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 03/30/2022

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/27/22 to 3/30/22. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID# 1UJX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/27/2022 through 3/30/2022. Event ID# 1UJX11. The following intakes were investigated NC00180961 and NC00186643. 1 of the 3 complaint allegations was substantiated resulting in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		4/27/22

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

Electronically Signed | 04/14/2022

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on 2 of 2 dining observations, record reviews, and staff interviews, the facility failed to ensure staff were seated while assisting Resident #38 during dining. Findings included: 1a. Resident #38 was admitted to the facility on 7/2/21 with diagnoses which included: Alzheimer's disease, diabetes mellitus, and protein-calorie malnutrition. The quarterly minimum data set dated 2/3/22 indicated Resident #38 was severely, cognitively impaired; was total dependent on staff for eating; and had a swallowing disorder of holding food in her mouth/cheeks.	F 550	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 – F550 (D) Resident Rights	

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F 550	Continued From page 2 The care plan revealed Resident #38 received a mechanically altered and therapeutic diet and was at high risk for weight loss. Interventions included: the resident was to be fed by staff. On 3/28/22 at 1:01 p.m., Resident #38 was in bed with the head of the bed raised to approximately 85 degrees. Nursing assistant (NA#1) was standing next to the resident's bed as he fed the resident a pureed meal with regular liquids. During an interview on 3/30/22 at 10:04 a.m., nursing assistant (NA#1) acknowledged his standing while feeding Resident #38. He revealed he had been educated on the correct way to feed residents; he should have been sitting in a chair when feeding the resident. NA#1 stated he stood while feeding Resident #38 because there was no chair in the room, and he did not want to disrespect the resident by sitting in her wheelchair. 1b. An observation was conducted on 3/29/2022 at 9:34 AM of Resident #38 lying in bed, turned to her right side, sitting with the head of the bed elevated, being fed her meal by Nursing Assistant, NA, #2. The NA was standing beside the bed while feeding assistance was provided from 9:34 AM until 9:45 AM. An interview was conducted on 3/29/2022 at 9:30 AM with NA #2 and the NA revealed that Resident #38 was the only Resident she had to provide total feeding assistance to during the breakfast meal on this day because other staff helped with the other residents. She added that she preferred to stand when she fed residents but does not always stand, it depended on how the day goes and the Resident she was working with. She stated she stood while feeding Resident #38	F 550	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. NA #1 was educated on 4-8-22, NA #2 was educated on 3-29-22 and Nurse #3 was educated on 3-29-22 all 3 were re-educated by SDC about assisting residents with eating meals. They were reminded about being seated at eye level and engaging in conversation with resident while assisting resident to eat meals. Nurse was reassured that she can correct staff with surveyor present. Resident # 38 has had no adverse effects. 2. How you will identify other residents having the potential to be affected by the same deficient practice. Resident rights will be maintained for all residents that require assistance with meals as identified on the plan of care. All staff that assist Residents with meals were re-educated by Administrator/SDC on the proper way to assist a resident with a meal. Staff education done on 3-29-22 and was reported to surveyor prior to exit on 3-30-22. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; Staff were reminded via electronic message (the system sends a text to their personal cellular phone in the same way they receive their schedule) on 3-29-22 about how to properly assist a resident with eating meals. Staff were reminded to be seated in a chair near the resident at	

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F 550	Continued From page 3 often. She denied being told to not stand while feeding. During the interview Nurse #3 was present and did not add any further information. An interview was conducted with Nurse #3 on 3/29/2022 at 9:46 AM upon exiting Resident #38's room. When asked what the facility policy for feeding a resident while standing was, she identified it was the facility policy to not stand while feeding a resident. She then went back into Resident #38's room and requested NA #2 to not stand while feeding the Resident.	F 550	eye level, not standing over them and to use this time to encourage them and get to know them. Socialization and eye contact will make for a pleasant dining experience. Town Hall Meetings were conducted in person by Administrator/SDC on 3-31-22 to 4-15-22 on all shifts for every department to follow up on text and to remind staff of the issue of Resident Rights regarding meal assistance. Additionally, a mailer was sent to the home address of all staff that assist residents with meals on 4-11-22 by Administrator. ADON/SDC developed a schedule to audit by observation Resident meal assistance daily for 5 days, weekly for one month, then Monthly and as needed for the remainder of one year. Meal assistance monitoring will be turned in to ADON/QA Nurse led PIP team weekly then monthly as indicated. 4. How the corrective actions will be monitored to make sure solutions are sustained. ADON/SDC has developed an audit tool to track meal assistance that will be monitored by ADON/ QA Nurse each week for one month and then each month for the year. Results will be reported to Performance Improvement team monthly. Quality Assurance Performance Improvement plans have been put in place for Monitoring Resident meal assistance by ADON on 4-12-22. ADON/SDC will report results to QAPI committee quarterly for one year.	

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F 641	Continued From page 4	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to accurately assess and code the minimum data set for 1 of 3 sampled residents (Resident #26) reviewed for range of motion/positioning; 1 of 6 sampled residents (Resident #40) reviewed for nutrition; and 1 of 2 sampled residents (Resident #11) reviewed for hospice services. Findings included: 1. Resident #26 was admitted to the facility on 8/31/21 re-admitted: 9/27/21 with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting her right dominant side. The quarterly minimum data set (MDS) dated 1/25/22 indicated Resident #26 was moderately, cognitively impaired; required extensive assistance with bed mobility and transfers; required supervision when eating; and had no impairments with range of motion of her upper and lower extremities. On 3/28/22 at 11:47 a.m., Resident #26 was observed in the dining room feeding herself. The resident was using her left hand to hold the fork. The resident revealed her right hand was her dominant hand but was unable to use it due to difficulty with straightening the fingers of her right	F 641	Plan of Correction – F641 (D) Accuracy of Assessments 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Assessment dated 1-11-22 for Resident #11 was modified and transmitted with correction to reflect a prognosis of 6 months to live, in conjunction with the hospice designation and presented to surveyor prior to exit conference on 3-30-22 by the MDS Coordinator. For resident #40 a correction to assessment date 1-24-22was made by MDS Coordinator to reflect resident's independence with eating, it was transmitted and presented to surveyor prior to exit on 3-30-22. For resident #26, a correction was made by MDS Coordinator to assessment 1-25-22 to reflect impairment of one side in conjunction with hemiparesis on 4-12-22, it was transmitted and accepted. 2. How you will identify other residents having the potential to be affected by the same deficient practice. Along with the Corporate Nurse consultant, audits were conducted by MDS Coordinator on 3-30-22 of 100% of	4/27/22

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F 641	Continued From page 5 hand. During an interview on 3/30/22 at 2:30 p.m., MDS Coordinator #1 acknowledged Resident #26 had a diagnosis of right sided hemiparesis of her upper and lower extremities. She stated that section G0400 A and B of Resident #26's MDS were incorrectly coded as no impairment due to human error. 2. Resident #40 was admitted to the facility on 9/21/20 with diagnoses which included: hypertensive heart and chronic kidney disease, congestive heart failure, and diabetes mellitus with diabetic peripheral angiopathy. The quarterly minimum data set (MDS) dated 1/24/22 indicated Resident #40 was cognitively intact, eating occurred only 1-2 times with setup; had no weight loss; and received a mechanical altered diet. During an interview on 3/29/22 at 2:43 p.m., MDS Coordinator #2 indicated Resident #40 was independent with eating. She revealed she referred to and documented using the nursing assistants' tracking information for the period of 1/18/22 -1/24/22 when coding the MDS for eating function. She stated that a corrected MDS should have been re-submitted and the nursing assistant's error of the resident's eating assessment should have been documented in the nurse's note. 3. Resident #11 was admitted to the facility on 10/18/21. Diagnoses included, in part, cerebral infarction and dysphagia.	F 641	MDSs for all Residents on Hospice care for section J1400 prognosis. One correction was made and modification was done to reflect accurate prognosis information by MDS coordinator on 3-30-22. Also, an audit was conducted by Nurse Consultant/MDS on residents with Functional limitation to check for an impairment to one side in Section G0400A&B and one correction was made on 4-8-22. An audit was conducted by Nurse consultant/MDS of residents Eating ADL status to make sure they are coded correctly in section G0110H and four corrections were made as needed on 4-13-22. All 3 areas were reviewed by Corporate Nurse consultant. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; An in-service education was conducted for the MDS coordinators on accurate Coding Section J1400 for prognosis, Section G0400A&B Functional Limitation, and Section G0110H Eating ADL by the Corporate Nurse Consultant on 4-12-22. Nursing staff were educated about the importance of accurate documentation to be used for assessments in a mailer sent to staff home address by Administrator on 4-11-22. An audit tool was developed by the ADON/MDS coordinator for accuracy of MDS sections J1400 prognosis monitoring, G0400A&B Functional Limitation, and G0110H Eating ADL. The audit will be conducted for accuracy of these areas for assessments completed	

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F 641	Continued From page 6 The medical record revealed Resident #11 was admitted to Hospice services on 1/1/22. The comprehensive MDS assessment dated 1/14/22 indicated the resident received Hospice services. Further review of the MDS assessment revealed a prognosis of less than six months was not checked. The Hospice agency's plan of care dated 1/1/22 was reviewed and indicated a prognosis of a life expectancy of six months or less. During an interview with MDS Nurse #1 on 3/29/22 at 11:21 AM, she explained she routinely checked Hospice care on the MDS when she completed the assessment for a resident who was admitted to Hospice services and checked "yes" on the assessment that the resident had a life expectancy of less than six months. MDS Nurse #1 verified she completed the MDS assessment dated 1/14/22 and stated the prognosis of less than six months should have been checked on the assessment. She thought it was an oversight that she missed the coding on the prognosis question. On 3/30/22 at 3:53 PM an interview was completed with the Administrator. She indicated the facility had corporate support who assisted with monitoring/auditing the accuracy of MDS assessments.	F 641	weekly for one year by the QA Nurse/RN Auditor. Any findings will be corrected by MDS coordinator and reported to Performance Improvement Team. The Corporate Nurse Consultant will also do an audit of 10 assessment samples of sections J1400, G0400A&B and G0110H monthly for one year. 4. How the corrective actions will be monitored to make sure solutions are sustained. A Quality Assurance Performance Improvement Plan has been put into place by MDS Coordinator on 4-12-22. The MDS Coordinator will report results of these audits and corrections made monthly to Performance Improvement team, which will report results quarterly to the QAPI committee.	
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	F 656		4/27/22

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F 656	Continued From page 7	F 656		

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 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:

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F 656	Continued From page 8 Based on observation, record review and staff interviews the facility failed to follow care planned interventions for 1 of 2 residents (Resident #10) reviewed for accidents. The findings included: Resident #10 was admitted to the facility on 8/4/2021 with diagnoses that included vascular dementia, an autoimmune disease, diabetes mellitus II, chronic kidney disease, pressure ulcers of the right and left heels with a history of falls. A review of the quarterly Minimum Data Set (MDS), dated 1/5/2022, revealed Resident #10 had severe cognitive impairment, required extensive assistance of one staff for activities of daily living (ADL) care and total assistance with dressing. The assessment revealed the Resident had a fall with minor injury since the last assessment. The care plan had a focused area for falls that read, Resident #10 had the potential to fall down and hurt herself because she had decreased safety awareness and mobility with a goal to stay safe while she was moving about to avoid injury. An intervention was added on 10/29/2021 that read, bilateral fall mats and bolsters to the bed were added. The intervention was still active at the time of the investigation. A review of the physician orders revealed an order that read, floor mats to both sides when in bed for safety due to multiple falls with continuous use. An observation was conducted of Resident #10,	F 656	Plan of Correction – F656 (D) Develop/ Implement Comprehensive Care Plan 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. One of 2 fall mats was not present as stated on the fall care plan for resident #10 during survey and was put back into place during survey prior to the exit conference on 3-30-22 by the MDS coordinator. Nurse #4 was educated on checking for fall mat interventions prior to sign off on 3-29-22 by SDC. 2. How you will identify other residents having the potential to affect residents by the same deficient practice. An audit was conducted of all residents having floor mats for intervention on the falls care plan by HIM Director/MDS coordinator on 3-30-22 and was used by IDT to check for the presence of physical floor mat interventions as compared to care plans. Two corrections were made by the IDT during the audit on 3-30-22. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; An in-service education was conducted for the MDS coordinators on 4-12-22 by the Corporate Nurse Consultant on Implementation of fall mat interventions on the care plans. An education was provided for nursing staff regarding interventions being in place per the care plans by the Administrator/SDC in person on 3-30-22 to 4-15-22 on all shifts. A	

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F 656	Continued From page 9 on 3/27/2022 at 3:36 PM, lying in bed with a fall mat on the right side of the bed, between the wall and the bed, and not on the left side of the bed. An observation was conducted of Resident #10, on 3/28/2022 at 3:47 PM, lying in bed with a fall mat on the door side of the room and no fall mat on the window side of the bed. An observation was conducted of Resident #10, on 3/29/2022 at 11:52 AM, lying in bed with a fall mat between the bed and the wall with no fall mat on the window side of the bed. A review of the Medication Administration Record (MAR) for the date of 3/29/2022 revealed the order for the bilateral floor mats had been signed as complete and in place by Nurse #4. An interview was conducted with Nurse #4 on 3/29/2022 at 11:54 AM and she revealed that she had signed the MAR today that Resident #10 had bilateral fall mats in place. She then observed Resident #10 in bed and stated the Resident only had one fall mat on the wall side of the bed and she did not see a second fall mat anywhere in the room. She denied seeing a second fall mat prior to signing the MAR. She added she would try to acquire a second mat as soon as possible. An interview was conducted with the Nurse Practitioner on 3/29/2022 at 2:15 PM, and he revealed when an order was written and care planned for a resident, such as the order for bilateral fall mats for Resident #10, it was his expectation that the order or care planned intervention be followed as written.	F 656	mailer on this topic was also sent to the home address of staff on 4-11-22. The IDT will monitor fall mat interventions weekly for one month and then monthly for the remainder of the year and make corrections as needed. 4. How the corrective actions will be monitored to make sure solutions are sustained. IDT will report monitoring and corrections to floor mat fall interventions to MDS led Performance Improvement team. A Quality Assurance Performance Improvement Plan has been developed by the MDS Coordinator for fall mat interventions on falls care plans on 4-12-22. MDS Coordinator will report results to the QAPI committee quarterly for one year.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		4/27/22

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F 689	Continued From page 10 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Nurse Practitioner interviews the facility failed to provide the interventions for fall prevention for 1 of 2 residents (Resident #10) reviewed for falls. The findings included: Resident #10 was admitted to the facility on 8/4/2021 with diagnoses that included vascular dementia, an autoimmune disease, diabetes mellitus II, chronic kidney disease, pressure ulcers of the right and left heels with a history of falls. A review of the quarterly Minimum Data Set (MDS), dated 1/5/2022, revealed Resident #10 had severe cognitive impairment, required extensive assistance of one staff for activities of daily living (ADL) care and total assistance with dressing. The assessment revealed the Resident had a fall with minor injury since the last assessment. A review of the fall incident reports revealed Resident #10 had an incident on 9/16/2021 that documented the Resident was observed on the floor with a fall from the bed.	F 689	Plan of Correction – F689 (D) Free of Accident Hazards/Supervision/Devices 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. One of 2 fall mats was not present as stated on the fall care plan for resident #10 during survey and was put back into place during survey prior to the exit conference on 3-30-22 by the MDS coordinator. Nurse #4 was educated on checking for fall mat interventions prior to sign off on 3-29-22 by SDC. 2. How you will identify other residents having the potential to affect residents by the same deficient practice. An audit was conducted of all residents having floor mats for intervention on the falls care plan by HIM Director/MDS coordinator on 3-30-22 and was used by IDT to check for the presence of physical floor mat interventions as compared to care plans. Two corrections were made by the IDT during the audit on 3-30-22. 3. What measures will be put into place	

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F 689	Continued From page 11 A review of the fall incident reports revealed Resident #10 had an incident on 9/17/2021 that documented the Resident was observed on the floor in the Resident's room with a fall from the bed. A review of the fall incident reports revealed Resident #10 had an incident on 10/11/2021 that documented the Resident was observed on the floor in the Resident's room. A review of the physician orders revealed an order, dated 10/27/2021, that read, floor mats to both sides when in bed for safety due to multiple falls with continuous use. A review of the fall incident reports revealed Resident #10 had an incident on 10/29/2021 observed in the floor next to the bed on a floor mat. The care plan had a focused area for falls that read, Resident #10 had the potential to fall down and hurt herself because she had decreased safety awareness and mobility with a goal to stay safe while she was moving about to avoid injury. An intervention was added on 10/29/2021 that read, bilateral fall mats and bolsters to the bed were added. The intervention was still active at the time of the investigation. An observation was conducted of Resident #10, on 3/27/2022 at 3:36 PM, lying in bed with a fall mat between the bed and the wall and there was no fall mat on the window side of the bed. An observation was conducted of Resident #10, on 3/28/2022 at 3:47 PM, lying in bed with a fall	F 689	or what systemic changes you will make to ensure that the deficient practice will not recur; An in-service education was conducted for the MDS coordinators on 4-12-22 by the Corporate Nurse Consultant on Implementation of fall mat interventions on the care plans. An education was provided for nursing staff regarding interventions being in place per the care plans by the Administrator/SDC in person on 3-30-22 to 4-15-22 on all shifts. A mailer on this topic was also sent to the home address of staff on 4-11-22. The IDT will monitor fall mat interventions weekly for one month and then monthly for the remainder of the year and make corrections as needed. 4. How the corrective actions will be monitored to make sure solutions are sustained. IDT will report corrections to floor mat fall interventions to MDS led Performance Improvement team. A Quality Assurance Performance Improvement Plan has been developed by the MDS Coordinator for fall mat interventions on falls care plans on 4-12-22. MDS Coordinator will report results to the QAPI committee quarterly for one year.	

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F 689	Continued From page 12 mat on the door side of the room and no fall mat on the window side of the bed. An observation was conducted of Resident #10, on 3/29/2022 at 11:52 AM, lying in bed with a fall mat between the bed and the wall with no fall mat on the window side of the bed. A review of the Medication Administration Record (MAR) for the date of 3/29/2022 revealed the order for the bilateral floor mats had been signed as complete and in place by Nurse #4. An interview was conducted with Nurse #4 on 3/29/2022 at 11:54 AM and she revealed that she had signed the MAR today that Resident #10 had bilateral fall mats in place. She then observed Resident #10 in bed and stated the Resident only had one fall mat on the wall side of the bed and she did not see a second fall mat anywhere in the room. She denied seeing a second fall mat prior to signing the MAR. She added she would try to acquire a second mat as soon as possible. An interview was conducted with the Nurse Practitioner on 3/29/2022 at 2:15 PM, and he revealed when an order was written and care planned for a resident, such as the order for bilateral fall mats for Resident #10, it was his expectation that the order or care planned intervention be followed as written.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690		4/27/22

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F 690	Continued From page 13 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and nurse practitioner interviews the facility failed to prevent a urinary catheter bag from encountering the floor to reduce the risk of infection or injury for 2 of 2 residents (Resident #10 and #29) reviewed for urinary catheter care.	F 690	Plan of Correction – F690 (E) Bowel/Bladder Incontinence, Catheter, UTI 1. What corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 690	Continued From page 14 The findings included: A review of the facility policy, titled: "Catheter care, Urinary" from the manual, LSC Nursing Services, under the section, Urinary and Renal Conditions, was conducted. On page 1, under infection control, the policy read: The catheter tubing and drainage bag should be kept off the floor. 1. Resident #10 was admitted to the facility on 8/4/2021 with diagnoses that included vascular dementia, an autoimmune disease, diabetes mellitus II, chronic kidney disease, chronic use of steroid medications and a history of infection. A review of the quarterly Minimum Data Set (MDS), dated 1/5/2022, revealed Resident #10 had severe cognitive impairment, required assistance of one staff for activities of daily living (ADL) care and total assistance with dressing. The assessment revealed the Resident had a urinary catheter. A review of the care plan dated 10/19/2021 revealed a focused area that read: Resident #10 had a urinary catheter because she had chronic kidney disease with a goal that she would be free from a urinary tract infection. Interventions included to provide care to the catheter, monitor for signs and symptoms of infections, take care of the catheter equipment. A review of the physician orders revealed an order to provide catheter care every shift, dated 2/1/2022. An observation was conducted on 3/28/2022 at 3:47 PM of Resident #10 lying in bed with a urine	F 690	practice. Residents #10 and #29 had basins placed below the catheter bag as a barrier so that the catheter bag would not touch the floor even if the bed was in the lowest position on 3-29-22. 2. How you will identify other residents having the potential to affect residents by the same deficient practice. An audit was conducted of all 4 residents with catheters by observation by the ADON/SDC on 3-29-22 to place a basin as a barrier between the catheter and the floor. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; NA #4 was educated on catheters and infection control on 4-8-22 by SDC. Administrator sent an electronic message to staff on catheter care and to prevent catheters from touching floor on 3-29-22. Administrator/SDC conducted Town Hall meetings in person on 3-29-22 to 4-15-22 on all shifts to educate on using basin under catheter bags to allow beds to be lowered without catheter touching the floor. A mailer was also sent to home address of staff for education on this topic on 4-11-22 by Administrator. 4. How the corrective actions will be monitored to make sure solutions are sustained. ADON/SDC will audit through observations on residents with catheter bags 5x per week for one week, weekly for one month and monthly for the remainder of the year.	

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F 690	Continued From page 15 catheter bag hanging on the bed frame at the foot of the bed with the lower half of the bag on the floor. The bed was in the lowest position. An interview was conducted on 3/28/2022 at 3:50 PM with Nursing Assistant (NA) #3 and he revealed when a resident had a catheter bag, the bag should not touch the ground because it was not sanitary. An interview was conducted on 3/28/2022 at 3:45 PM with NA #4 that was assigned to Resident #10 and #29 and she revealed when she has a resident with a urine catheter bag she hangs the bag on the side of the bed and likes to make sure the bag was emptied at the first of her shift and the end of her shift. She added that she had already made rounds and emptied the catheters for this shift. An observation was then conducted inside Resident #10's room with NA #4 and she stated she observed the urine catheter bag lying on the ground with the bed in the lowest position and the bag should not be touching the ground because this will cause the bag to leak urine. She raised the bed to take the bag off of the ground and stated the bed was to be in the lowest position but the bag touches. An interview was conducted with the Staff Development Coordinator (SDC) on 3/28/2022 at 4:03 PM and she revealed the facility expectation was for a urinary catheter bag to not touch the floor in order to prevent bacteria from entering the system through the tubing and causing the potential for infection. She stated she would follow up with NA #4 and provide education. She added that NA #4 was a new NA and had only been certified a brief time period.	F 690	A Quality Assurance Performance Improvement plan for preventing catheter bags from touching the floor was implemented by ADON/SDC on 4-12-22. Results of catheter observations and any corrections will be reported monthly to Performance Improvement Team and ADON/SDC will report quarterly to QAPI committee for one year.	

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F 690	Continued From page 16	F 690		

An observation was conducted on 3/29/2022 at 9:55 AM of Resident #10 lying in bed with half of the urine catheter bag lying on the floor. The bed was in the lowest position.

An interview was conducted with Nurse #4 on 3/29/2022 at 10:01 AM in Resident #10's room and Nurse #4 revealed she observed the urinary collection bag lying on the floor with half of the bag on the floor. She stated it was her expectation that the bag be off the floor. She stated the bed was to be in the lowest position for the fall safety intervention for the Resident and something needs to be thought of to go between the floor and the collection bag for the Resident. She stated she was going to think of something and place it as a barrier.

An interview was conducted with the Nurse Practitioner on 3/29/2022 at 2:15 PM, and he revealed, in regard to a urine catheter collection bag touching the floor, the catheter bag was a direct line to the bladder and an increased risk for infection when it touches the floor. He added that Resident #10 was a high risk for infection from the amount of steroids she was ordered to take due to her disease process. He stated it was his expectation that the catheter bags be kept off of the floor.

2. Resident #29 was admitted to the facility on 3/31/2021 with diagnoses that included Alzheimer's disease, chronic kidney disease stage 3, atrial fibrillation, and chronic congestive heart failure with a history of urinary tract infections.

A significant change MDS, dated 1/27/2022, revealed Resident #29 had severe cognitive

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F 690	Continued From page 17	F 690		

impairment and required total assistance of one staff member with toilet use and personal hygiene. The assessment revealed the Resident had an indwelling urinary catheter.

The care plan for Resident #29 revealed she had a focused area that read, she had a catheter because she had chronic kidney disease and was on Lasix with a goal to be free from urinary tract infections with the catheter functioning properly with adequate fluid intake. The interventions included to have catheter care, ensure the catheter was not kinked, monitor for signs and symptoms of infections, and have the NAs provide care to the catheter equipment and skin.

An observation was conducted on 3/28/2022 at 3:44 PM with Resident #29 lying in bed with the urinary catheter collection bag hanging on the bed frame at the foot of the bed with the bag sitting on the floor.

An interview was conducted on 3/28/2022 at 3:50 PM with Nursing Assistant (NA) #3 and he revealed when a resident had a catheter bag, the bag should not touch the ground because it was not sanitary.

An interview was conducted on 3/28/2022 at 3:45 PM with NA #4 that was assigned to Resident #10 and #29 and she revealed when she has a resident with a urine catheter bag, she hangs the bag on the side of the bed and likes to make sure the bag was emptied at the first of her shift and the end of her shift. She added that she had already made rounds and emptied the catheters for this shift. At 4:00 PM an observation was conducted with NA #4 of Resident #29's urine collection bag touching the floor and she stated

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F 690	Continued From page 18 she would raise the bed immediately. An interview was conducted with the Staff Development Coordinator (SDC) on 3/28/2022 at 4:03 PM and she revealed the facility expectation was for a urinary catheter bag to not touch the floor in order to prevent bacteria from entering the system through the tubing and causing the potential for infection. She stated she would follow up with NA #4 and provide education. She added that NA #4 was a new NA and had only been certified a brief time period. An interview was conducted with the Nurse Practitioner on 3/29/2022 at 2:15 PM, and he revealed, in regard to a urine catheter collection bag touching the floor, the catheter bag was a direct line to the bladder and an increased risk for infection when it touches the floor.	F 690		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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.	F 812		4/27/22

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F 812	Continued From page 19 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain sanitary conditions in the kitchen by not labeling and dating resealed food items; by failing to store food items off the floor; by failing to ensure kitchen equipment was clean and free from debris; by not correctly storing food service cleaning supplies; by not ensuring hair covering was worn by anyone entering the kitchen; and by not ensuring food items served at acceptable temperatures. Findings included: 1. During the initial tour on 3/27/22 at 10:32 a.m., 6-cases of food items were observed stacked in the middle of the floor in the dry storage room in the kitchen. There were multiple cases of food items stacked on the floor in the walk-in freezer. During an interview on 3/27/22 at 11:00 a.m., the Dietary Manager (Assistant DM) revealed food deliveries to the kitchen were on Wednesdays and Fridays. She indicated the items observed on the floors in the dry storage room and in the walk-in freezer were delivered on Friday (3/25/22). 2. On 3/27/22 at 10:50 a.m., during observations of the refrigeration units in the kitchen the following were observed: a dietary staff did not ensure the door to the walk-in cooler was completely closed (the door remained	F 812	Plan of Correction – F 812 (F) Food Store/Prepare/Serve - Sanitary 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. CDM labeled and dated resealed food items, had stock put up, closed cooler door and completed work order, removed unopened water bottles from cooler, had cleaning done for food warmer and trays, flour & sugar bins and scoops, and kitchen ice machine vents, and hung brooms up on rack on 3-27-22. On 3-30-22, CDM had the 4 pans that were stacked wet with particles rewashed, had sugar bin lid re-cleaned after new sugar was poured into bin, and cleaned ice machine vents on satellite pods. Tuna melt sandwiches were not served and CDM consulted RD regarding a new policy for food temps to be put into place on 3-30-22. Food vendor was contacted on 4-5-22 by Administrator to have them complete education with delivery drivers to wear hair covering while in kitchen area. 2. How you will identify other residents having the potential to affect residents by the same deficient practice. Dining staff were educated on proper temperatures for food safety on 3-30-22 and education was presented to surveyor	

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F 812	Continued From page 20 approximately six inches open for five minutes until this Surveyor entered the cooler); stored in the walk-in cooler was a stainless-steel container of a prepared food item, covered with cellophane wrap and dated 3/25 with no identifying label; stored in the reach-in refrigerator were 1-unopened (33 ounce) plastic bottle of water, 1-unopened (16.9 ounce) plastic bottle of water, and 1-unopened (16.9 ounce) plastic bottle of tea (all with the date of 3/27). The dietary cook revealed these 3-bottles belonged to the second shift cook. The dry storage room contained 1-resealed bag of croutons, 1-resealed bag of dry milk, and 1-resealed bag of batter stored on the storage racks but were not dated. 3a. On 3/27/22 at 11:05 a.m. during the kitchen observation, the 2-filters and vents of the ice machine were observed with thick, dark gray lint. The outside and outside of the food warmer was stained with dark brown substances and the stainless-steel trays inside the warmer contained food crumbs. The lid of the flour bin was stained, and the handle of the scoop stored in the bin was stained with a yellow-brown substance. The lid of the sugar bin was covered with sugar particles. The 6-brooms in the broom/mop closet were stored against the wall with the bristle heads on the floor of the closet. 3b. During a follow-up observation in the kitchen during meal preparation on 3/30/22 at 11:55 a.m., a food vendor deliveryman was observed transporting cases of food items through the kitchen to the storage areas. The deliveryman's hair was not covered. Also observed in the kitchen were dirty and wet pans were stacked on the storage rack: 1-(1/2 sized) steamtable pan	F 812	prior to exit. Dining staff were educated on labeling/dating food items, proper storage of food items, stock being put up upon delivery, hair coverings, cleaning supply storage, cleaning and storage of kitchen equipment and pans, cleaning ice machine vents, storage of employee items, and temperatures by CDM on 3-30-22 to 4-15-22. A mailer was also sent to dining staff home address on these topics by Administrator on 4-11-22. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; Cleaning schedules have been updated to reflect ice machine vents, labels and dates on resealed food, placement of stock, storage of employee items, storage of cleaning supplies, cleaning and storage of kitchen equipment, hair coverings for those entering kitchen, and food temperatures. AFSD will perform weekly checks for one quarter and monthly checks for the remaining quarters of the year of ice machine vents, labels and dates on resealed food, placement of stock, storage of employee items, storage of cleaning supplies, cleaning and storage of kitchen equipment, hair coverings for those entering kitchen, and food temperatures. Corrections will be completed and education given as needed. AFSD will then submit audits and corrections to CDM led PIP team. 4. How the corrective actions will be monitored to make sure solutions are sustained. CDM and PIP team will then evaluate	

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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 812	Continued From page 21 stained with yellow particles, 1-(2 inch deep) steamtable pan, and 1-large muffin pan with yellow/white particles. There was 1-(2 inch deep) steamtable pan stacked wet on the storage rack. In the dry storage room, the lid of the sugar bin was covered with fine white particles. 3c. On 3/30/22 at 12:17 p.m., during the 500/600 hall satellite kitchen observation, the 2-filters and vents of the ice machine were observed with thick, dark gray lint. 4. During an observation of the meal tray line service in the 500/600 hall satellite kitchen on 3/30/22 at 12:25 p.m., a pan of tuna with cheese sandwiches (alternate entrée) was observed on the counter, next to the steamtable. The temperatures of the tuna with cheese sandwiches in the pan were 90 degrees Fahrenheit. The meal tray service consisting of one of the tuna sandwiches was stopped by this Surveyor before it was served to a resident. The Dietary Manager removed the sandwiches from the meal serving line and stated that she was unsure if the tuna sandwiches were to be served cold or hot but acknowledged the 90-degree Fahrenheit temperature was not acceptable for a food item to be served cold (41 degrees Fahrenheit or below) or a food item to be served hot (135 degrees Fahrenheit or above).	F 812	progress upon each report, make any needed changes and will report progress to QAPI committee quarterly for one year.	