	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345088	B. WING		08/11/2016
NAME OF PR				STREET ADDRESS, CITY, STATE, ZIP COE 849 WATER WORKS ROAD WINSTON-SALEM, NC 27105	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLET E APPROPRIATE DATE
SS=D A	ACCURACY/COORI	SSMENT DINATION/CERTIFIED st accurately reflect the	F 27	8	9/8/16
	A registered nurse m each assessment wir participation of health				
	A registered nurse m assessment is comp	ust sign and certify that the leted.			
		completes a portion of the n and certify the accuracy of sessment.			
	willfully and knowing false statement in a r subject to a civil mor \$1,000 for each asse willfully and knowing to certify a material a	Medicaid, an individual who ly certifies a material and resident assessment is ley penalty of not more than essment; or an individual who ly causes another individual and false statement in a is subject to a civil money han \$5,000 for each			
	Clinical disagreemer material and false sta	it does not constitute a atement.			
	by: Based on record rev facility failed to code (MDS) assessments 13, #111, #59 & # 28	Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately for 4 (Residents # 13, #111, #59 & # 28) of 17 sampled residents in he areas of falls, dialysis and medication.		Preparation and/or execution of correction does not constit admission or agreement by th the truth of the facts alleged conclusions set forth in the st deficiencies. The plan of corr	tute he provider of or tatement of

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Electronically Signed

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.

08/26/2016

PRINTED: 09/12/2016

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 278 Continued From page 1 F 278 prepared solely because it is required by 1. Resident #13 was readmitted to the facility on the provision of federal and state law. To 6/11/15. The significant change in status MDS remain in compliance with all federal and assessment dated 6/1/16 was reviewed. The state regulations, the facility has taken or assessment indicated that Resident #13 had will take the actions set forth in this plan of severe cognitive impairment and had 1 fall with correction. The plan of correction no injury since admission, reentry or prior constitutes the facility □s allegation of assessment (3/15/16). compliance such that all alleged deficiencies cited have been or will be The incident reports were reviewed. The reports corrected by the date(s) indicated. indicated that Resident #13 had falls on 3/20/16 with no injury, on 4/17/16 with injury and on F278 (D) Assessment 4/28/16 with no injury. Accuracy/Coordination/Certified Trinity Glen will continue to complete On 8/10/16 at 12:10 PM, MDS Nurse #1 was assessments that accurately reflect the interviewed. MDS Nurse #1 stated that MDS resident's status. Nurse #2 completed the significant change in For all residents affected: status assessment for Resident #13. She added Minimum Data Set (MDS) assessments that MDS Nurse #2 started as MDS Nurse in were modified and transmitted by the January 2016. MDS Nurse #2 was new to MDS, MDS Nurse #1 for residents as follows: had not received MDS training yet, and she was resident #13 (to reflect 2 falls no injury, 1 still learning. MDS Nurse #1 acknowledged that fall with injury) 8-10-16, #111 (to include dialysis)8-10-16, #59 (to include multiple the assessment should have been coded 2 for falls with no injury and 1 fall with falls without injury and 1 for falls with injury. injury)8-10-16 & #28 (to include no hypnotic on quarterly 8-12-16 and no 2. Resident #111 was readmitted to the facility on hypnotic on annual 8-24-16). 7/2/16. The significant change in status MDS assessment dated 7/9/16 indicated that Resident For all residents that have the potential to #111 did not receive dialysis while at the facility. be affected: Current assessments were reviewed by The electronic records for Resident #111 were Registered Nurse (RN) consultant on reviewed. The records indicated that on 7/7/16 at 8-23-16 for other residents coded with 11:24 AM, Resident #111 had left for dialysis via falls, dialysis and hypnotic medications. facility transportation and was back at 4:34 PM. No errors were noted on area of dialysis. The records dated 7/9/16 indicated that Resident 4 Corrections were needed in the area of #111 had left for dialysis at 11:00 AM via family falls. 9 corrections were needed in the car and was back at 5 PM. area of hypnotic medications. Any errors identified were corrected through

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		MEDICAID SERVICES			OMB NO. 093	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVE COMPLETED	
		345088	B. WING		08/11/20	16
IAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE	
				849 WATER WORKS ROAD		
RINITY	JLEN			WINSTON-SALEM, NC 27105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE COMP THE APPROPRIATE D	(X5) PLETIC DATE
F 278	Continued From page	e 2	F 27	8		
		M, MDS Nurse #1 was		modifications and transm	itted by MDS	
	interviewed. MDS Nu	urse #1 stated that MDS the significant change in		nurse #1 on 8-24-16.		
		r Resident #111. She added		Measures put in place to	ensure deficient	
	that MDS Nurse #2 st	tarted as MDS Nurse in		practice will not reoccur:		
	January 2016. MDS	Nurse #2 was new to MDS,		MDS nurses #1 & 2 will b	e re-educated by	
		S training yet, and she was		8-31-16 by the Corporate		
		urse #1 acknowledged that		Consultant on accurate c	•	
		coded incorrectly, Resident		assessments including fa	-	
		alysis while at the facility. admitted to the facility on		medications. An RN audit		
		lagnoses that included right		not have primary duty of		
		admission Minimum Data		facility) will check any ME		
		ent dated 6/8/16 indicated		residents with falls, dialys		
	she had moderate co	gnitive impairment. Section		medications weekly for or		
	J, the Health Condition			monthly for one year to ve		
		o or more falls without injury		has been coded properly		
		ury (minor or major) since		be used that lists: resider		
	her admission to the	facility.		date; assessment date; M in sections J (falls with or		
	A review of the medic	al record indicated Resident		major injury), O (Dialysis)		
	#59 had five total falls			(antianxiety and hypnotic		
		iew period (6/1/16 through		Completed MDS will be v		
	6/8/16). These five fa			checking chart for resider	nt in the areas of	
		, 6/6/16, 6/7/16, and 6/8/16)		falls, dialysis and Medica		
		y (6/6/16). The injury		physician orders, MAR, n		
		all on 6/6/16 indicated		incidents. Any modification		
	Resident #59 had a h			be made and transmitted MDS nurse.	at that time by	
		mplained of pain in her left ower extremity, and her		MDS huise.		
	head.	ower extremity, and her		Monitoring plan to ensure	solutions are	
				sustained:		
	An interview was con	ducted with MDS Nurse #1		Director of Nursing (DON)/Assistant DON	
	on 8/10/16 at 12:08 F	PM. The MDS dated 6/8/16		will audit 5 completed ME		
	for Resident #59 was	reviewed with MDS Nurse		ensure coding has been	-	
		ord documentation of falls		accurately and report to C		
	-	5/8/16 for Resident #59 was		Assurance Performance		
		lurse #1. She revealed this I just had been missed. She		(QAPI) - (MDS Performar Plan (PIP) team). The MI		
	was an error and had	Lillist nad heen missed. She	1	Ino MI		

Facility ID: 923392

			0/02 11 11			O. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION		E SURVEY PLETED	
		345088	B. WING		08	8/11/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	GLEN			849 WATER WORKS ROAD WINSTON-SALEM, NC 27105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 278	reported a revision with MDS Nurse #1 indicated a revision with MDS Nurse #1 indicated were both completing was not certain who has this MDS (6/8/16) for #1 explained that MD in her position in Janut the MDS process. She had not completed for MDS Nurse #1 indicated assessments were been assessments were been missed. An interview was con Nursing on 8/11/16 at she expected the MD4. a. Resident #28 was 6/10/11. Cumulative Alzheimer's disease, dementia without behi psychosis, depression A review of physician revealed the following (anti-anxiety medication) 2.5 millig Lantus insulin 50 unit bedtime. An Annual Minimum I indicated Resident #22 term memory impairm impaired in decision-revealed in decision-revealed in the following (anti-anxiety medication) 2.5 millig Lantus insulin 50 unit bedtime.	as going to be submitted. ted she and MDS Nurse #2 MDS assessments and she had completed Section J of Resident #59. MDS Nurse S Nurse #2 began working uary of 2016 and was new to he indicated MDS Nurse #2 rmal training of the MDS. ted that MDS Nurse #2's eing reviewed for accuracy. IDS was an easy place to this was an error that had ducted with the Director of t 10:33 AM. She indicated S to be coded accurately. as admitted to the facility diagnoses included: diabetes, insomnia, avioral disturbance,	F 23	includes MDS Nurse #1, MDS N DON, and Administrator. The tea identify any trends and change t needed. MDS nurses will report collected and any changes made plan in the quarterly QAPI meeti year.	am will ne plan as the data e to the		

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ___ 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 278 Continued From page 4 F 278 days of injection, seven days of insulin administration, seven days of antipsychotics, seven days of antidepressants, seven days of antianxiety medication and seven days of hypnotic medication. A review of the Medication Administration Record (MAR) for the look back period of 1/28/16 --2/3/16 revealed the following medications were administered-Lantus insulin, Ativan, Zyprexa, Remeron. There was no hypnotic medication noted as having been administered during that time frame. On 8/11/2016 at 7:54AM, an interview was held with both MDS coordinators. They stated they coded the Ativan as an antianxiety and as a hypnotic because it was noted in the drug book as being a hypnotic as well as an antianxiety medication. They reviewed the manual used to complete the MDS and noted that medications should be coded according to their classification. On 8/11/16 at 10:33AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate. b. Resident #28 was admitted to the facility 6/10/11. Cumulative diagnoses included: Alzheimer's disease, diabetes, insomnia, dementia without behavioral disturbance, psychosis, depression and anxiety. A review of physician orders for August 2016 revealed the following medications: Ativan (anti-anxiety medication) 0.5 milligrams by mouth daily, Remeron (antidepressant medication) 15 milligrams by mouth daily, Zyprexa (antipsychotic medication) 2.5 milligrams by mouth daily and

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 278 Continued From page 5 F 278 Lantus insulin 50 units subcutaneous daily at bedtime. A Quarterly MDS dated 7/22/16 indicated Resident #28 had short term and long term memory impairment and was severely impaired in decision-making. No behaviors were noted. Medications administered during the assessment period was noted as follows: seven days of injection, seven days of insulin administration, seven days of antipsychotics, seven days of antidepressants, seven days of antianxiety medication and seven days of hypnotic medication. A review of the Medication Administration Record (MAR) for the look back period of 7/ 16/16--7/22/16 revealed the following medications were administered-Lantus insulin, Ativan, Zyprexa, Remeron. There was no hypnotic medication noted as having been administered during that time frame. On 8/11/2016 at 7:54AM, an interview was held with both MDS coordinators. They stated they coded the Ativan as an antianxiety and as a hypnotic because it was noted in the drug book as being a hypnotic as well as an antianxiety medication. They reviewed the manual used to complete the MDS and noted that medications should be coded according to their classification. On 8/11/16 at 10:33AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate. F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED F 282 9/8/16 PERSONS/PER CARE PLAN SS=D

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 6 F 282 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff F282 (D) Services by Qualified interview, the facility failed to follow the plans of Persons/Per Care Plan care for range of motion (Residents #40, #4, and Trinity Glen will continue to provide #107) and accidents (Residents #13 & #151) for 5 services by qualified persons in of 17 sampled residents. Findings included: accordance with each resident's written plan of care. 1. Resident #40 was admitted to the facility on For all residents affected: 3/31/14 with multiple diagnoses that included Resident #13 had pommel cushion and osteoporosis, diabetes mellitus, and intellectual chair alarm put into place on 8-10-16. disabilities. Resident #151 had chair alarm put into place on 8-10-16. Residents #13 & 151 The quarterly Minimum Data Set (MDS) were reviewed by the interdisciplinary assessment dated 6/23/16 indicated Resident team (IDT included: Administrator, MDS #40 had moderate cognitive impairment and a Nurse #1, MDS Nurse #2, Safety Director, limited range of motion to both sides of her lower Therapy Manager, Health Information, extremities. Dietary, Social Services, Activities, Nursing) to assess the plan of care for A review of Resident #40's plan of care, with a accidents on 8-11-16. Resident #13 & 151 review date of 7/12/16, revealed interventions to were discussed by team for toileting address the range of motion (ROM) and program. Bedside commode was placed functioning of her bilateral upper extremities in room of Resident #13 by Therapy on (BUE) and the prevention of further contractures 8-11-16. Resident #13 sent to ED & to her bilateral lower extremities (BLE). The expired on 8-13-16. Staff Development to interventions indicated restorative services were educate staff on toileting plan for Resident to apply a knee separator daily to Resident #40 #151 on 8-25-16 and then implement. for 4-6 hours per day in the morning and a resting Residents #40, 4, & 107 were right hand splint 6 days per week. Additionally, re-evaluated by therapy to ensure passive range of motion (PROM) was to be treatment plans for splints/Range of provided to Resident #40 on 6 days per week for Motion (ROM) were still appropriate on her BLE and BUE. 8-24-16. Residents #40, 4, & 107 were reviewed by the interdisciplinary team

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 7 F 282 A review of Resident #40's restorative services including therapy to assess the plan of documentation from 7/13/16 through 8/10/16 care for splints/range of motion on revealed restorative services were provided on 12 8-24-16, plans were continued. out of 29 calendar days. There were 17 days during the review period of 7/13/16 through For all residents that have the potential to 8/10/16 that Resident #40 was not provided be affected: restorative services. The 17 days that All residents with orders for splints/ROM restorative services were not provided were: were reviewed on 8-24-16 by the 7/16-7/18, 7/21, 7/23-7/31, 8/3-8/5, and 8/7. interdisciplinary team (IDT) (IDT included: Therapy manager, ADON, Health An interview was conducted with MDS Nurse #2 Information, MDS Nurse #1, MDS Nurse on 8/10/16 at 3:00 PM. She indicated she was #2, DON, Administrator) to assess the the supervisor of restorative nursing services. continued plan of care. One splint/ROM The restorative documentation for Resident #40 order was added and one device order was reviewed with MDS Nurse #2. She revealed was discontinued as not an actual splint. she could not explain why Resident #40 had not All residents with a plan of care for received restorative as indicated on her plan of accidents were reviewed on 8-25-16 by care for 17 out of 29 days. the interdisciplinary team (IDT included: ADON, Health Information, MDS Nurse An interview was conducted with the Director of #1, MDS Nurse #2, DON, Administrator, Nursing (DON) on 8/11/16 at 9:40 AM. The DON and Supervisor) to assess the continued indicated the facility had a minimum of 1 plan of care. Team made 14 changes to restorative nursing assistant scheduled to work 7 care plans and 38 order clarifications. days per week. She stated she reviewed the Changes were made to the plans of care staff schedules for the dates restorative services for the most appropriate course of action were not provided to Resident #40 and confirmed and orders were adjusted to reflect changes on 8-25-16. Restorative Nursing that a restorative nursing assistant was working on each of those days. She revealed she could Assistants (RNA) #1 & 2 were not explain why Resident #40 had not received re-educated by Restorative Nursing restorative services as indicated on her plan of Assistant (RNA) Supervisor on 8-11-16 care for 17 out of 29 days. and counselled by Director of Nursing (DON) on 8-26-16 regarding the An interview was conducted with Restorative omissions and the importance of range of Nursing Assistant (RNA) #1 on 8/11/16 at 9:45 motion and splinting. Four new AM. She indicated she normally worked with Restorative Nursing Assistants will be Resident #40. She indicated she reviewed the trained by Staff Development Coordinator documentation from the time period in guestion (SDC) by 8-31-16 and will be utilized to (7/13/16 - 8/10/16) for Resident #40. RNA #1 ensure services are provided as ordered. revealed that if restorative services were not Nurses, Medication Administration Aides

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345088	B. WING		08/11/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		IP CODE
				849 WATER WORKS ROAD	
TRINITY	JLEN			WINSTON-SALEM, NC 27105	i
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE
F 282	Continued From page	A		2	
F 282	documented that they indicated if she had p services to Resident a completed the docum "just missed those da received a computer of all residents she w restorative services. large volume of reside sometimes she was n residents. RNA #1 st reporting to her super was unable to provide indicated on her assig A follow up interview Nurse #2, the supervise 8/11/16 at 9:50 AM. Soverseeing restorative She indicated she had services were not bei until it was brought to She stated she had ju were provided. MDS in the process of deve restorative staff would assignments at the en they had been completion	y had not occurred. She rovided the restorative #40 she would have hentation. She stated she ys". RNA #1 stated she generated list each morning as assigned to provide She indicated she had a ents on her caseload and not able to get to all of her rated she had not been rvisor, MDS Nurse #2, if she e restorative services as	F 28	 82 (MAA)s and Nursing Ass (including NA #1 & 3) wi by Staff Development C (SDC)/Supervisor/ Direct (DON) by 9-7-16 to chect supportive devices on pl Measures put in place to practice will not reoccur: System developed to ha DON/Staff Development (SDC)/RNA Supervisor at documentation at least 3 and meet with RNAs to omissions or issues. Re to RNA supervisor for ar issues and changes will of care/orders as neede RNA will be reviewed by Supervisor on an ongoir appropriateness of conti resident programs. A list alarms will be reviewed meeting (a meeting to di weights, skin issues or at that is attended by (IDT Administrator, MDS Nur #2, Safety Director, The Health Information, Diet 	ill be re-educated oordinator ctor of Nursing ck kiosk for lan of care. be ensure deficient to ensure deficient to coordinator audit restorative 3 times per week discuss any ports will be given ny omissions or be made to plans d. Caseload of r DON/RNA ng basis to ensure inued need for t of splints and in weekly Trek iscuss: falls, any other incidents including: se #1, MDS Nurse rapy Manager,
	•	-		Services, Activities, Nur- revisions will be given to nurse/Supervisor by AD review in huddle meeting hall staff to discuss each	o the hall ON each week for gs (a meeting for
	expected restorative	services to be provided as of care. She stated she		or issues) with nurse, M assistants. Monitoring w Charge Nurse/Superviso	AA, nursing rill be done by
	supervisor, MDS Nur	se #2, if they were unable to ments. She indicated she		each hall 3 times per we ensure splints/supportive	eek for one year to

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUITIPI	E CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED		
		345088	B. WING		08/11/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	GLEN			849 WATER WORKS ROAD WINSTON-SALEM, NC 27105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLE		
F 282	Continued From page	e 9	F 282	2			
	 had not known restorative services were not provided consistently. 2. Resident #4 was admitted to the facility on 10/12/12 with multiple diagnoses that included cerebral palsy. The significant change Minimum Data Set (MDS) assessment dated 6/23/16 indicated Resident #4 had significant cognitive impairment and a limited range of motion to one side of his upper extremities and both sides of his lower extremities. A review of Resident #4's plan of care, with a review date of 8/3/16, revealed interventions to address the prevention of further contractures to his bilateral lower extremities (BLE) and to maintain his current functional bed mobility. The interventions indicated restorative services were to provide a splint to Resident #4's bilateral knees 1 to 3 hours daily and assist with passive range of motion (PROM) to lower extremities and bed mobility exercises 6 days per week. 			place as ordered/care planned for more of residents. This will be documented on a Splint/Supporti			
				Devices Audit Tool, which include Resident, device, in place – Y or what action was taken.	es		
				Monitoring plan to ensure solutio sustained: RNA Supervisor will report result weekly audits on omissions quar Quality Assurance Performance	s of terly to		
				Improvement (QAPI) for one yea as any changes made to the plar regarding documentation of splin of motion and accidents.	1		
	documentation from 8 revealed restorative s out of 7 calendar day the review period of 8 Resident #4 was not	s that restorative services					
	on 8/10/16 at 3:00 PM the supervisor of rest	ducted with MDS Nurse #2 M. She indicated she was corative services. The locumentation for Resident					

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 10 F 282 revealed she could not explain why Resident #4 had not received restorative services as indicated on her plan of care for 4 out of 7 days. An interview was conducted with the Director of Nursing (DON) on 8/11/16 at 9:40 AM. The DON indicated the facility had a minimum of 1 restorative nursing assistant scheduled to work 7 days per week. She stated she reviewed the staff schedules for the dates restorative services were not provided to Resident #4 and confirmed that a restorative nursing assistant was working on each of those days. She revealed she could not explain why Resident #4 had not received restorative services as indicated on her plan of care for 4 out of 7 days. An interview was conducted with Restorative Nursing Assistant (RNA) #2 on 8/11/16 at 9:45 AM. He indicated he normally worked with Resident #4. He indicated he reviewed the documentation from the time period in question (8/4/16 - 8/10/16) for Resident #4. RNA #2 stated that if restorative services were not documented that they had not occurred. He indicated if he had provided the restorative services to Resident #4 he would have completed the documentation. He stated he received a computer generated list each morning of all residents he was assigned to provide restorative services. RNA #2 indicated he had a large volume of residents on his caseload and on occasion he was pulled away from restorative services to assist the nurse on the floor. He stated that when he was pulled to the floor it was difficult to get back on track with his restorative services and to complete all of his assignments. RNA #2 stated he had not been reporting to his supervisor, MDS Nurse #2, if he was unable to provide restorative services as

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 09/12/2016 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	
		345088	B. WING				08/	11/2016
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP (CODE	-	
	GLEN				49 WATER WORKS ROAD VINSTON-SALEM, NC 27105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD B		(X5) COMPLETION DATE
F 282	indicated on his assig A follow up interview Nurse #2, the supervi 8/11/16 at 9:50 AM. S overseeing restorative She indicated she had services were not bei until it was brought to She stated she had ju were provided. MDS in the process of deve restorative staff would assignments at the er they had been complet also instructed restora- the end of each day if complete their assign A follow up interview DON on 8/11/16 at 10 expected restorative s indicated in the plan of expected RNAs to rep supervisor, MDS Nurs- complete their assign had not known restora- provided consistently 3. Resident #13 was 6/11/15. The signification assessment dated 6/- #13 had severe cogni- fall with no injury. The care plan dated 7- of the care plan dated 7- of the goal was " I we	Inment sheet. Was conducted with MDS sor restorative services, on She stated she began e services in March 2016. d not known that restorative ng provided consistently her attention yesterday. Just assumed the services Nurse #2 indicated she was eloping a system where d need to sign off on their nd of each day to indicate if eted. She stated she had ative staff to inform her at f they were unable to ments. was conducted with the 0:30 AM. She indicated she services to be provided as of care. She stated she port to her or to their se #2, if they were unable to ments. She indicated she ative services were not	F	282				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/12/2016 MAPPROVED D. 0938-0391		
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3) DATE	SURVEY PLETED		
		345088	B. WING			08/	/11/2016		
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE				
TRINITY G	ILEN			849 WATER WORKS ROAD WINSTON-SALEM, NC 27105					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 282	AM, Resident #13 wa wheelchair. Resident chair alarm nor pomm wheelchair. On 8/10/16 at 11:30 A NA #2 was assigned that Resident #13 wa a chair alarm in his w that he was trying to g the night shift staff go didn't know why he di his wheelchair. NA # Resident #13 was not his wheelchair. NA # Resident #13 was not his wheelchair. On 8/10/16 at 11:35 A (DON) was interviewe she expected the staff prevent further falls. Resident #13 should pommel cushion in hi planned. 4. Resident #151 was 8/8/15. The annual M 8/5/16 indicated that I	heelchair. I and on 8/10/16 at 11:30 is observed up in t #13 was observed with no- hel cushion in his AM, NA #2 was interviewed. to Resident #13. She stated is a high risk for falls and has heelchair to alert the staff get up. NA #2 added that t him up this morning and dn't have the chair alarm in 2 also indicated that t using a pommel cushion in AM, the Director of Nursing ed. The DON stated that if to follow the care plan to The DON added that have the chair alarm and		282					
	The care plan dated & of the care plan probl related to history of fa	8/8/16 was reviewed. One ems was " I have falls alls " and the goal was " I ry related to falls." The							

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 09/12/2016 // APPROVED). 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE		
		345088	B. WING				08/	11/2016	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, Z	IP CODE			
	GLEN			849 WATER WORKS ROAD WINSTON-SALEM, NC 27105					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE	
F 282	Continued From page	e 13	F	282					
	On 8/10/16 at 10:45 AM, Resident #151 was observed up in wheelchair in her room. She did not have a chair alarm in her wheelchair.								
	NA #3 was assigned to stated that the resider and has a chair alarm was getting out of her	AM, NA #3 was interviewed. to Resident #151. She nt was a high risk for falls to alert the staff that she chair. NA #3 added that s and didn't know why the the chair alarm in her							
	(DON) was interviewe she expected the staf	AM, the Director of Nursing ed. The DON stated that f to follow the care plan to She added that Resident hair alarm when up in							
	facility 3/13/15. Cumi dementia, hypertensio (difficulty swallowing)	s originally admitted to the ulative diagnoses included on, diabetes, dysphagia , aphasia (absence of omy tube (feeding tube in							
	dated 6/14/16 indicate term and long term m severely impaired in c care was required for	Minimum Data Set (MDS) ed Resident #107 had short emory impairment and decision-making skills. Total all activities of daily living ion noted impairment on and lower extremities.							
	-	/16 indicated Resident #107 rehabilitation for her right ;) related to possible							

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 14 F 282 contractures. Approaches included restorative nursing was to provide passive range of motion to RUE daily and apply splint to RUE daily for 3-4 hours. Use a calm, gently approach and monitor for skin breakdown. On 8/10/16 at 8:05AM, an observation of Resident #107 revealed Resident #107 with a right elbow splint in place and a hand splint on her right hand. On 8/10/16 at 10:51 AM, an interview was conducted with NA#1. She stated restorative nursing had just started applying braces to Resident #107's right elbow and hand last week. She stated the splints were applied by restorative staff, kept on for a couple of hours or so and removed by restorative nursing staff. A review of restorative nursing notes noted splint/ brace applied to Resident #107's right elbow and hand on 8/4/16. 8/5/16. 8/8/16. 8/9/16 and 8/10/16. There was no documentation that the brace and splint had been applied to Resident #107 on 8/6/16 or 8/7/16. An interview was conducted with MDS Nurse #2 on 8/10/16 at 3:00PM. She indicated she was the supervisor of restorative nursing services. The restorative documentation for Resident #107 was reviewed with MDS Nurse #2. She revealed she could not explain why Resident #107 had not received restorative as indicated on her care plan for 8/6/16 or 8/7/16. An interview was conducted with the Director of Nursing (DON) on 8/11/16 at 9:40AM. The DON indicated the facility had a minimum of 1 restorative nursing assistant scheduled to work 7

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 15 F 282 days a week. She stated she reviewed the staff schedules for the dates restorative services were not provided for Resident #107 and confirmed a restorative aide was working on both days. She revealed she could not explain why Resident #107 had not received restorative services as indicated on her care plan. On 8/11/16 at 9:47 AM, an interview was conducted with Restorative Nursing Assistant #2. He stated he was responsible for the application of the brace and splint application for Resident #107 on 8/6/16 and 8/7/16. He stated restorative staff often got pulled to do other duties and it was hard to keep "on track" with restorative duties when that happened. Restorative Nursing Assistant #2 stated he was told to do other duties on 8/6/16 and 8/7/16 along with doing restorative nursing so he could not get to everybody. He stated if the brace and splint had been applied on 8/6/16 and 8/7/16, it would have been documented. A follow up interview was conducted with MDS Nurse #2, the supervisor of restorative services, on 8/11/16 at 9:50 AM. She stated she began overseeing restorative services on March 2016. She stated she had not known that restorative services were not being provided consistently until it was brought to her attention yesterday. She stated she had just assumed the services were provided. MDS Nurse #2 indicated she was in the process of developing a system where restorative staff would need to sign off on their assignments at the end of each day to indicate if they had been completed. She stated she had also instructed restorative staff to inform her at the end of each day if they were unable to complete their assignments.

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 16 F 282 On 8/11/2016 at 10:28 AM, an interview was conducted with the Director of Nursing. She stated she expected the care plan to be followed. F 318 483.25(e)(2) INCREASE/PREVENT DECREASE F 318 9/8/16 SS=D IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced bv: Based on observation, medical record review, F318 (D) Increase/Prevent Decrease in and staff interview, the facility failed to Range Of Motion consistently provide range of motion and splinting Trinity Glen will continue to do for 3 of 3 residents (Residents #40, #4, and #107) comprehensive assessments of residents reviewed for a limited range of motion. and ensure that a resident with limited range of motion receives appropriate 1. Resident #40 was admitted to the facility on treatment and services to increase range 3/31/14 with multiple diagnoses that included of motion and/or to prevent further osteoporosis, diabetes mellitus, and intellectual decrease in range of motion. disabilities. For all residents affected: Residents # 40. 4. and 107 were The quarterly Minimum Data Set (MDS) re-evaluated by therapy to ensure treatment plans for splints/Range of assessment dated 6/23/16 indicated Resident #40 had moderate cognitive impairment and a Motion (ROM) were still appropriate on limited range of motion to both sides of her lower 8-24-16. Residents # 40, 4, and 107 were extremities. reviewed by the interdisciplinary (IDT including: Administrator, MDS Nurse #1, A review of Resident #40's plan of care, with a MDS Nurse #2, Safety Director, Therapy review date of 7/12/16, revealed interventions to Manager, Health Information, Dietary, address the range of motion (ROM) and Social Services, Activities, Nursing) to

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	PLE CONSTRUCTION		TE SURVEY MPLETED
		345088	B. WING		0	8/11/2016
AME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				849 WATER WORKS ROAD		
RINITY G	ILEN			WINSTON-SALEM, NC 27105		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	COMPLETIO
F 318	Continued From page	e 17	F 31	18		
	1 0	ateral upper extremities		assess the continued pla	an of care for	
		ntion of further contractures		splints/range of motion of		
		extremities (BLE). The		were continued.		
		d restorative services were				
	to apply a knee separ	rator daily to Resident #40		For all residents that have	e the potential to	
	for 4-6 hours per day	in the morning and a resting		be affected:		
	•	ys per week. Additionally,		All residents that have be		
		ion (PROM) was to be		Minimum Data Set (MDS		
	•	#40 on 6 days per week for		of motion have been rev		
	her BLE and BUE.			interdisciplinary team (ID		
				Therapy manager, ADO		
		#40's restorative services 7/13/16 through 8/10/16		Information, MDS Nurse #2, DON, Administrator)		
		services were provided on 12		assess the continued pla		
		lys. There were 17 days		splints/range of motion, i		
		iod of 7/13/16 through		of splint application. One	-	
		t #40 was not provided		order was added and on		
	restorative services.			was discontinued as not		
	restorative services w	vere not provided were:		Any changes were made	e to the plan of	
	7/16-7/18, 7/21, 7/23-	-7/31, 8/3-8/5, and 8/7.		care and orders were up	dated as needed	
				on 8-24-16. Restorative	•	
		ducted with MDS Nurse #2		Assistants (RNA) #1 & 2		
		M. She indicated she was		re-educated by RNA Sup		
	-	orative nursing services.		8-11-16 and counselled	•	
		mentation for Resident #40 DS Nurse #2. She revealed		8-26-16 regarding the or importance of range of n		
		why Resident #40 had not		splinting. Four new Rest		
		as indicated on her plan of		Assistants will be trained	-	
	care for 17 out of 29	•		will be utilized to ensure	•	
				provided as ordered. Nu		
	An interview was con	ducted with the Director of		Administration Aide (MA		
	Nursing (DON) on 8/2	11/16 at 9:40 AM. The DON		Assistant (NA)s (includin		
	indicated the facility h			be re-educated to check		
	-	ssistant scheduled to work 7		supportive devices on pl		
		stated she reviewed the		DON/SDC/Supervisor by		
		e dates restorative services		MAAs, and NAs not worl		
		Resident #40 and confirmed sing assistant was working		will be mailed an education home address on 9-7-16		
	TOOL O FOOTOPOTIVO DUR					

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		MEDICAID SERVICES				T T	<u>). 0938-03</u>
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				1 Y /	E SURVEY PLETED
		345088	B. WING			08	/11/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	GLEN				9 WATER WORKS ROAD INSTON-SALEM, NC 27105		
					· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 318	Continued From page	e 18	F 31	18			
		dent #40 had not received			Measures put in place to ensure defici	ent	
		s indicated on her plan of			practice will not reoccur:		
	care for 17 out of 29	•			System developed to have Assistant		
		-			Director of Nursing (ADON)/RNA		
	An interview was con	ducted with Restorative			supervisor /MDS nurse audit restorativ		
		NA) #1 on 8/11/16 at 9:45			documentation at least 3 times per we	ek	
		ne normally worked with			and meet with RNAs to discuss any		
		idicated she reviewed the			omissions or issues. Reports will be gi		
		he time period in question			to RNA supervisor for any omissions of		
	,	r Resident #40. RNA #1			issues and changes will be made to pl	ans	
		ative services were not			of care/orders as needed. Four new		
	-	/ had not occurred. She rovided the restorative			Restorative Nursing Assistants will be trained By Staff Development coordina	ator	
	services to Resident				(SDC) by 8-31-16 and will be utilized to		
		nentation. She stated she			ensure services are provided as order		
	-	ys". RNA #1 stated she			Caseload of RNA will be reviewed by	ou .	
		generated list each morning			DON/RNA Supervisor on an ongoing		
	-	as assigned to provide			basis to ensure appropriateness of		
		She indicated she had a			continued need for resident programs.	А	
	large volume of resid	ents on her caseload and			list of splints/ROM will be reviewed in		
	sometimes she was r	not able to get to all of her			weekly Trek meeting (a meeting to		
	residents. RNA #1 st	ated she had not been			discuss: falls, weights, skin issues or	any	
		rvisor, MDS Nurse #2, if she			other incidents that is attended by (ID		
		e restorative services as			including: Administrator, MDS Nurse #		
	indicated on her assig	gnment sheet.			MDS Nurse #2, Safety Director, Thera	ру	
					Manager, Health Information, Dietary,		
		was conducted with MDS			Social Services, Activities, Nursing). A	ny	
		isor restorative services, on			revisions given to the hall nurse/Supervisor by ADON for review	in	
		She stated she began e services in March 2016.			huddle meetings (a meeting for hall sta		
	-	d not known that restorative			to discuss each resident's care or issu		
		ng provided consistently			with nursing assistants. Monitoring will	,	
		her attention yesterday.			done by Charge Nurse/Supervisor/MD		
	-	ust assumed the services			Nurse on each hall 3 times per week for		
	-	Nurse #2 indicated she was			one year to ensure splints/supportive		
		eloping a system where			devices are in place as ordered/care		
	-	d need to sign off on their			planned for 10% or more of residents.		
		nd of each day to indicate if			This will be documented on a		
	they had been compl				Splint/Supportive Devices Audit Tool,		1

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 318 Continued From page 19 F 318 also instructed restorative staff to inform her at which includes Resident, device, in place the end of each day if they were unable to - Y or N, if no what action was taken. complete their assignments. Monitoring plan to ensure solutions are A follow up interview was conducted with the sustained: DON on 8/11/16 at 10:30 AM. She indicated she RNA Supervisor will report results of expected restorative services to be provided as weekly audits on omissions guarterly to indicated in the plan of care. She stated she **Quality Assurance Performance** expected RNAs to report to her or to their Improvement (QAPI) for one year as well supervisor, MDS Nurse #2, if they were unable to as any changes made to the plan complete their assignments. She indicated she regarding documentation of splints/range had not known restorative services were not of motion. provided consistently. 2. Resident #4 was admitted to the facility on 10/12/12 with multiple diagnoses that included cerebral palsy. The significant change Minimum Data Set (MDS) assessment dated 6/23/16 indicated Resident #4 had significant cognitive impairment and a limited range of motion to one side of his upper extremities and both sides of his lower extremities. A review of Resident #4's plan of care, with a review date of 8/3/16, revealed interventions to address the prevention of further contractures to his bilateral lower extremities (BLE) and to maintain his current functional bed mobility. The interventions indicated restorative services were to provide a splint to Resident #4's bilateral knees 1 to 3 hours daily and assist with passive range of motion (PROM) to lower extremities and bed mobility exercises 6 days per week. A review of Resident #4's restorative services documentation from 8/4/16 through 8/10/16 revealedrestorative services were provided on 3

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 318 Continued From page 20 F 318 out of 7 calendar days. There were 4 days during the review period of 8/4/16 through 8/10/16 that Resident #4 was not provided restorative services. The 4 days that restorative services were not provided were: 8/4 and 8/6-8/8. An interview was conducted with MDS Nurse #2 on 8/10/16 at 3:00 PM. She indicated she was the supervisor of restorative services. The restorative services documentation for Resident #4 was reviewed with MDS Nurse #2. She revealed she could not explain why Resident #4 had not received restorative services as indicated on her plan of care for 4 out of 7 days. An interview was conducted with the Director of Nursing (DON) on 8/11/16 at 9:40 AM. The DON indicated the facility had a minimum of 1 restorative nursing assistant scheduled to work 7 days per week. She stated she reviewed the staff schedules for the dates restorative services were not provided to Resident #4 and confirmed that a restorative nursing assistant was working on each of those days. She revealed she could not explain why Resident #4 had not received restorative services as indicated on her plan of care for 4 out of 7 days. An interview was conducted with Restorative Nursing Assistant (RNA) #2 on 8/11/16 at 9:45 AM. He indicated he normally worked with Resident #4. He indicated he reviewed the documentation from the time period in guestion (8/4/16 - 8/10/16) for Resident #4. RNA #2 stated that if restorative services were not documented that they had not occurred. He indicated if he had provided the restorative services to Resident #4 he would have completed the documentation. He stated he received a computer generated list

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/12/2016 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE	
		345088	B. WING			08/	11/2016
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
TRINITY G	LEN			49 WATER WORKS ROA /INSTON-SALEM, NC			
				•			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 318	Continued From page	22	F 318				
	facility 3/13/15. Cumu dementia, hypertensio (difficulty swallowing), speech) and gastrosto the stomach).	omy tube (feeding tube in					
	dated 6/14/16 indicate term and long term m severely impaired in c care was required for	Minimum Data Set (MDS) ed Resident #107 had short emory impairment and lecision-making skills. Total all activities of daily living ion noted impairment on and lower extremities.					
	needed nursing ADL r upper extremity (RUE contractures. Approa nursing was to provide RUE daily and apply s	/16 indicated Resident #107 rehabilitation for her right () related to possible ches included restorative e passive range of motion to splint to RUE daily for 3-4 ently approach and monitor					
		l, an observation of ed Resident #107 with a ace and a hand splint on					
	nursing had just starte Resident #107 ' s righ She stated the splints	. She stated restorative ed applying braces to t elbow and hand last week. were applied by restorative uple of hours or so and					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 318 Continued From page 23 F 318 A review of restorative nursing notes noted splint/ brace applied to Resident #107 's right elbow and hand on 8/4/16, 8/5/16, 8/8/16, 8/9/16 and 8/10/16. There was no documentation that the brace and splint had been applied to Resident #107 on 8/6/16 or 8/7/16. An interview was conducted with MDS Nurse #2 on 8/10/16 at 3:00PM. She indicated she was the supervisor of restorative nursing services. The restorative documentation for Resident #107 was reviewed with MDS Nurse #2. She revealed she could not explain why Resident #107 had not received restorative as indicated on her care plan for 8/6/16 or 8/7/16. An interview was conducted with the Director of Nursing (DON) on 8/11/16 at 9:40AM. The DON indicated the facility had a minimum of 1 restorative nursing assistant scheduled to work 7 days a week. She stated she reviewed the staff schedules for the dates restorative services were not provided for Resident #107 and confirmed a restorative aide was working on both days. She revealed she could not explain why Resident #107 had not received restorative services as indicated on her care plan. On 8/11/16 at 9:47AM, an interview was conducted with Restorative Nursing Assistant #2. He stated he was responsible for the application of the brace and splint application for Resident #107 on 8/6/16 and 8/7/16. He stated restorative staff often got pulled to do other duties and it was hard to keep "on track" with restorative duties when that happened. Restorative Nursing Assistant #2 stated he was told to do other duties on 8/6/16 and 8/7/16 along with doing restorative nursing so he could not get to everybody. He

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ___ 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 318 Continued From page 24 F 318 stated if the brace and splint had been applied on 8/6/16 and 8/7/16, it would have been documented. A follow up interview was conducted with MDS Nurse #2, the supervisor of restorative services. on 8/11/16 at 9:50AM. She stated she began overseeing restorative services on March 2016. She stated she had not known that restorative services were not being provided consistently until it was brought to her attention yesterday. She stated she had just assumed the services were provided. MDS Nurse #2 indicated she was in the process of developing a system where restorative staff would need to sign off on their assignments at the end of each day to indicate if they had been completed. She stated she had also instructed restorative staff to inform her at the end of each day if they were unable to complete their assignments. On 8/11/2016 at 10:28AM, an interview was conducted with the Director of Nursing. She stated expected restorative nursing services to be provided as indicated in the plan of care. She stated she expected restorative nursing assistants to report to her or to their supervisor, MDS Nurse #2, if they were unable to complete their assignments. She indicated she had not known restorative services were not provided consistently. F 323 483.25(h) FREE OF ACCIDENT F 323 9/8/16 HAZARDS/SUPERVISION/DEVICES SS=D The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 27 F 323 On 8/10/16 at 11:35 AM, the Director of Nursing implementation and changes will be made (DON) was interviewed. The DON stated that at that time as needed. Any revisions will she expected the staff to follow the care plan to be given to the hall nurse/Supervisor by prevent further falls. She added that Resident ADON each week for review in huddle #151 should have a chair alarm when up in meetings (a meeting for hall staff to wheelchair. The DON stated that the discuss each resident's care or issues) incident/accident reports were reviewed weekly with nurse, MAA, nursing assistants. by the committee. She was aware that most of Monitoring will be done by Charge the resident's falls happened in the bathroom but Nurse/Supervisor/MDS Nurse on each had not tried a toileting program for the resident. hall 3 times per week for one year to The DON added that educating the resident to ensure splints/supportive devices are in call for assistance was not effective due to her place as ordered/care planned for 10% or cognitive impairment. more of residents. This will be documented on a Splint/Supportive 2. Resident #13 was readmitted to the facility on Devices Audit Tool, which includes 6/11/15 with multiple diagnoses including Resident, device, in place - Y or N, if no Alzheimer's Disease. The significant change in what action was taken. status MDS assessment dated 6/1/16 indicated that Resident #13 had severe cognitive Monitoring plan to ensure solutions are impairment and had a fall with no injury. The sustained: Facility Safety Director/Director of Nursing assessment further indicated that the resident was always incontinent of bowel and bladder. will audit 10 residents monthly for effective interventions and report findings to Quality needed extensive assist with transfer and toilet Assurance Performance Improvement use and a trial of toileting program has not been attempted on admission /reentry. (QAPI) guarterly for one year. Plan will be The care plan dated 7/3/16 was reviewed. One monitored and changes made if needed. of the care plan problems was "I have a fall" and the goal was "I will have no injury due to falls." The approaches included chair alarm and pommel cushion in wheelchair. The fall risk assessments for Resident #13 were reviewed. The risk assessments dated 3/20/16. 4/17/16, 6/5/16, 7/13/16 and 8/6/16 indicated that Resident #13 was a high risk for falls. The incident/accident reports for Resident #13 were reviewed. The report dated 3/20/16 at 12:02 PM indicated that Resident #13 was

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 09/12/2016 1 APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY		
		345088	B. WING		_	08/	11/2016		
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	•			
	GLEN		849 WATER WORKS ROAD WINSTON-SALEM, NC 27105						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 323	observed on the bath immediate action was dated 4/17/16 at 3:26 #13 was observed on PM. The resident was his lower back. The in bed. The report dated indicated that Resider floor in his room on 4/ resident was educate The report dated 7/12 that the resident was 1:50 AM. The resider of call light and the im bed. The report dated indicated that Resider floor at 11:30 AM. Th the use of call light. On 8/9/16 at 9:50 AM AM, Resident #13 wa wheelchair. Resident chair alarm nor pomm wheelchair. On 8/10/16 at 11:30 A NA #2 was assigned to that Resident #13 was a chair alarm in his wit that he was trying to g the night shift staff go didn't know why he di his wheelchair. On 8/10/16 at 11:35 A (DON) was interviewed	room floor at 11:35 AM. The chair alarm. The report PM indicated that Resident the bathroom floor at 2:45 is noted to have a bruise on mmediate action was low d 4/29/16 at 8:54 AM nt #13 was observed on the 28/16 at 3:00 PM. The d on the use of call light. /16 at 4:00 AM indicated observed on the floor at nt was instructed on the use imediate action was low d 8/6/16 at 5:55 PM nt #13 was observed on the e resident was instructed on and on 8/10/16 at 11:30 is observed up in #13 was observed with no hel cushion in his MM, NA #2 was interviewed. to Resident #13. She stated is a high risk for falls and has heelchair to alert the staff get up. NA #2 added that thim up this morning and dn't have the chair alarm in	F 323						

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			()(0)		OMB NO. 0938-039	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING		08/11/2016		
NAME OF PROVIDER OR SUPPLIER			:			
			849 WATER WORKS ROAD WINSTON-SALEM, NC 27105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 323	Continued From page	e 29	F 323	3		
		She added that Resident nair alarm and pommel				
		vheelchair. The DON stated				
	that the incident/accident reports were reviewed					
	weekly by the committee. She was aware that					
	some of the resident's falls happened in the bathroom but had not tried a toileting program for					
	the resident. The DON added that educating the					
	resident to call for assistance was not effective					
	due to his cognitive in	-				
F 332 SS=D	483.25(m)(1) FREE (RATES OF 5% OR M	OF MEDICATION ERROR	F 332		9/8/16	
	The facility must ens					
	medication error rate	s of five percent or greater.				
		Γ is not met as evidenced				
	by: Based on record rev	iew, observation and staff		F332 (D) Free of Medication Error Ra	tes	
		failed to maintain their		of 5% or More		
		at 5% or below by not		Trinity Glen will continue to ensure that	t it	
	administering the Lasix (diuretic) as ordered and not administering each medication separately via			is free of medication error rates of five		
		T). There were three errors		percent or greater. For all residents affected:		
		unities for error resulting in a		Resident #46 & 107 had order to cock	ail	
	12 % error rate. Find			medications for Gastrostomy Tube (G-	.	
	1 Desident #46 wee	admitted to the facility on		Tube) administration discontinued on		
		admitted to the facility on e diagnoses including		8-16-16 by Physician services.		
	Edema. The physician's orders for Resident #46			For all residents that have the potentia	l to	
	were reviewed. The orders included Lasix 40			be affected:	.	
		blet via GT three times a ednesday and Friday.		All residents with G-tubes had orders f medication administration via G-tube	or	
	week on worlday, we	eunesuay anu rhuay.		reviewed by physician services on		
	On 8/10/16 at 8:26 A	M, Nurse #2 was observed		8-23-16, cocktail medication orders we	ere	
	during the medication	n nass Nurse #2 was		all discontinued. All residents with		

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345088 B. WING 08/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD TRINITY GLEN WINSTON-SALEM, NC 27105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 332 Continued From page 30 F 332 observed to prepare the medications for Resident G-tubes had orders for medication #46 except the Lasix 40 mgs 1 tablet. The nurse administration via G-tube reviewed by was observed to double check the medications Registered Dietician (RD) on 8-25-16 to and started to crush the tablets ready to be assess for any possible outcomes of administered by GT. increased fluids and 3 order changes were made. Physician services & RD On 8/10/16 at 8:30 AM. Nurse #2 was were educated on interpretive guidance to interviewed. Nurse #2 acknowledged that she surveyors regarding administering forgot to pull the Lasix tablet. Nurse #2 was medications via G-tube by Administrator observed to pull the Lasix and crushed it. on 8-25-16. All licensed Nurses (including nurse #1 & # 2) and MAAs will be On 8/11/16 at 10:33 AM, the Director of Nursing educated on interpretive guidance to (DON) was interviewed. The DON stated that surveyors regarding administering she expected the nurse to administer the medications via G-tube by Staff medications as ordered. Development Coordinator (SDC)/Director of Nursing (DON)/Supervisor as they are scheduled by 9-7-16. Nurses and MAAs 2. Resident #46 was admitted to the facility on not working those dates will be mailed an 11/16/15 with multiple diagnoses including Edema education packet to their home address and Seizure disorder. on 9-7-16. On 8/10/16 at 8:26 AM. Nurse #2 was observed Measures put in place to ensure deficient during the medication pass. Nurse #2 was practice will not reoccur: observed to prepare the medications for Resident An Audit of orders and fluid restrictions will #46 including Depakote capsule, Vimpat liquid, be monitored for residents with G- tubes Ferrous Sulfate liquid, Plavix tablet, Potassium by the Director of Nursing Chloride liquid, Dilantin tablet, B12 tablet, (DON)/Assistant DON each week to Metoprolol tablet and Omeprazole capsule. The ensure medication orders do not state that nurse was observed to crush the tablets and then they can be cocktailed. Director of poured the liquid medications, crushed tablets Nursing/ADON/RN Supervisors/Pharmacy and the contents from the capsule in one cup and consultant will observe medication dissolved them with water. The nurse was administration via G-tube seven days per observed to flush the GT with water and then week to include rotating all shifts and poured the dissolved medications and then weekends for one week, then weekly for flushed the tube with water. one quarter then monthly for remainder of one year to ensure procedures for On 8/10/16 at 8:30 AM. Nurse #2 was medication administration were followed. interviewed. She stated that all the residents receiving medications by GT had a doctor's order Monitoring plan to ensure solutions are

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		IDENTIFICATION NUMBER:	A. BUILDING	A. BUILDING		
		B. WING		08/11/2016		
NAME OF PROVIDER OR SUPPLIER TRINITY GLEN			STREET ADDRESS, CITY, STATE, ZIP CO		DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		IOULD BE COMPLETIN	
F 520	Continued From pag	e 39	F 520	nurse #1 on 8-24-16. All residents orders for splints/ROM were review 8-24-16 by the interdisciplinary tea (IDT included: Therapy manager, / Health Information, MDS Nurse #1 Nurse #2, DON, Administrator) to a the continued plan of care. One splint/ROM order was added and of device order was discontinued as actual splint. All residents with a pl care for accidents were reviewed of 8-25-16 by the interdisciplinary tea included: ADON, Health Information MDS Nurse #1, MDS Nurse #2, DO Administrator, and Supervisor) to a the continued plan of care. Team r changes to care plans and 38 order clarifications. Changes were made plans of care for the most appropri- course of action and orders were a to reflect changes on 8-25-16. Res Nursing Assistants (RNA) #1 & 2 w re-educated by Restorative Nursin Assistant (RNA) Supervisor on 8-1 and counselled by Director of Nursi (DON) on 8-26-16 regarding the omissions and the importance of ra motion and splinting. Four new Restorative Nursing Assistants will trained by Staff Development Coord (SDC) by 8-31-16 and will be utiliz ensure services are provided as on Nurses, Medication Administration (MAA)s and Nursing Assistant (NA) (including NA #1 & 3) will be re-ed by Staff Development Coordinator (SDC)/Supervisor/ Director of Nursi (DON) by 9-7-16 to check kiosk for supportive devices on plan of care	ved on m (IDT) ADON, , MDS assess one not an an of on m (IDT on, ON, assess nade 14 er to the ate adjusted storative vere g 1-16 sing ange of be rdinator ed to rdered. Aides)s ucated sing r	

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		IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
		B. WING		08/11/2016		
NAME OF PROVIDER OR SUPPLIER TRINITY GLEN			STREET ADDRESS, CITY, STATE, ZIP CODE			
				849 WATER WORKS ROAD WINSTON-SALEM, NC 27105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIC	
F 520	Continued From pag	e 40	F 52	o		
	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			Measures put in place to ensure de practice will not reoccur: MDS nurses #1 & 2 will be re-educ 8-31-16 by the Corporate Nurse Consultant on accurate coding for assessments including falls, dialysis medications. An RN auditor (a regi Nurse that has MDS experience bu not have primary duty of MDS in th facility) will check any MDS' comple- residents with falls, dialysis, or hyp medications weekly for one quarter monthly for one year to verify that I has been coded properly. An audit be used that lists: resident name; a date; assessment date; MDS items in sections J (falls with or without in major injury), O (Dialysis), and N (antianxiety and hypnotic medication Completed MDS will be verified by checking chart for resident in the a falls, dialysis and Medications; utiliz physician orders, MAR, nurses not incidents. Any modifications requir be made and transmitted at that tim MDS nurse. System developed to I Assistant DON/Staff Development Coordinator (SDC)/RNA Superviso restorative documentation at least per week and meet with RNAs to d any omissions or issues. Reports v given to RNA supervisor for any omissions or issues and changes v made to plans of care/orders as ne Caseload of RNA will be reviewed DON/RNA Supervisor on an ongoin basis to ensure appropriateness of continued need for resident progra	ated by MDS is and stered it does is eted for notic r, then MDS tool will nudit is listed njury or ons). reas of zing es and red will ne by nave r audit 3 times iscuss vill be reded. by ng	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088		(X2) MULTIP	OMB NO. 0938-0 (X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		B. WING		08/11/2016	
NAME OF PROVIDER OR SUPPLIER TRINITY GLEN			STREET ADDRESS, CITY, STATE, ZIP CODE 849 WATER WORKS ROAD		ODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLET THE APPROPRIATE DATE
F 520	Continued From pag	e 41	F 52	 list of splints and alarms wi in weekly Trek meeting (a r discuss: falls, weights, skir other incidents that is atten including: Administrator, MI MDS Nurse #2, Safety Dire Manager, Health Informatic Social Services, Activities, revisions will be given to th nurse/Supervisor by ADON review in huddle meetings of hall staff to discuss each re or issues) with nurse, MAA assistants. Monitoring will b Charge Nurse/Supervisor/M each hall 3 times per week ensure splints/supportive d place as ordered/care plant more of residents. On 8-24-16, Administrator of Casey Conner, MHA, Quali Alliant Quality, Quality Impr Organization (QIO) of North provide continuing educatio Assurance Performance Im (QAPI) process and refinen maintaining implemented p effectiveness to the QAPI of 9-1-16. Monitoring plan to ensure s sustained: Director of Nursing (DON)// will audit 5 completed MDS ensure coding has been co accurately and report to Qu Assurance Performance Im (QAPI) - (MDS Performance 	meeting to n issues or any ded by (IDT DS Nurse #1, ector, Therapy on, Dietary, Nursing). Any e hall each week for (a meeting for isident's care , nursing be done by MDS Nurse on for one year to evices are in ned for 10% or contacted ity Advisor for rovement n Carolina to on on Quality oprovement nents of lans for committee on solutions are Assistant DON 6' monthly to impleted iality oprovement

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		B. WING	08/11/2016		
NAME OF PROVIDER OR SUPPLIER TRINITY GLEN				CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE
F 520	Continued From pag	e 42	F 524	 Plan (PIP) team). The MD2 includes MDS Nurse #1, M DON, and Administrator. T identify any trends and cha needed. MDS nurses will r collected and any changes plan in the quarterly QAPI year. RNA Supervisor will weekly audits on omission Quality Assurance Perform Improvement (QAPI) for or as any changes made to th regarding documentation of of motion and accidents. On 8-25-16, Administrator Conner, MHA, Quality Adv Quality QIO of North Carol the QAPI plans and progree monitoring effectiveness o quarter for one year to give perspective to the QAPI pr changes will be made to plant 	MDS Nurse #2, The team will ange the plan as report the data is made to the meeting for one report results of is quarterly to hance he plan of splints/range invited Casey risor for Alliant lina to review less of nce each e an outside rocess. Any

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