STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345088	A. BUILDING _____ B. WING _____	12/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		1/2/20

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

Electronically Signed | 12/18/2019

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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and family and staff interviews, the facility failed to maintain clean wheelchairs for a sampled resident (Resident #57) and failed to maintain wheelchairs in good repair for 2 sampled residents (Resident #'s 57 and 70). The findings included: An observation on 12/19/19 at 12:01 PM revealed Resident #57 was in his wheelchair in the dining room of the 300 hall locked unit waiting to eat lunch. His wheelchair was observed to be soiled with dried debris on the seat in front of the cushion and along the inner sides. The wheelchair was also observed to have several cracks in the vinyl of the left armrest pad. An interview was conducted on 12/2/19 at 2:48 PM with Resident #70's family member during the initial pool process. An observation conducted in conjunction with the interview revealed Resident #70's wheelchair had several tears in the vinyl on the armrest pad. Resident #70's family member stated the wheelchair armrest pads did not look good. An observation on 12/5/19 at 3:15 PM revealed Resident #57's wheelchair remained soiled with dried food debris and the armrest pads remained torn. Resident #70's wheelchair armrest pads remained torn. An interview was conducted on 12/5/19 at 3:22 PM with the Housekeeping Director. She	F 584	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provision of federal and state law. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Plan of Correction – F584 (D) Safe/ Clean/ Comfortable Environment 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #57’s wheelchair was cleaned and pressure washed by housekeeping supervisor and completion was reported to surveyor prior to exit conference on 12-5-19. Resident #57 and #70 both had wheelchair repairs done by maintenance during survey and completion was reported to surveyor prior to exit conference on 12-5-19. 2. How you will identify other residents having the potential to affect residents by the same deficient practice.	

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F 584	Continued From page 2 revealed she tried to do wheelchair cleaning monthly when she had the staff to do it, but she didn't always have the staff available. She stated when any staff members see a soiled wheelchair, it should be cleaned at that time. An interview was conducted on 12/5/19 at 3:37 PM with the Maintenance Director. He stated he did monthly and quarterly inspections and items such as wheelchairs are included in the inspection. He stated housekeeping cleans the wheelchairs monthly and should be notifying maintenance at that time if a wheelchair needs repairing. He also stated any nursing staff member can let maintenance know if a wheelchairs armrest pads need to be replaced.	F 584	All resident's wheelchairs 100% were inspected for any needed repairs by Maintenance Supervisor on 12-6-19. Inspection audit found 8 chairs needed an armrest repair and repairs were completed from 12-6-19 to 12-9-19 by Maintenance. All resident's wheelchairs 100% were inspected for cleaning needs on 12-6-19 by Housekeeping Supervisor. Inspection audit found 6 wheelchairs needed cleaning and cleanings were completed from 12-6-19 to 12-10-19 by housekeeping supervisor and team. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; Staff were reminded via electronic message (the scheduling system sends a text to their personal cellular phone in the same way they receive their schedule) on 12-6-19 to fill out maintenance repair slips located in lobby and service hall for any needed wheelchair repair/ deep cleaning. Town Hall Meetings were conducted in person by Administrator on 12-11-19 on all shifts for every department to follow up on text and to remind staff of the issue of doing wheelchair cleaning and reporting needed repairs. DON/ ADON developed schedule for cleaning all 100% wheelchairs weekly by third shift. Nursing department educated staff via electronic message (the scheduling system sends a text message to their personal cellular phones the same way they receive their schedule) of new wheelchair weekly cleaning schedule on	

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F 584	Continued From page 3	F 584	12-16-19 by ADON. Weekly cleaning schedule will be signed off and turned in to ADON/ QA Nurse weekly. Housekeeping Supervisor will inspect 100% of resident's wheelchairs monthly for needed deep cleaning. Maintenance Supervisor will monitor and complete any repair/ deep cleaning request slips 5 days per week. Maintenance Supervisor will inspect 100% of all resident's wheelchairs monthly to look for any needed repairs. 4. How the corrective actions will be monitored to make sure solutions are sustained. Nursing has developed an audit tool to track 100% wheelchair monitoring and cleaning on a weekly schedule that will be monitored by DON/ ADON/ QA Nurse each week for one year. Results will be reported to Performance Improvement team monthly. Maintenance Supervisor has developed a Wheelchair Repair Audit Tool to use in tracking any needed repairs on 100% wheelchair rounds on a monthly schedule each month for one year. Results will be reported to Performance Improvement team monthly. Housekeeping Supervisor has developed a 100% wheelchair cleaning audit tool to use in tracking any needed wheelchair cleaning rounds on a monthly schedule each month for one year. Results will be reported to Performance Improvement team monthly. Quality Assurance Performance Improvement plans have been put in	

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F 584	Continued From page 4	F 584	place for Wheelchair cleaning by DON and Housekeeping Supervisor; and for wheelchair repairs by Maintenance Supervisor. DON, Maintenance Supervisor and Housekeeping Supervisor will report results to QAPI committee quarterly for one year. Date of completion: 1-2-20	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the minimum data set (MDS) assessment for the resident discharge to an assisted living facility for 1 of 1 sampled resident reviewed for MDS accuracy (Resident #103). Findings included: 1. Resident # 103 was admitted to the facility on 8/1/19 with a history of Type 2 diabetes, coronary artery disease, chronic kidney disease, and dementia. The discharge minimum data set (MDS) dated 9/4/19 identified resident was discharged to an acute care hospital. Review of Nurses note dated 9/4/19 revealed the resident was discharged to an assisted living facility on 9/4/19 at 2:40 PM.	F 641	Plan of Correction – F641 (D) Accuracy of Assessments 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Assessment dated 9-4-19 for Resident #103 was modified and transmitted with correction to reflect discharge to Assisted Living facility and presented to surveyor prior to exit conference on 12-5-19 by the MDS Coordinator. The modification resulted in no change to RUG score. 2. How you will identify other residents having the potential to affect residents by the same deficient practice. An audit was conducted by MDS Coordinator on 12-6-19 to 12-18-19 of 100% of MDSs for all Residents discharged within the last quarter for MDS	1/2/20

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F 641	Continued From page 5 An interview was conducted with MDS Nurse #1 on 12/05/19 at 9:57 am and she stated Resident #103 was discharged back to an assisted living facility and not the hospital as indicated on the MDS assessment. She stated it was an honest mistake and she will do a modification to the assessment.	F 641	section A2100 discharge location. Audit revealed one additional correction was needed. Correction was made and modification was done to reflect accurate discharge information by MDS coordinator on 12-18-19. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; An in-service education was conducted for the MDS coordinators on accurate Coding Section A2100 for discharge destination by the Corporate Director of Clinical Compliance RN RAC-CT on 12-9-19. An audit tool was developed by the Administrator and MDS coordinator for accuracy of MDS section A2100 discharge location monitoring. The audit will be conducted for accuracy of discharge location on MDS section A2100 for 100% all residents discharged twice per month for one year by the QA Nurse/ RN Auditor. Any findings will be corrected by MDS coordinator and reported to Performance Improvement Team. 4. How the corrective actions will be monitored to make sure solutions are sustained. The Corporate Director of Quality Life and Care will audit 100% of discharges for accuracy in MDS section A2100 discharge location - weekly for one month, then 10% monthly for one year. A Quality Assurance Performance Improvement Plan has been put into place. The MDS Coordinator will report results monthly to Performance	

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F 641	Continued From page 6	F 641	Improvement team, and will report results quarterly to the QAPI committee. Date of completion: 1-2-20	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		1/2/20

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F 656	Continued From page 7 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive individualized and person-centered care plan in the area of antipsychotics for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #70). The findings included: Resident #70 was admitted to the facility on 10/18/19 with diagnoses of, in part, Dementia with behaviors and anxiety. A review of Resident #70's admission Minimum Data Set (MDS) assessment dated 10/25/19 indicated Resident #70 had severe cognitive impairment. Resident #70 had exhibited physical behaviors toward others daily and verbal behaviors directed toward others 1-3 days during the assessment period. The assessment revealed Resident #70's behaviors put her at significant risk for illness or injury and interfered with her care. Resident #70's behaviors had also put others at significant risk for physical injury and intruded on the privacy or activity of others. The assessment revealed she had received an antipsychotic medication during the assessment period.	F 656	Plan of Correction – F656 (D) Develop/ Implement Comprehensive Care Plan 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. An antipsychotic plan of care was added to the person-centered care plan for resident #70 during survey and was presented to the surveyor prior to the exit conference on 12-5-19 by the MDS coordinator. 2. How you will identify other residents having the potential to affect residents by the same deficient practice. An audit was conducted of all 100% of residents with an antipsychotic medication order by the MDS coordinators on 12-6-19 to check for the presence of an antipsychotic plan of care. Additions/ Corrections were made to 6 plans of care, completed 12-8-19. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; An in-service education was conducted	

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F 656	Continued From page 8 A review of the Resident #70's care plan did not include use of an antipsychotic medication. A record review revealed a physician's order dated 10/2219 for Zyprexa 2.5 milligrams by mouth at bedtime. A review of the Medication Administration Record revealed Resident #70 had received Zyprexa 2.5 milligrams by mouth 4 times during the look back period. An interview was conducted with NA #1 on 12/5/19 at 9:49 AM. She revealed Resident #70 was combative with care at times, wandered around the unit frequently and was difficult to redirect. An interview was conducted with MDS #1 on 12/5/19 at 2:00 PM. She revealed Resident #70 did have antidepressant and antianxiety medication care planned. She also stated Resident #70 was not on the antipsychotic medication when she was admitted.	F 656	for the MDS coordinators on Updating Baseline care plan/ Baseline Care Plan Summary to discuss timeliness of adding antipsychotic medications to the plan of care by the Corporate Director of Clinical Compliance RN, RAC-CT on 12-9-19. The electronic resident charting system received a system change to begin sending an alert to the MDS coordinator's computers each time an order for antipsychotic medication is entered into a resident chart. This change was implemented on 12-9-19 by the Director of Quality of Life and Care. MDS Coordinators will review these alerts each working day and will update the Resident Person-centered Care Plans to reflect a plan of care for antipsychotics. 4. How the corrective actions will be monitored to make sure solutions are sustained. All residents 100% with orders to receive antipsychotic medications will have a chart audit to ensure a care plan for antipsychotic medications is in place weekly for one month then twice per month for one year by the QA Nurse/ Health Information Manager for one year. MDS coordinators will be notified at the time of the audit for needed corrections and results will be reported to Performance Improvement team. A Quality Assurance Performance Improvement Plan has been developed by the MDS Coordinator for antipsychotic plans of care. MDS Coordinator will report results to the QAPI committee quarterly for one year.	

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F 656	Continued From page 9	F 656	Date of completion: 1-2-20	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		1/2/20

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F 842	Continued From page 10 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to accurately document on the Medication/Treatment Administration Records (MAR/TAR) that an order to monitor wound vacuum was discontinued for 1 of 3 residents reviewed for skin conditions (Resident#2). Nursing staff continued to document that they were monitoring the wound	F 842	Plan of Correction – F842 (D) Resident Records 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The portion of the order to monitor the	

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F 842	Continued From page 11 vacuum even when the resident no longer had the wound vacuum. Findings included: Resident #2 was originally admitted to the facility on 3/26/19 with diagnoses which included: closed left hip fracture, disruption of external operation (surgical wound), for adjustment and management of vascular access device, and dementia. Review of the most recent minimum data set dated 11/21/19 indicated Resident #2 severely, cognitively impaired; had lower left extremity impairment; and had a surgical wound. The care plan dated 11/26/19 revealed Resident #2 had the potential for skin injury due to the left hip surgical wound and had a wound vacuum in place. The Approaches to the care plan included: provide wound care if needed; check skin weekly; inform the physician of any changes; and report any fever or odor to the hip surgical site to nursing. The care plan was updated on 11/29/19 indicating the wound vacuum was discontinued. A review of the NP (Nurse Practitioner's) written order dated 11/26/19 included: 1) discontinue treatment to the left thigh wound. 2) Clean surgical wound with puracyn (wound cleansing solution) spray; apply (pack) with algicell ag strip gauze (Antimicrobial silver dressing) to base of wound; cover with foam dressing; and change daily in the morning. 3) X-ray left hip and femur due to decreased healing wound. The review of the November 2019's MAR/TAR for	F 842	wound vacuum on the MAR/TAR for resident #2 had been correctly discontinued by the night shift Supervisor on 12-4-19 at 1:04am from MAR/TAR prior to the surveyor interviews on that same date. Staff that documented incorrectly in between the wound vacuum removal on 11-26-19 and the correction to the MAR/TAR for the portion of the order to monitor wound vacuum on 12-4-19 were counselled and this was reported to surveyor prior to exit conference on 12-5-19 by the Director of Nursing. 2. How you will identify other residents having the potential to affect residents by the same deficient practice. An audit was conducted of 100% of all residents with orders on the MAR/TAR for skin conditions for accuracy by the Director of Nursing on 12-6-19, with one correction made at that time. An additional audit was done on 12-16-19 with no corrections needed. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; Administrator and DON conducted Nurses meetings in person on all shifts for nurses, Medication Aides and Treatment Aides (C.N.A. IIs) to educate them regarding the importance of accuracy of documentation on MAR/TAR on 12-11-19. Nurses or MAAs not in attendance were mailed a letter to their home address on 12-12-19 by the Administrator. ADON/QA Nurse will do a triple check on all orders for skin conditions three times per week for one year. This check will	

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	345088	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 12 Resident #2 revealed the NP's order to discontinue the treatment using the wound vacuum was not transferred to the MAR/TAR. The nursing staff documented the wound vacuum portable device was monitored during first, second and third shifts on 11/27/19, 11/28/19, 11/29/19 and 11/30/19. The wound vacuum device was not discontinued on the MAR/TAR until 12/4/19. During an observation on 12/02/19 at 4:19 p.m., Resident #2 was reclining in her bed with the bedlinen to her waist, watching television. There was no wound vacuum observed in the room. During an interview on 12/03/19 at 2:28 p.m., the DON (Director of Nursing) revealed Resident #2 was admitted to the facility on 3/26/19 with a deep surgical wound to her left hip and a wound vacuum which was discontinued a week prior to this interview. The DON stated that the resident was hospitalized on 4/1/19 through 4/3/19 due to anemia and the treatment continued upon her readmission. She stated that in May 2019, the resident developed cellulitis in the wound and was sent to infectious disease consult. During an interview on 12/4/19 at 3:21 p.m., and after reviewing Resident #2's MAR/TAR, the DON acknowledged the nursing staff continued signing the MAR/TAR on November 27 through November 30, 2019 indicating the wound vacuum was monitored after the wound vacuum was discontinued. She stated the order should have been removed from the MAR/TAR by the person who transferred the order onto the MAR/TAR on the day the wound vacuum was discontinued. The DON stated indicated only part of the NP's order was transferred to the MAR/TAR; the	F 842	include that once the Nurse receives the order for skin condition, a carbon copy will be placed in a designated basket and will be collected by ADON/QA Nurse for review of accuracy of order entry. ADON notified all nurses, MAAs, and treatment Aides via electronic message (through the scheduling system that sends a text to their personal cellular phones in the same way they receive their schedule) of new triple check process for orders on skin conditions on 12-16-19 and the schedules have been given to supervisors for follow up, with questions asked and answered and these will be signed off and turned in to ADON/QA Nurse weekly. DON has developed an audit form to monitor accuracy of skin condition orders and documentation. The DON will do an audit of all MAR/TAR skin condition orders and documentation each month for one year. 4. How the corrective actions will be monitored to make sure solutions are sustained. The DON will do an audit of 100% all MAR/TAR skin condition orders and documentation each month for one year. A Quality Assurance Performance Improvement plan for skin condition orders and MAR/TAR documentation has been developed by the Director of Nursing. The DON will report results of MAR/TAR accuracy for skin conditions orders and documentation quarterly to QAPI committee for one year.	

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F 842	Continued From page 13 monitoring of the wound vacuum was mistakenly left on the MAR/TAR. During an interview on 12/4/19 at 3:35 p.m., Nursing Supervisor #1 revealed she removed the wound vacuum and started the new wound treatment on Resident #2 on November 26, 2019. During an interview on 12/4/19 at 4:13 p.m., Staff Nurse #1 stated the NP wrote the order which included discontinuing the wound vacuum treatment. The Nurse Supervisor signed the order and transferred the order to the MAR/TAR. Staff Nurse #1 stated that she re-checked the order to ensure it was transferred to the MAR/TAR but failed to notice that the monitoring of the wound vacuum was still on the MAR/TAR. She revealed she mistakenly signed the MAR/TAR on 11/27/19 during second shift indicating she monitored the wound vacuum. During an interview on 12/4/10 at 4:30 p.m., Med Aide #1 (Medication Aide) revealed she was aware the wound treatment with the wound vacuum was discontinued for Resident #2. She stated that she mistakenly signed the MAR/TAR for the monitoring of the wound vacuum on 11/27/19 and 11/29/19.	F 842	Date of completion: 1-2-20	