment remotely and send it back to the facility. According to the RD, she preferred to assess residents soon after wounds were identified so she could review meal intake, lab values, current supplements and vitamins, and protein intake and needs. The RD stated when meal intake was marginal, no supplements were already in place, and/or the resident did not seem to be meeting his/her protein needs, she usually attempted to identify natural foods high in protein first that the compromised resident might be willing to eat. She commented if she could not identify natural foods then she considered supplement products such as Magic Cups, shakes, med pass, fortified juices,and prostat. She reported she usually looked at albumin or prealbumin labs to help determine resident protein status. The RD explained good quality and adequate nutrition, adequate protein, and key minerals were important in promoting wound healing.

On 10/12/17 at 8:50 AM the treatment nurse stated she depended on the direct care staff to inform her when residents developed new pressure ulcers. She reported staff could inform her of such through handwritten notes, texts, or electronic notification, but she liked to assess new areas within a day of being found, but it could be longer if the ulcer was identified on the weekend. She commented in her assessment she liked to include information about the stage,

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location, measurements, wound tissue, odor, surrounding tissue, pain at the ulcer site, exudate/drainage, signs of infection, current treatment, healing progress, and causative factors. According to the treatment nurse, the facility was trying to get the hall nurses/direct care staff out of the mindset of assessing and monitoring pressure ulcers on their own, and instead involving her as the treatment nurse. She commented the facility was working on better communication between staff members, and she thought she should have been brought into the loop quicker to assess and monitor Resident #109's right heel pressure ulcer. She stated nutrition was very important in wound healing, and she felt the use of supplement products and nutrients could help speed up the healing process.

On 10/12/17 at 9:38 AM the director of nursing (DON) stated the treatment nurse was in the building during the week, five days each week, and during this time period she expected the treatment nurse to assess wounds the day they were found or the next day at the latest. She commented if wounds were discovered on the weekend it might be Monday before the treatment nurse could assess them. She reported after her initial assessment she expected the treatment nurse to assess wounds weekly thereafter. She explained the staff was supposed to notify the treatment nurse of new wounds using nursing cards. After reviewing the documentation on Resident #109's right heel pressure ulcer, she stated the wound assessment was not completed timely by the treatment nurse. According to the DON, TREK notes should have captured information about Resident #109's right heel ulcer which was discovered on 06/26/17. However,

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when the DON reviewed these weekly TREK notes the first discussion about Resident #109's right heel ulcer was not until 09/06/17. The DON commented nutrition was very important in wound healing, and the facility used a lot of fortified juices which provided extra protein and nutrients. She reported the delay of incorporating Resident #109 in the TREK meetings may have contributed to the CDM and RD not being aware of the emergence of a heel ulcer so they could make sure nutritional supplementation was begun to promote healing.

On 10/12/17 at 10:05 AM Nurse #2, who cared for Resident #109, stated the resident was never a big eater, but 2 - 3 months ago the resident was eating an average of 50% of her meals. However, she reported in last month the resident's meal intake probably decreased to 25% and in the last couple of weeks decreased to a couple of bites.