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
	345153	A. BUILDING _____ B. WING _____	C 11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC RD SALISBURY, NC 28144

(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 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to assess and identify fall risk factors after a fall incident and failed to implement interventions to reduce fall risk based on this information for 1 (Resident #70) of 3 residents with falls in the facility. The findings included: Resident # 70 was admitted on 6/4/13 with diagnosis including coronary artery disease, hypertension, diabetes mellitus, thyroid disorder, benign prostatic hyperplasia and dementia. Resident #70 also had a right partial hip replacement in April 2013. The Care Plan dated 6/14/13 had the following problem statement regarding falls " I have a history of falls with injury and the potential for falls manifested by history of falls, impaired sense of balance, poor leg control and unsteady gait dizziness. " The goal was no injury due to falls for 3 months and the interventions included observe, record and report all unsafe situations and conditions, postural dizziness (dizziness on standing often related to a drop in blood pressure upon standing), encourage to ask for assistance, monitor closely, assess change in level of	F 323	PLAN OF CORRECTION TAG # F323 This plan of correction is the facility□s credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction is submitted to meet the requirements established by federal and state law. For the resident affected: Resident #70 was discharged from the facility on 10/8/13 and did not return. For Residents having potential to be affected: To ensure that each resident receives adequate supervision and assistive devices to prevent accidents, all residents were re-assessed for fall risk factors and appropriate interventions on December 8,	12/14/13

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

Electronically Signed | 12/12/2013

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.

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
	345153	A. BUILDING _____ B. WING _____	C 11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC RD SALISBURY, NC 28144

(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 323	Continued From page 1 consciousness, instruct on safety, call light on reach, assist with ambulating and toileting, do not leave unattended while toileting, bed in locked position. On 9/17/13 the Nursing Notes revealed that at 5 PM a new order for Ativan (lorazepam) 0.5 mg (milligrams) every 6 hours as needed for anxiety was obtained (ativan is an anti-anxiety medication with adverse effects that can include dizziness, unsteadiness and delirium). The Significant Change Minimum Data Set (MDS) assessment dated 9/25/13 revealed Resident # 70 was moderately cognitively impaired and required extensive assistance of two people for transfers and was only able to be steady while standing or transferring with human assistance. It also indicated he had no impairment of his upper or lower extremities. The MDS also indicated Resident #70 had no falls since admission. Review of the electronic medical record dated 9/30/13 at 5:44 PM revealed documentation of a fall incident. According to the notes Resident #70 was observed on the floor at 5 PM and he was confused. Under the heading ' Contributing Factors ' the note stated " sat down Resident started sliding out of chair and stated he just slid out of chair onto floor. " The location of the incident was the resident ' s room and the activity at the time of the incident was " unknown. " There were no witnesses or staff involved indicated in the note. The following vital signs were documented pulse (P) 100, respirations (R) 24, temperature (T) 98.4 and blood pressure (BP)106/40; whether this was a standing or sitting blood pressure was not indicated. Blood glucose	F 323	2013. Care plans were reviewed and revised as indicated. System Change: Measures put into place to ensure that the residents□ environment remains as free of hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents are as follows: A. Fall risk assessments will be completed on admission, quarterly, with a significant change in status, and after a fall incident to assess and identify fall risk factors by licensed nursing staff. Interventions will be implemented and care planned as indicated. Staff development coordinator, director of nursing, unit managers, and corporate nurse consultants conducted in service trainings for licensed nurses and care plan team members on the risk assessment process. Trainings were conducted between 12/10/13 and 12/14/13. B. Root-cause analysis approach using the ten questions from the Empira Falls Prevention program as presented at the NCHCFA Fall Prevention program was implemented on 12/14/13. The staff development coordinator, director of nursing, and corporate nurse consultants conducted in service trainings for nursing staff on the ten questions, which follow: 1. Ask resident: are you ok?	

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
	345153	A. BUILDING _____ B. WING _____	C 11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC RD SALISBURY, NC 28144

(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 323	Continued From page 2 was not indicated. Under " Neuro (Neurological) Checks " the note said " Pupils equal and reactive to light, (immediately after). Bilateral hand grip firm. " There was no apparent injury and the teaching done was " instructed resident on use of call light " . The immediate actions taken were " Resident assisted back to reclining chair. Resident reclined with feet up. " Nurse #1, who worked with Resident #70 on the evening of 9/30/13 when he had a fall incident (slipped from his recliner chair), was interviewed on 11/15/13 at 3:30 PM and stated that she vaguely, remembered Resident #70 sliding out of his chair on 9/30/13. When asked about the position of the recliner chair he slid out of she stated she did not remember and she did not remember what footwear he was wearing at the time, but believed he always wore gripper socks. She stated that she recalled him having bed and chair alarms and a personal alarm. She did not recall if she heard an alarm ringing when he slipped off the recliner chair or if she was the staff member who initially found the resident sitting on the floor. Nurse #1 did not know what the resident had been trying to do as he slipped to the floor, how long he had been in the chair or who helped him to the chair or if he got in the chair himself. She did say that the resident ' s call bell had been in his recliner within reach but that he would forget to use it. She acknowledged that her documentation did not include any of the details she was being asked about and she had not asked any of the Nursing Assistants for information about what the resident had been doing, or what care had been provided and when. She said that she had also not been asked for more information by anyone who attended the weekly Interdisciplinary Team meeting. Nurse #1	F 323	2. Ask resident: what were you trying to do? 3. Ask resident or determine: What was different this time? 4. Position of the resident: Did they fall near a bed, toilet or chair? How far away? On their back, front, L side or R side? Position of their arms and legs? 5. What was the surrounding area like? Noisy, busy, or cluttered? If in bathroom, contents of toilet? Poor lightening or visibility? Position of furniture and equipment? Correct bed height? 6. What was the floor like? Wet floor? Urine on floor? Uneven floor? Shiny floor? Carpet or tile? 7. What was the resident□s apparel? Shoes, socks, slippers, bare feet, poorly fitting clothes? 8. Was the resident using an assistive device? (walker, cane, wheelchair, merry walker, other) 9. Did the resident have glasses and /or hearing aides on? 10.Who was in the area when the resident fell? C. Staff members from all departments were trained on team approach to monitoring for and responding to falls by	

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
	345153	A. BUILDING _____ B. WING _____	C 11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC RD SALISBURY, NC 28144

(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 323	Continued From page 3 added that the falls were also reviewed in the weekly Interdisciplinary Team meeting and new interventions were sometimes added at that time. On 10/7/13 at 11:09 AM, Nurse #2 discontinued the falls Care Plan problem statement, goals and interventions in the electronic medical record. The same problem statement, goal, and interventions for Resident #70 ' s fall risk that had been originally written on 6/14/13, were then reinstated in the electronic medical record by Nurse #2, on 10/7/13 at 11:09 AM, with a new 3 month review date. There were no changes to the care plan when it was reinstated. Review of the Supportive Devices orders dated 10/7/13 at 12:04 PM revealed " Resident does not have floor mat. Still has low bed and side rails for mobility. " On 10/8/13 at 2:51 PM ativan (lorazepam) was documented in the Nursing Note as being given for agitation. On 10/8/13 at 3:04 PM the Nursing Note revealed Resident #70 pulled out his indwelling urinary catheter and he was then transferred to the Emergency Room by EMS (Emergency Medical Services) for treatment and evaluation. A Readmission Note dated 10/8/13 revealed Resident #70 returned to the facility at 6 PM with a new urinary catheter inserted. Review of the Plan of Care Note dated 10/8/13 at 4:31 PM, indicated the Interdisciplinary Team met to discuss Resident #70 ' s plan of care and that they discussed that he had " No falls " . This was the first Plan of Care meeting note following the	F 323	staff development coordinator, director of nursing, unit managers, and corporate nurse consultants. This includes recognition and reporting of possible hazards and resident behaviors that may lead to a fall, using a team huddle immediately following a fall, intervening when safe to do so and obtaining immediate assistance when a fall appears likely or imminent. D. Nurses were trained on documentation of falls, investigation, and follow-up by staff development, director of nursing, unit managers, and corporate nurse consultants from Dec. 10 to Dec. 14, 2013. Documentation includes reporting of contributing factors, physical assessment, and immediate measures taken to reduce risk of subsequent falls. E. Fall incident reports will be reviewed and evaluated no later than the following day to ensure that appropriate measures were put in place. Director of Nursing, unit manager, or weekend supervisor will be responsible. F. Falls will be reviewed by the interdisciplinary team in weekly at risk meetings to evaluate if measures that were put into place are effective and to observe for any trends. Measures put in place to ensure solutions are sustained: In order to monitor performance and make sure solutions are sustained, the	

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
	345153	A. BUILDING _____ B. WING _____	C 11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC RD SALISBURY, NC 28144

(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 323	Continued From page 4 residents first fall in the facility on 9/30/13. Review of the electronic medical record dated 10/8/13 revealed documentation of a second fall incident. According to the notes Resident #70 was observed on the floor at 7:30 PM and he was confused. Under the heading ' Contributing Factors ' the note stated " history of falls did not call for staff assist Resident did not use call bell. " The location of the incident was the resident ' s room and the activity at the time of the incident was " unknown. " There were no witnesses or staff involved indicated in the note. The following vital sign was documented BP 130/70. Under the heading " Injury " the note said " Right leg appears to be broken. EMS (Emergency Medical Services) called immediately. Resident not moved until EMS arrived. " Another Nursing Note dated 10/8/13 at 10:34 PM indicated that at 7:30 PM Resident #70 was observed on the floor with right swollen leg and upper thigh and his right lower leg at a 90 degree angle. At 7:45 EMS arrived and stabilized the resident for transfer to the hospital and the family was notified. Nurse #1 also worked with Resident #70 on 10/8/13 when he had his second fall. During interview on 11/15/13 at 3:30 PM she stated Resident #70 returned to the facility after supper but they had kept his meal tray for him. Nurse #1 said that one of the Nursing Assistants brought Resident #70 ' s tray and she (Nurse #1) and the Nursing Assistant set Resident #70 up for supper. Nurse #1 said she went back to Resident #70 ' s room to check on him because he couldn ' t give very coherent answers when she had tried to ask him questions on his return from the hospital and	F 323	director of nursing and/or assistant administrator will audit 5 fall investigations weekly for 3 months then 10 fall investigations quarterly for one year. Audits will include timeliness of fall risk assessments, root-cause analysis, appropriate documentation and implementation of interventions, care plan updates, and nursing assessments and documentation. Findings will be reviewed quarterly by the Quality Assurance and Performance Improvement committee with changes made as needed for compliance.	

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
	345153	A. BUILDING _____ B. WING _____	C 11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC RD SALISBURY, NC 28144

(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 323	Continued From page 5 did not seem like his normally pleasant self. She said the next time she went to check on him he was on the floor. She could not recall if an alarm was ringing at that time. Nursing Assistant #2 (NA #2) who worked with Resident #70 on 10/8/13 when he had his fall was interviewed 11/15/13 at 5:20 PM. She stated that the fall on 10/8/13 happened around supper time, but it was a late supper because they had to hold his tray for him. She also remembered family was in to visit before he fell but had already left. NA#2 said she was not the staff member who set up the resident ' s tray for dinner but that he had been set up to eat in his bed, which was where he usually ate. She said that he was sometimes confused or anxious but that on the evening of 10/8/13 he seemed more confused than usual and that she thought maybe it had something to do with his transfer to and from the hospital that day. NA #2 added that because the resident was eating dinner in bed the bed was not in the low position, since the over bed table would not reach low enough. She added that otherwise the bed was always low. NA#2 also said that Resident #70 usually had a floor mat on the floor but it was not on the floor at that time. NA#2 said Resident #70 usually wore protective booties on his feet but he did not have them on when she was called to his room and saw him on the floor and she didn ' t think he had socks on either. NA #2 also indicated that Resident #70 had an alarm on his bed and recliner but she did not recall if alarmed or not when he fell. The Hospital History and Physical dated 10/8/13 revealed " presents (with) mechanical fall from standing at SNF (Skilled Nursing Facility) just PTA (prior to arrival) with R (right) femur deformity.	F 323		

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
	345153	A. BUILDING _____ B. WING _____	C 11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC RD SALISBURY, NC 28144

(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 323	Continued From page 6 Per facility pt (patient) got OOB (out of bed) and tried to walk to bathroom, fell, and was found on floor. " The Problems list dated 10/9/13 revealed " Falls: Reported as mechanical by EMS, but also noted that he was found lying on the floor by SNF staff, which suggests it may have been un-witnessed. Possibly due to orthostatic hypotension (postural hypotension), afib with RVR (atrial fibrillation with rapid ventricular response) or lorazepam (ativan). The Plan included " discontinue home lorazepam (ativan). " The Hospital Discharge Summary dated 11/1/13 revealed Resident #70 had a peri-prosthetic femoral shaft fracture (a break near the top of the femur which is the thigh bone and near or at the area of a previous hip replacement) and underwent open reduction with external fixation surgery (surgery requiring a surgical opening to repair a bone using plates and screws into the bone). Resident #70 was discharged from the hospital on 11/1/13 to another Skilled Nursing Facility. Interview with the Director of Nursing (DON) on 11/15/13 at 6 PM revealed that falls were discussed at the weekly TRECK meetings (Interdisciplinary Team meetings/Plan of Care meetings) and that the team focused on what could be done differently to prevent future falls. She added that they also looked at whether or not residents had started new medications. However, she did not indicate why there were no new interventions for Resident #70 after his fall on 9/30/13. The DON did state that new falls were discussed every morning in the weekly standup meeting. When asked how a resident ' s fall could be adequately investigated when so few details were documented she indicated that they did have more detailed data.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC RD SALISBURY, NC 28144

(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 323	Continued From page 7 Interview with the Minimum Data Set (MDS) Coordinator on 11/15/13 at 6:20 PM revealed that on 10/7/13, the day before Resident #70 fell and broke his leg, she and another staff member who was on leave at the time of the survey, did rounds in the facility to see who had supportive devices that could be discontinued. The MDS Coordinator stated that she recalled Resident #70 never had any bed or chair alarms because she did periodic rounds of supportive devices to ensure the Supportive Devices orders and Care Plans were consistent with what devices residents had and needed. She also pointed out that Resident #70 never had a Supportive Devices order for any bed or personal alarms although sometimes nurses initiated them as an intervention. The MDS Coordinator said that on 10/7/13 she and the other staff member (a Nursing Supervisor) discontinued the floor mat for Resident #70 as he hadn ' t gotten out of bed on his own and didn ' t seemed to want to because he had complaints of dizziness several months ago. She also stated that the fall on 9/30/13 was not a fall out of bed and was therefore unrelated to the floor mat. The MDS Coordinator indicated that the fall on 9/30/13 involved sliding out of a geri-chair. During this interview the MDS Coordinator indicated that the Plan of Care meeting documentation dated 10/8/13, which said Resident #70 had " No falls " , was what was discussed at the weekly TRECK (Interdisciplinary Team meeting) about Resident #70 following his fall on 9/30/13.	F 323		