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 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GLEN	**849 WATERWORKS ROAD** **WINSTON-SALEM, NC 27101**

(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 IDR 12/18/17 resulted in deletion of tag F 353	F 000		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to promote dignity during Resident #71 incontinence care. Full visual privacy was not provided when Resident #71 was not fully clothed. This was evident in 1 of 5 residents reviewed for activities of daily living. Findings included: Resident #71 was admitted to the facility on 2/8/17 with cumulative diagnoses which included Parkinson's disease. Review of the quarterly Minimum Data Set (MDS) assessment dated 8/3/17 revealed the resident had impaired cognition and totally dependent on 2 staff for bathing and extensive assistance for personal hygiene Observation on 11/02/2017 at 10:46 AM of incontinence care performed by Nursing Assistant (NA) # 5 and NA #4 was conducted. Resident #71 experienced a bowel and urine episode of incontinence. The privacy curtain was pulled between A and B bed, but was not pulled	F 241	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. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Plan of Correction – F 241(D) Dignity The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Nursing Assistant (NA) #5 pulled the privacy curtain between A and B beds and closed the bedroom door, however, did	11/30/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/21/2017

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.

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 11/02/2017

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F 241	Continued From page 1 completely around the bed exposing the Resident #71's unclothed body during incontinence care. Interview on 11/02/2017 at 10:58 AM with NA #5 who stated, "I pulled the curtain between her roommate." An interview on 11/2/17 at 5:00 pm with the Assistant Director of Nurses revealed her expectation that privacy would be private during incontinence care.	F 241	not pull the curtain around the foot of the A bed. NA made human error in not following the procedure that she had been trained to follow. NA #5 has received 1:1 education and disciplinary action on 11-2-17 by Director of Nursing (DON). NA #4 did not intervene and has also received 1:1 education and coaching on 11-10-17 by Staff Development Coordinator (SDC). The procedure for implementing the acceptable plan of correction for the specific deficiency cited; All NAs will be re-educated by 11-30-17 by SDC regarding pulling the privacy curtain to provide complete privacy during care of residents. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Staff Development Coordinator (SDC) or assigned nurse will monitor privacy provision during patient care twice per week each shift each hall for one week, then will monitor privacy provision during patient care once per week each shift each hall for three weeks. Then will do six (6) privacy provision checks weekly on random shifts and random halls for two months. Any non-compliance issues will be addressed at time of discovery and changes made to plan as needed. SDC will then evaluate results with assistance of the Performance Improvement Plan Team (PIP) and will report results to the Quality Assurance Performance	

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	345088	A. BUILDING ______ B. WING ______	C 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GLEN	**849 WATERWORKS ROAD** **WINSTON-SALEM, NC 27101**

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F 241	Continued From page 2	F 241	Improvement (QAPI) committee quarterly. At the quarterly reviews, the PIP team will determine frequency of checks for the following quarter and SDC will report results to QAPI committee quarterly for one year. The title of the person responsible for implementing the acceptable plan of correction. Staff Development Coordinator Completion date: 11-30-17	
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 279		11/30/17

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 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GLEN	849 WATERWORKS ROAD WINSTON-SALEM, NC 27101

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F 279	Continued From page 3 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive	F 279	Plan of Correction – F 279 (D) Develop Comprehensive Care Plans	

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 11/02/2017

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F 279 Continued From page 4

interdisciplinary care plan that addressed Resident #86 behaviors in 1 of 3 residents reviewed with behavioral issues.

Findings included:

Resident #86 was originally admitted to the facility on 5/5/17 and readmitted on 9/19/17 with cumulative diagnoses which included traumatic brain injury.

Review of the behavior sheets from 5/9/17 through 8/1/17 revealed 55 (fifty-five) episodes in which Resident #86 was either screaming, grabbing, hitting, throwing, smearing food/waste, or refusing care.

Review of the admission 5/12/17 and quarterly 8/4/17 the Minimum Data Set (MDS) revealed impaired cognition with behavioral issues of rejection of care and other behaviors such as hitting, scratching and screaming.

Record review reviewed on 6/15/17 a mental health consultation was performed due to slapping another resident on the cheek.

Review of the care plan dated 10/19/17 revealed a problem with the tendency of being combative during care related to dementia and anxiety manifested by hostile actions of striking out and refusing care. There were no interventions for what the staff should do to address these behaviors except for 1:1visits by the social worker, allow resident to vent (referring to expressing feeling) and referral for a psychiatric consultation.

Interview on 11/02/2017 at 11:31AM with Nurse

F 279

The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;
Resident #86 had a care plan in place for behaviors. Nursing Assistants (NA) receive at least 2 hours of training annually and upon hire through Relias on dealing with aggressive residents. Staff interview with surveyor revealed that staff were aware of interventions for resident #86; however, NA interventions were not listed specifically on Resident #86's plan of care. NA interventions were discontinued when resident #86 was discharged and had not been reactivated upon re-admission. Care Plan was revised by MDS nurse (Care Plan Coordinator) to include additional interventions for the NA to follow for Resident #86 on 11/2/17 during survey process and was presented to the surveyor.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
Care Plan was revised by MDS nurse to include additional interventions for the NAs to follow for Resident #86 on 11/2/17 during survey process and was presented to the surveyor. Interdisciplinary Care Plan Team (IDT) was re-educated by the Corporate Nurse Consultant on Individualized Person-Centered Care Plans on 11-14-17. An audit was done of 100% of behavior care plans by IDT to make sure that NA interventions are

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	345088	A. BUILDING ______ B. WING ______	C 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GLEN	849 WATERWORKS ROAD WINSTON-SALEM, NC 27101

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F 279	Continued From page 5 #1 revealed Resident #86 had outburst during care and resisted care. Nurse #1 stated the staff need to tell her what you are doing or have another person to talk with Resident #86 while care was given. Continued interview with Nurse #1 revealed staff are supportive to the resident every day. Interview on 11/02/2017 at 1:27 PM with MDS #1 (responsible for updating care plans) revealed she did not realize that the care plan had not been updated with individualized resident centered interventions. Interview on 11/02/2017 at 6:27 PM with the administrator and Director of Nurses was held. The administrator stated her expectations for staff were to follow the regulations when care plans need to be updated and reflect the interdisciplinary team.	F 279	present or put in place as needed by 11-30-17. IDT will double check during care plan process that NA interventions are present for behavioral issues. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Interdisciplinary Care Plan Team (IDT) was re-educated by the Corporate Nurse Consultant on Individualized Person-Centered Care Plans on 11-14-17. An audit was done of 100% of behavior care plans by IDT to make sure that NA interventions are present or put in place as needed by 11-30-17. IDT will double check during care plan process that NA interventions are present for behavioral issues. MDS Nurse will form a Performance Improvement Plan (PIP) team. PIP team will review charted behaviors weekly to determine NA interventions and determine need to proceed to care plan. Results will be reviewed by PIP team and any changes made to the plan as needed. MDS Nurse will report to QAPI Committee quarterly for one year. The title of the person responsible for implementing the acceptable plan of correction. MDS Nurse (Care Plan Coordinator) Completion Date: 11-30-17	

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 11/02/2017

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TRINITY GLEN	849 WATERWORKS ROAD WINSTON-SALEM, NC 27101

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F 280	Continued From page 6	F 280		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	F 280		11/30/17

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

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	345088	A. BUILDING ______ B. WING ______	C 11/02/2017

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TRINITY GLEN	849 WATERWORKS ROAD WINSTON-SALEM, NC 27101

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F 280	Continued From page 7	F 280		

(iii) Incorporate the resident’s personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident’s medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident’s care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary

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 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GLEN	**849 WATERWORKS ROAD** **WINSTON-SALEM, NC 27101**

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F 280 Continued From page 8
team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation and staff interview the facility failed to reassess and update the effectiveness of the care plan interventions associated with the use of an antipsychotic and antidepressant medication for Resident #1. The facility failed to reassess and update the effectiveness of the care plan interventions associated with the use of an antidepressant, antianxiety, a diuretic and anticoagulant medication for Resident #10. The facility failed to update the care plan for falls risk for Resident #10. This was evident in 2 of 5 residents reviewed for unnecessary medications. The facility failed to update the effectiveness of the interventions associated with functional incontinence for Resident #127 in 1 of 5 reviewed for activities of daily living.
Findings included:

1.Resident #1 was originally admitted to the facility on 2/6/2001 with cumulative diagnoses which included unspecified schizophrenia.

Review of the medical record revealed physician orders for Seroquel 100 milligrams (mg) twice a day by mouth (po) and Effexor XR 75 mg at bed time. Seroquel is used to treat the symptoms of schizophrenia and major depressive disorder. Effexor XR is an extended release. antidepressant.

Review of the care plan dated 6/21/17 revealed a problem of potential for adverse medication side effects related to depression and psychosis

F 280

Plan of Correction – F 280 (D) Revise CP

The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;
Care plans had been reviewed by the Interdisciplinary Team (IDT) at the most recent care plan meeting, residents and families were invited to attend care plan meetings, and revisions were made to the plans of care at that time as needed for residents #1 (10-10-17), #10 (9-27-17) and #127 (10-4-17). In each instance, no revision was needed to the interventions in question, however, a date change was missed on noted interventions within the plan of care. This occurred due to IDT human error of changing page to next care plan without changing date on last intervention. On 11/2/17 IDT once again reviewed the plan of care to discuss if changes were needed. For resident #1, there has been no change in medications (antipsychotic and antidepressant) since the interventions noted on the care plan 6/21/17, and nursing staff continue to monitor for side effects. Resident #10 continues with falls risk interventions, which have been effective and on the medications (antidepressant, antianxiety, diuretic, and anticoagulant) which were addressed in the care plan on 7/3/17 and staff continue to monitor for side effects.

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 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GLEN	849 WATERWORKS ROAD WINSTON-SALEM, NC 27101

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F 280	Continued From page 9	F 280		

treated with the antipsychotic use of Seroquel and antidepressant use of Effexor XR. The interventions included to monitor for side effects and request dose reduction bi-annually. The goal to reassess the problem was 3 months. Further review of the care plan revealed no update or reassessment since 6/21/17 related to the use of the antipsychotic and antidepressant medications.

Review of the quarterly Minimum Data Set (MDS) assessment dated 10/11/17 indicated the resident had impaired cognition, dependent on staff for care and had no behavioral problems identified during this assessment.

Observation of Resident #1 on11/1/17 at 2:10 PM revealed Resident #1 was ambulating in a wheelchair and would not speak or respond nonverbal.

Interview on 11/02/2017 at 11:29 AM with Nurse #1 who stated Resident #1 was pleasant, may start laughing when not obvious to anyone else what the laughter was about and cooperative.

Interview on 11/02/2017 at 1:27 PM with MDS #1 (responsible for updating care plans) stated she had not realized the care plans had not been updated.

Interview on 11/02/2017 at 6:27 PM with the administrator and Director of Nurses was held. The administrator stated her expectations for staff were to follow the regulations when care plans need to be updated.

2.Resident #10 was initially admitted to the facility on 7/16/2012 with cumulative diagnoses which

Resident #127 continues to have functional incontinence which was addressed on the care plan on 6/27/17. Care Plan goals and intervention dates were updated by IDT for Resident #1 (for medications), Resident #10 (for fall risk and medications), and Resident #127 (for incontinence) during the survey process and presented to the surveyor on 11-2-17. Going forward, IDT will continue to review and revise care plan after each assessment including comprehensive and quarterly assessments.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
Care Plans intervention dates were updated by IDT on 11-2-17 for Resident #1 (for medications), resident #10 (for fall risk and medications), and resident #127 (for incontinence) during the survey process and presented to surveyor. IDT was re-educated by corporate nurse consultant on individualized person-centered care plans on 11-14-17. An audit was done of current residents to ensure care plan interventions have been updated by PIP team with any corrections made by MDS nurse by 11-30-17. Going forward, IDT will continue to review and revise care plan after each assessment including comprehensive and quarterly assessments.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory

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 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GLEN	849 WATERWORKS ROAD WINSTON-SALEM, NC 27101

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F 280

Continued From page 10

included dementia without behavior, depression and anxiety.

Review of the significant change Minimum Data Set (MDS) assessment dated 7/3/2017 revealed in the last seven days Resident # 10 received antianxiety, antidepressant and diuretic therapy.

Review of the care plan dated 7/3/2017 revealed the resident had a potential for side effects related to the use of an antidepressant and antianxiety medication. The interventions included monitoring of side effects and report unusual behaviors. Additionally, the care plan addressed the use of anticoagulant therapy (Aspirin) and falls risk. The goal time to be reassessed was 3 months. These care plans were not updated.

Review of the October 2017 physician orders included:
" Buspar 7.5 milligrams (mg) once a day by mouth (po) since 5/3/17. Buspar is a drug used to treat generalized anxiety disorder.
" Bumex 2 mg po since 7/1/17 due to chronic systolic congestive heart failure.
" Cymbalta 20 mg delayed capsules po since 6/27/16. Cymbalta is used to treat major depressive disorder, general anxiety disorder and nerve pain.
" Aspirin 81 mg po once a day to prevent blood clots.

Interview on 11/02/2017 at 1:27 PM with MDS #1 (responsible for updating care plans) stated she had not realized the care plans had not been updated.

Interview on 11/02/2017 at 6:27 PM with the

F 280

requirements;
MDS Nurse (Care Plan Coordinator) will provide list to PIP team to include Health Information Manager (HIM) of all care plans reviewed weekly. HIM or ADON to double check via chart audit that no date changes to interventions were missed. Any corrections will be made each week by MDS coordinator or IDT member. PIP Team will review and progress will be reported by MDS Nurse to QAPI committee quarterly for one year with any changes being made to the plan as needed.

The title of the person responsible for implementing the acceptable plan of correction.
MDS Nurse (Care Plan Coordinator)

Completion date: 11-30-17

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 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GLEN	**849 WATERWORKS ROAD WINSTON-SALEM, NC 27101**

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F 280	Continued From page 11 administrator and Director of Nurses was held. The administrator stated her expectations for staff were to follow the regulations when care plans need to be updated. 3. Resident #127 was admitted to the facility on 2/8/17 with cumulative diagnoses which included Parkinson's disease. Review of the quarterly Minimum Data Set (MDS) assessment dated 8/3/17 revealed the resident was totally dependent on 2 staff for bathing and extensive assistance for personal hygiene. The MDS coded the resident as incontinent of bowel and bladder. Reviewed the care plan dated 8/16/17 revealed the problem of functional incontinence was not updated since 6/27/17. Interview on 11/02/2017 at 1:27 PM with MDS #1 (responsible for updating care plans) stated she had not realized the care plans had not been updated. Interview on 11/02/2017 at 6:27 PM with the administrator and Director of Nurses was held. The administrator stated her expectations for staff were to follow the regulations when care plans need to be updated.	F 280		
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		11/30/17

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 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312

Continued From page 12

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview the facility failed to appropriately and thoroughly provide incontinence care for Resident #127 and Resident #71 in 2 of 5 residents reviewed for activities of daily living.

Findings included:

1, Resident #127 was initially admitted to the facility on - 3/13/15 and readmitted on 3/21/17 with cumulative diagnoses which included a cerebral vascular accident (CVA-stroke).

Review of the quarterly Minimum Data Set (MDS) assessment dated 0/6/17 revealed Resident #127 was severely cognitively impaired, required total dependence of one person for dressing and bathing and extensive assistance of one person for toilet use and personal hygiene. The MDS coded the resident as always incontinent of bowel and bladder.

Review of the care plan dated 4/5/17 included:
-I have self-care deficit related to CVA. Goal: I will have my ADL needs identified and met with staff assistance and intervention while maintaining highest level of independent function possible.
- I have functional incontinence related to CVA. Goal: I will maintain fluid balance. Interventions: Wear incontinence briefs, change PRN, Cleanse peri-area and apply barrier cream to skin after incontinent episodes and whenever necessary.

An observation on 11/1/2017 at 4:00 PM was conducted during incontinent care performed by Nursing Assistant (NA) #2 and NA #3 for Resident #127 who was observed to be incontinent of both

F 312

Plan of Correction – F 312 (D) ADL Care

The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;
Nursing Assistants (NAs) made human error by not following proper procedure that they had previously been trained for on perineal care for residents #127 and #71. Infection Control Preventionist monitored residents #127 and #71 for any signs and symptoms of adverse effects for two weeks and no adverse reactions were noted. NA #5 and #3 each received disciplinary action by DON on 11-2-17 and 11-7-17. NA #2, #3, #4, and #5 each received 1:1 re-education by the Staff Development Coordinator (SDC) by 11-30-17.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
NA #2, #3, #4, & #5 were all re-educated 1:1 by SDC on perineal care with return demonstration by 11-30-17. Each has received a copy of the policy for personal reference. All NAs will be re-educated on proper perineal care by SDC by 11-30-17. Perineal care will be checked off on the skills checklist for new hires as part of the orientation process and on their annual skills checklist.

The monitoring procedure to ensure that the plan of correction is effective and that

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F 312	Continued From page 13	F 312		

urine and stool. NA #3 obtained soap, wash cloths and a basin of water. Then NA #3 removed the stool using a washcloth and placed the soiled washcloth in a plastic bag. Additional stool was removed with another soapy washcloth. NA #3 then proceeded to rinse the soiled washcloth in the basin of water. Using the same soiled washcloth, NA #3 washed the perineal area. During the washing of Resident #127's perineal area NA #3 was first noted to use a circular motion to cleanse the perineal area and then vertically from back to front then front to back. NA #2 assisted NA #3 to turned Resident #127 on her side and was noted with urine that continued to "dribble." NA #3 did not attempt to clean the urine that had dribbled out before an application of a barrier cream.

An interview with NA #3 on 11/1/2017 immediately after the observation of the incontinence care revealed that this was how she always performed incontinence care.

An interview on 11/2/2017 at 5:00 PM with the Assistant Director of Nurses revealed her expectation was that incontinence care would be provided utilizing clean wash cloths and cleansing the perineal area from a front to back motion.

Interview on 11/02/2017 at 6:07 PM with the Administrator and Director of Nurses (DON) was held. The DON stated her expectations for staff during perineal care was to follow the basic procedure of washing the perineal area with soapy water in a front to back motion and obtain clean water to rinse the skin.

2. Resident #71 was admitted to the facility on 2/8/17 with cumulative diagnoses which included

specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
All NAs will be re-educated on proper procedure for perineal care. Staff Development Coordinator (SDC) or nurse designee will monitor perineal care for dependent residents by return demonstrations twice per week each shift each hall for one week, then once per week each shift each hall for three weeks. Then will do six (6) perineal care checks weekly on random shifts and random halls for two months. Any non-compliance issues will be addressed at time of discovery and changes made to plan as needed. SDC will then evaluate results with assistance of the Performance Improvement Plan Team (PIP) and will report results to the Quality Assurance Performance Improvement (QAPI) committee quarterly. At the quarterly reviews, the PIP team will determine frequency of checks for the following quarter. SDC will report results to QAPI committee quarterly for one year.

The title of the person responsible for implementing the acceptable plan of correction.
Staff Development Coordinator

Completion Date: 11-30-17

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 11/02/2017

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F 312	Continued From page 14	F 312		

Parkinson's disease.

Review of the quarterly Minimum Data Set (MDS) assessment dated 8/3/17 revealed the resident had impaired cognition and totally dependent on 2 staff for bathing and extensive assistance for personal hygiene. The MDS coded the resident as incontinent of bowel and bladder.

Review of the care plan dated 8/16/17 revealed the problem of functional incontinence was not updated.

Observation on 11/02/2017 at 10:46 AM of incontinence care performed by Nursing Assistant (NA) # 5 and NA #4 was conducted. Resident #71 experienced a bowel and urine episode of incontinence. NA #5 wet 2 washcloths at the bathroom sink and brought them into the resident's room along with a dry towel. NA #5 placed soap on one of the wet wash cloths. Then NA #5 used the wet wash cloth without the soap to remove stool and cleanse Resident #71's perineal area using a back and forth motion front to back then back to front. Resident #71 was repositioned on her left side with the assistance of NA #4. Resident # 71's 's buttocks was cleansed with the same wet wash cloth previously used to remove the stool. Then used the wet washcloth with soap to rinse the skin. While using the soaped wash cloth NA #-5 stated to NA #4 "I used the soaped wash cloth to rinse the _____ [referring to the buttocks]." NA #5 then dampened the end of the towel at the bathroom sink to remove the soap off the skin then proceeded to applied barrier cream on the buttocks.

Interview on 11/02/2017 at 10:58 AM with NA #5

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 11/02/2017

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F 312	Continued From page 15 who stated this was her usual routine because "that is the way everyone [referring to other NA] does." An interview on 11/2/2017 at 5:00 PM with the Assistant Director of Nurses revealed her expectation was that incontinence care would be provided utilizing clean wash cloths and cleansing the perineal area from a front to back motion. Interview on 11/02/2017 at 6:07 PM with the Administrator and Director of Nurses (DON) was held. The DON stated her expectations for staff during perineal care was to follow the basic procedure of washing the perineal area with soapy water in a front to back motion and obtain clean water to rinse the skin.	F 312		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in	F 371		11/30/17

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 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GLEN	849 WATERWORKS ROAD WINSTON-SALEM, NC 27101

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F 371	Continued From page 16	F 371		

accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews the facility failed to allow dishware to air dry and failed to maintain dishware free of food debris in the main kitchen and 3 of 4 service kitchens. The facility failed to maintain clean ice machine filters in 3 of 4 service kitchens.

Findings Included:

1. An observation of the main kitchen with the Dietary Manager (DM) was conducted on 10/30/17 at 3:15 pm and revealed:
A) 11 steam table pans were stacked together wet on a shelf for storage of clean dishware
B) 1 steam table pan with dried food particles was on a shelf for storage of clean dishware

2. An observation of service kitchen #1 with the DM was conducted on 10/30/17 at 3:30 pm and revealed:
A) 2 - 8 ounce (oz.) bowls were wet and stored inverted on a solid tray ready for service
B) 2 - 8 oz. bowls contained food particles and were stored on a solid tray ready for service
C) The ice machine filter had a build-up of dust

3) An observation of service kitchen #2 with the DM was conducted on 10/30/17 at 3:45 pm revealed the ice machine filter had a build-up of dust.

Plan of Correction – F 371 (E) Food Store/Serve Sanitary

The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;
Ice machine air filters in 3 pods had dust. Director of Dining Services (DDS) cleaned ice machine air filters on 10-30-17. The ice machine air filters were previously on a monthly schedule and have been added to the weekly cleaning schedule for the dietary aides.
Dishware had water and particles. There was not adequate drying time between meals for the amount of dishware in service. DDS removed dishes that were wet or had particles from service on 10-30-17 and 11-1-17.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
DDS cleaned ice machine air filters. The ice machine air filters have been added to the weekly cleaning schedule for the dietary aides on each pod.
DDS removed dishware that was wet or had particles from service. Dining

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 11/02/2017

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TRINITY GLEN	849 WATERWORKS ROAD WINSTON-SALEM, NC 27101

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F 371	Continued From page 17 4) An observation of service kitchen #3 with the DM was conducted on 10/30/17 at 3:50 pm and revealed: A) 13 - 8 oz. coffee mugs were wet and stored inverted on a solid tray ready for service B) 2 - 8 oz. coffee mugs contained food particles and were stored on a solid tray ready for service C) The ice machine filter had a build-up of dust 5) An observation of service kitchen #4 with the DM was conducted on 10/30/17 at 4:00 pm and revealed: A) 5 - 8 oz. bowls were wet and stored inverted on a solid tray ready for service B) 2 - 8 oz. bowls contained food particles and were stored on a solid tray ready for service 6) An observation of service kitchen #4 with the DM was conducted on 11/1/17 at 12:10 pm and revealed 24 - 8 oz. glasses were wet and stacked together on a solid tray ready for service. An interview with the DM on 11/2/17 at 11:45 am revealed it was her expectation that all dishware were clean and allowed to air-dry before being placed into service for the next meal. She stated she expected the ice machine filters to be clean and free from dust. An interview with the Administrator on 11/2/17 at 4:31 pm revealed she expected dishware to be clean and dry before being used. The Administrator stated she expected the ice machine filters to be clean.	F 371	Services staff were re-educated on storing clean and dry dishes for service by DDS on 11-1-17 to 11-30-17. DDS obtained an additional par level of plastic ware to allow extra drying time between meals. Juice glasses will be utilized at breakfast meal only to allow other wares to dry. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Ice machine air filters cleaning list will be monitored by DDS. Air Filters on ice machines will be checked by DDS or PIP team designee weekly with corrections made at point of service and results reported quarterly to QAPI committee for one year with any changes made to plan as needed. DDS or PIP team member will evaluate kitchen for best placement to allow for adequate drying of dishware. DDS checking Ecolab vendor to seek a better drying agent. PIP team will check dishes on each pod and main kitchen for water and particles each shift five times per week for two weeks. Then will check twice per week on each pod each shift for two weeks. Then will check random shifts random pods three times per week for two months. Any corrections will be made at point of service. DDS and PIP team will then evaluate progress quarterly and make any needed changes and will determine frequency of checks for next quarter. DDS will report progress to QAPI committee quarterly for one year.	

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F 371	Continued From page 18	F 371	The title of the person responsible for implementing the acceptable plan of correction. Director of Dining Services Completion date: 11-30-17	