STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345106	A. BUILDING _____ B. WING _____	C 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY RIDGE	**2140 MEDICAL PARK DRIVE HICKORY, NC 28602**

(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 survey. Event ID #7FYN11.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to post the notice of location and availability of the facility's survey results.	F 577	1. Survey book was located in the front lobby of facility. No other signage was in place for notification of location of survey book.	9/10/18

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

Electronically Signed | 09/10/2018

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F 577	Continued From page 1 Findings included: During initial tour of building on 08/20/2018 at 10:00 am, the notebook of survey results was located in main lobby. No signage was observed posted regarding the availability and location of recent survey results. Resident Council interview was conducted on 08/22/2018 at 10:00 am. During the meeting, 10 of 10 Resident Council members stated they had no knowledge of the location of the survey results notebook. The resident council members stated they did not know where the survey results were located and had not seen any signage that directed residents to their location. An observation on 08/22/2018 at 10:45 am, revealed there were no notices posted in the facility regarding the availability and location of recent survey results, including the secured unit. An observation on 8/23/18 at 4:45PM, revealed there were no notices posted in the facility regarding the availability and location of recent survey results, including the secured unit. During an interview with the Administrator, Director of Nursing (DON) and Social Worker, on 8/23/18 at 5:00PM, they all stated they did not have signage posted for survey results. The Administrator and DON stated the survey results were located in the main lobby; however, the facility did not have signage posted that identified the location of the survey results notebook. The DON and Administrator said they were unaware that posting a notice of the location of survey results for the facility, including the secured unit,	F 577	2. Social worker posted location of survey results on August 23,2018 in the memory neighborhood I highly visible area. On August 31,2018, Administrator added to the central information board where survey results are located. Also during resident council monthly meetings the Activity Director or designee will share with resident council where the survey results are located beginning in September 2018. Location of survey results were added to the Admission packet. 3. Quality Assurance Registered Nurse will audit monthly times three (3) to ensure survey results are posted then quarterly times three (3) months, will report findings to the Quality Assurance committee. The Activity Director will confirm monthly that location of survey results were discussed in the resident council meeting and will report monthly times three (3) and then quarterly times three (3) to the Quality Assurance Committee. 4. Administrator will be implementing the acceptable plan of correction. 5. Dates of Corrective Action is 9/10/18.	

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F 577	Continued From page 2 was part of the regulation, but that going forward they would expect signage to be posted that directed residents and families to the location of the survey results.	F 577		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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 - (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	F 656		9/10/18

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F 656	Continued From page 3 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 care plan to address antipsychotic medication use for 1 of 5 sampled residents reviewed for unnecessary medication. (Resident #23). The findings included: Resident #23 was admitted to the facility on 11/29/2013 with diagnoses that included psychotic disorder, Alzheimer's dementia without behavioral disturbance, unspecified affective mood disorder, and major depressive disorder. The most recent Annual (Comprehensive) Minimum Data Set (MDS) dated 11/01/2017 specified the resident was severely impaired and the resident was receiving the antipsychotic medication, Risperdal on a routine basis. Review of Resident #23's Care Area Summary (CAA), dated 11/01/2017, revealed that the resident had the potential of having adverse reactions to the antipsychotic medication and that a care plan would be developed. Review of Resident #23's medical record revealed that her care plan was reviewed and	F 656	1. Resident #23 was care planned in April of 2018; however during transitioning to Person Centered Care Plans and care plan review in June of 2018 the antipsychotic care plan was not in place but was corrected on 8/22/18. 2. Resident #23's care plan was updated to include the use of antipsychotic medications by the Registered Nurse Case Manager on 8/22/18. The care plans for all residents were reviewed by the interdisciplinary care plan team (Registered Nurse Case Manager, Social Work, Dietary Manager, Activity Director, Quality Assurance Registered Nurse, Director of Nursing, Staff Development/Assistant Director of Nursing, and Administrator) and walking rounds were made to ensure every care plan was accurate and personalized for each resident. Revisions were made and completed by the interdisciplinary care plan team on 9/4/18. 3. Quality Assurance Registered Nurse will review the weekly care plan list, will review care plans of those residents that receive antipsychotics to ensure care plans are in place weekly and report to the	

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F 656	Continued From page 4 updated on 08/22/2018 by the interdisciplinary team and stated that the resident may experience side effects from the psychotropic medication. Further review of Resident #23's care plan revealed the resident did not have a care plan in place to address the antipsychotic medication between the months of April 2018 and August 2018. During an interview with Administrator, Director of Nursing (DON), Social Worker Director, MDS nurse on 08/23/2018 at 5:25 PM, they stated did not have an updated antipsychotic care plan in place from 4/29/2018 to 8/22/2018. The MDS Nurse stated the last antipsychotic care plan was discontinued on 04/29/2018 and that there should have been one in place prior to 08/22/2018. The DON and the Administrator both revealed it was their expectation any resident, who had been prescribed an antipsychotic, should have a care plan in place.	F 656	Quality Assurance Committee times three (3)and then quarterly times three (3). The Interdisciplinary care plan team will continue to do walking rounds as they review each care plan. 4. Administrator will be implementing the acceptable plan of correction. 5. Dates of Corrective action is 9/10/18.	