DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345565	A. BUILDING ______ B. WING ______	08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ELMS	**7449 FAIR OAKS DRIVE** **CLEMMONS, NC 27012**

(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 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an Emergency Preparedness (EP) plan. The EP plan did not address the resident population to include residents at risk, a process for cooperation and collaboration with local, state, regional, tribal and federal officials and the development of an arrangement with other long-term care facilities to receive residents. The facility also failed to develop a communication plan with names and contact information and a method of sharing	E 001	E001 Establishment of the Emergency Program The plan of correcting the specific deficiency; process that lead to the deficiency cited: Administration had the Emergency Preparedness Plan but did not have the already existing regulatory required supplemental information in the same book as the Emergency Plan; therefore, policies, procedures, and other	9/5/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/21/2018

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.

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E 001	Continued From page 1 information with resident's families/representatives regarding the EP plan. The facility failed to develop training and testing exercises for the facility using the EP plan. Findings included: 1. Review of the facility's Emergency Preparedness plan materials revealed: A. The EP plan did not address the resident population including at risk residents and the type of services the facility could provide in an emergency. B. The EP plan did not address how the facility planned to cooperate and collaborate with local, State, Federal, tribal and regional officials to maintain an integrated response in an emergency. C. The EP plan did not contain an arrangement with other facilities/providers to receive residents in an emergency. D. The EP plan did not include a communication plan that included the names and contact information for the following; staff, resident's physicians, other long-term care facilities and volunteers. E. The EP plan did not include a method of sharing information from the EP plan with residents and their families/representatives. F. Review of the facility's EP training information revealed the facility failed to conduct an initial training in the emergency preparedness procedures to all staff consistent with their	E 001	supportive information were not in one all-inclusive location. Although the facility did participate in a community table top drill and an in-house table top drill, the facility did not have specific documentation to show the review of the emergency plan with the staff that included their expected roles and did not conduct exercises to test the Emergency Plan with the staff. The procedure for implementing the plan of correction for the deficiency cited: The Administrator created an all-inclusive Emergency Plan Book for the facility that included the All Hazards Emergency Plan; the Emergency and Disaster Policy and Procedures; the Facility Assessment to address the resident population including at risk residents and type of services the facility could provide in an emergency; the documentation of how the facility planned to cooperate and collaborate with State, Federal, tribal, and Regional officials to maintain integrated response in an emergency; written verification from other facilities/providers to receive residents in an emergency; the communication plan that included names and contact information for staff, resident□s physicians, other long term care facilities, and volunteers; and the method of sharing information from the Emergency Plan with residents and their families/representatives. The Resident Handbook which is reviewed during the admission process to the facility with residents and their	

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E 001	Continued From page 2 expected roles. G. Further review of the EP training information revealed the facility failed to conduct exercises to test the EP plan. During an interview with the Administrator on 8-8-18 at 3:30pm she discussed many employees who collaborated with her to develop the EP plan and a way to make it easier to find information. She stated she was unaware the facility's EP plan did not contain all of the required information needed but she expected the plan to be "all-inclusive in one area" that included policy, procedures and supportive information.	E 001	families/representatives was updated to reflect the existence of an All Hazards Emergency Plan, the importance of current contact information, and the specific location where information concerning the Disaster Plans can be found. This information was included in the all-inclusive Emergency Plan Book as supplemental information. A letter was sent to all current families/representatives on 8-22-2018 by the Administrator to review the existence of an All Hazards Emergency Plan, importance of contact information, how the facility would make contact in an emergency, and specific location where information concerning the Disaster Plan can be found in the facility. The Staff Development Coordinator and Maintenance Director initiated inservicing on Friday, August 17, 2018 on Emergency Preparedness Procedures consistent with staff□s expected roles. The training will be completed by September 5, 2018. Any staff unable to be inserviced by this date will not be scheduled to work until they have completed this training. The Staff Development Coordinator revised the orientation process for new hire staff to include specific training on the Emergency Preparedness Procedures consistent with their expected roles. Documentation regarding emergency and disaster training will be placed in the employee□s personnel file. The Staff Development Coordinator will schedule annual re-training of the Emergency Preparedness Procedures and have records of attendance to verify this	

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E 001	Continued From page 3	E 001	training. The Administrator and Maintenance Director will conduct an unannounced Disaster Exercise with facility staff to test the Emergency Plan upon completion of the staff training. Disaster Exercises will be conducted quarterly for one year, then annually thereafter with revisions made to the plan if indicated. The Administrator developed a plan for coordinating with the emergency management officials and on 08-17-2018 initiated communication with the Forsyth County Assistant Fire Marshall and the Regional Healthcare Coordinator for the Triad Healthcare Preparedness Coalition to schedule a review of the facility All Hazards Emergency Plan Book and make any future recommendations to maintain an integrated and collaborative response in an emergency. The Maintenance Director will attend County emergency preparedness meetings as they are scheduled in the future. The monitoring procedure to ensure the Plan of Correction is effective and that specific deficiency cited remains corrected: The Staff Development Coordinator and Maintenance Director will complete a review of new hired staff orientation Emergency Plan training, existing staff annual Emergency Plan training compliance, review of emergency disaster exercises completed with results of participation and areas identified for improvement, and the all-inclusive	

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E 001	Continued From page 4	E 001	Emergency Plan Book to assess needs for updates and/or revisions weekly for four weeks, then monthly for four months, then quarterly on-going utilizing a Emergency Disaster Plan Compliance Review Quality Improvement Audit Tool. Any areas identified as needing improvement will have actions taken documented on the Quality Improvement Audit Tool. The Administrator will review the results of the Emergency Disaster Plan Compliance Review Quality Improvement Audit Tool weekly for four weeks, then monthly for four months, then quarterly on-going to assure completion of the audit, follow through of any areas identified during the audits, and for continued regulatory compliance in this area. The Administrator will submit the Emergency Disaster Plan Compliance Review Quality Improvement Audit Tool to the Executive Quality Improvement Committee monthly for five months, then quarterly on-going for monitoring, recommendation of changes as necessary, and to assure continued compliance in this area. The Executive Quality Improvement Committee includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Nurses, Environmental Services Directors, Social Worker, Life Enrichment Director, CNA, Dietary Aide/Cook, and Housekeeper. The title of the person responsible for	

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E 001	Continued From page 5	E 001	implementing the plan of correction is the Administrator.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not	F 655		9/5/18

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F 655	Continued From page 6 limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interviews and record review the facility failed to develop a base line care plan that included minimum healthcare information to provide effective, person centered care for residents with uncontrolled blood sugars or who required dialysis with fluid restrictions for 2 of 2 residents (Resident #343 and Resident #340) reviewed for base line care plans. Findings included: 1.Resident #343 was admitted to the facility on 8-1-18 with multiple diagnoses to include chronic systolic congestive heart failure, end stage renal disease, dependence on renal dialysis and below knee amputation of the left lower extremity. The 8-1-18 admission physician's orders were reviewed and revealed Resident #343 was ordered to have fluid restriction of 1500 milliliters daily and attend dialysis on Tuesday, Thursday and Saturdays. A review of Resident #343's base line care plan dated 8-2-18 revealed a goal that the resident would improve her ability to participate in her activities of daily living (ADL), transfer safely and	F 655	F655 - Base Line Care Plan The plan of correcting the specific deficiency; process that lead to the deficiency cited: The electronic health record system utilized by the facility creates a baseline care plan from the data obtained during clinical admission assessment; however it was discovered that some medical information was not transferring from the point of entry by the Admissions Nurse and/or MDS Coordinator over to the base line care plan document; therefore the baseline care plans did not include healthcare information to provide effective, person centered care for residents with uncontrolled blood sugars or who required dialysis with fluid restrictions. Resident #343 and # 340 no longer reside in this facility. The procedure for implementing the plan of correction for the deficiency cited: The MDS Coordinator contacted the representative that directs the electronic health record computer program on 08-08 -2018 and the computer program was	

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F 655

Continued From page 7

move around independently. The interventions for that goal were as followed; explain procedures, prompt use of analgesia, check skin, reposition while in bed, transfer with full body lift, assist with incontinence care and assist with ADL care. The second goal listed was for Resident #343 not to have any uncontrolled or abnormal bleeding or bruising. The interventions for that goal were as followed; assess for any abnormal bleeding, report labs to the physician, assess for pain and assess color or temperature changes to the resident's extremities. The resident's base line care plan did not address the resident's fluid restriction or her dialysis 3 times a week.

During an interview with Resident #343 on 8-6-18 at 2:00pm the resident stated when she was admitted, staff was allowing her to drink as much as she wanted and felt that was why her hands were swollen on 8-6-18. The resident also stated the only goal she knew of was for therapy, so she could go back home.

An interview with the Minimum Data Set (MDS) manager occurred on 8-8-18 at 2:19pm. The MDS manager stated she reviewed the base line care plans but that the admissions coordinator developed the plan. She also stated the facilities base line care plans "only discuss the ADL care the resident will need when they are admitted." The MDS manager also confirmed the resident's base line care plan did not address the resident's fluid restriction or her dialysis.

During an interview with the Administrator on 8-8-18 at 3:30pm she stated she expected base line care plans to reflect the needs of the resident while the full care plan was being developed.

F 655

corrected to allow pertinent medical information to carry over to the base line care plan on 8-8-2018. The MDS Coordinator then completed a 100 percent audit on 08-09-18 following this technical system correction to assure that all base line care plans included important healthcare information to provide person centered care for residents. Any areas identified in this audit were corrected as appropriate for the specific resident□s needs.

The Director of Nursing inserviced the Admissions Nurse and the MDS Coordinator on 08-22-2018 on the importance of making sure that pertinent medical information that is necessary to carry out a base line plan of care for residents is entered into the electronic health record within 48 hours of admission and the important step of verifying the base line care plan to make sure that pertinent medical information has actually carried over to the base line care plan to assure effective person centered care information is available.

The monitoring procedure to ensure the Plan of Correction is effective and that specific deficiency cited remains corrected:
The MDS Coordinator will review all new admissions to assure that pertinent clinical conditions are identified and listed on the new resident□s base line care plan weekly for four weeks, then bi-weekly for two months utilizing a Base Line Care Plan Review Quality Improvement Audit

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F 655	Continued From page 8 2.Resident #340 was admitted to the facility on 8-4-18 with multiple diagnoses which included surgical after care, diabetes, arthrodesis and chronic kidney disease. A review of Resident #340's base line care plan dated 8-4-18 revealed a goal that the resident will improve his ability to walk, transfer safely and complete his activities of daily living (ADL) independently. The interventions for that goal were as followed; explain procedures, prompt use of analgesia, assess skin, assist with toileting, assist with ADL care. The resident's base line care plan did not address his diabetes or his hyperglycemia. A review of the physician's history and physical dated 8-6-18 revealed Resident #340 had been hyperglycemic (high blood sugar) since admission. The Medication Administration Record (MAR) was reviewed from 8-4-18 to 8-7-18 and revealed Resident #340 had blood sugars ranging from 349 to 110 (normal range 70-130). During an interview with Resident #340 on 8-8-18 at 11:05am the resident stated the only goals he was aware of were for him to be more independent, so he could go home. An interview with the Minimum Data Set (MDS) manager occurred on 8-8-18 at 2:19pm. The MDS manager stated she reviewed the base line care plans but that the admissions coordinator developed the plan. She also stated the facility's base line care plans "only discuss the ADL care the resident will need when they are admitted." The MDS manager also confirmed the resident's	F 655	Tool. Any areas identified in this audit will be corrected and noted on the audit form for continued monitoring of potential patterns or additional concerns. The Administrator will review the Base Line Care Plan Review Quality Improvement Tool weekly for four weeks, then bi-weekly for two months to assure completion of the audit, follow through of any areas identified during the audits, and for continued regulatory compliance in this area. The Administrator will submit the Baseline Care Plan Review Quality Improvement Audit Tool to the Executive Quality Improvement Committee monthly for two months for monitoring, recommendation of changes as necessary, and to assure continued compliance in this area. The Executive Quality Improvement Committee includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Nurses, Environmental Services Directors, Social Worker, Life Enrichment Director, CNA, Dietary Aide/Cook, and Housekeeper. The title of the person responsible for implementing the plan of correction is the MDS Coordinator.	

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F 655	Continued From page 9 base line care plan did not address the resident's diabetes or his hyperglycemia. During an interview with the Administrator on 8-8-18 at 3:30pm she stated she expected base line care plans to reflect the needs of the resident while the full care plan was being developed.	F 655		