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

FORM APPROVED
OMB NO. 0938-0391

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 ______	09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD 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 000	INITIAL COMMENTS IDR completed 10/17/16 with deletion of F 278.	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to keep a resident ' s bathroom clean for 1 of 40 bathrooms observed. The findings include: On 09/26/2016 at 01:47 PM a splattered brown liquid was observed on the inner rim of the elevated toilet seat in the bathroom of room #30. An additional observation at 4:37 PM revealed the splattered brown liquid remained on the inner rim of the elevated toilet seat. On 09/27/2016 at 8:20 AM the splattered brown liquid continued to be observed on the inner rim of the elevated toilet seat. On 09/27/2016, a continuous observation of room #30 from 9:40 am to 9:45 am was conducted. Housekeeper #1 was observed going in and out of the bathroom, sweeping the floor of the room and mopping the floor of the room. The housekeeper exited the room at 9:43 am. An observation of the bathroom of room #30 on 9/27/16 at 9:45 am revealed the inner rim of the elevated toilet seat continued to contain the splattered brown liquid. An additional observation of room #30 bathroom on 09/27/2016 at 2:41 PM revealed splattered brown liquid remained on the inner rim of the	F 253	**PLAN OF CORRECTION TAG #483.15 F-253** The Director of Environmental Services was contacted by the surveyor on 09/26/2016 and made aware of the observation of brown spatters on the inner rim of the elevated toilet seat in room # 30. The Director of Environmental Services immediately had the resident bathroom completely cleaned. The Director of Environmental Services personally made visits to Room # 30 several times a day for the duration of the stay of that Resident. The Director of Environmental Services then conducted an in-service on 9/26/2016 with all housekeeping staff to review required standards of cleanliness for Resident Rooms and bathrooms. Staff was instructed to make frequent re-checks for known problem areas. All resident bathrooms were inspected and found to be in compliance. Additionally, a cleaning caddy with tools and labeled chemicals has been purchased for each of the three nursing neighborhoods and stored in a locked environmental services storage room in each neighborhood. Nursing staff were in serviced on location and use of the cleaning caddies and their contents.	10/27/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William M. Johnson	Administrator	10/21/16

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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F 253	Continued From page 1 elevated toilet seat. An interview was conducted with Housekeeper #1 on 09/27/2016 at 2:47 PM. She confirmed she cleaned the bathroom for room #30 earlier today. The housekeeper stated the staff do not keep record of cleaning the bathrooms or the rooms. Housekeeper #1 was unaware the toilet seat was soiled. During an interview with the Environmental Supervisor on 9/28/16 at 9:54 AM, she reported that the housekeepers were expected to check residents ' bathrooms every 2 hours. The housekeepers were to keep a record of the rooms cleaned. She reported she would be inspecting rooms behind housekeeping staff. She reported it was her expectation that bathrooms and resident equipment would be cleaned and monitored. She was unaware the bathroom and equipment of room #30 were not cleaned. An interview was conducted with the Administrator on 9/29/16 at 11:00 AM. He stated it was his expectation the housekeeping staff would keep bathrooms and resident equipment clean.	F 253	**PLAN OF CORRECTION TAG #483.15 F-253** Continued From Page 1 A checklist was developed for performing Housekeeping Audits. The Director of Environmental Services will conduct random checks of 5 Resident Rooms/Bathrooms three times per day for four weeks. The Environmental Services weekend lead person will conduct random checks of 5 Resident Rooms/Bathrooms three times per day for two weeks. Following that period of two weeks, the daily frequency and number of rooms will remain the same; however, the checks will occur two times weekly for four weeks. Following that period of four weeks, the daily frequency and number of rooms will remain the same; however, the checks will occur one time weekly for four weeks. Following that period of four weeks, the daily frequency and number of rooms will remain the same; however, the checks will occur one time monthly for three months. These findings and log sheets will be reported at the quarterly Quality Assurance meetings.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	**PLAN OF CORRECTION TAG #483.75 F-514** The Nurse Practitioner was contacted by Director of Nursing 9-29-16 and made aware that resident #78 had refused nebulizer treatments for greater than two consecutive doses and/or had areas on medication record not documented as administered or refused. Nurse Practitioner educated	10/27/2016

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F 514	Continued From page 2 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff and nurse practitioner (NP) interview, the facility failed to maintain complete and accurate medical records as evidenced by not documenting the administration or refusal of nebulizer inhalation medication as ordered by the NP on 07/27/2016 for one of six sampled residents (Resident # 78). The findings included: Resident #78 was readmitted to the facility on 02/10/2016 with diagnoses that included chronic obstructive pulmonary disease (COPD), oxygen dependence, severe congestive heart failure (CHF) and pulmonary heart disease. Review of the most recent comprehensive minimum data set (MDS) dated 08/02/2016 revealed that Resident #78 had no cognitive impairment and made decisions regarding tasks of daily living independently and utilized oxygen therapy during the review period. Review of the care area assessment (CAA) dated 08/02/2016 revealed that Resident #78 was alert and oriented with forgetfulness at times, received oxygen due to COPD. Review of the care plan dated 08/10/2016 for Resident #78 included the problem of ineffective breathing pattern related to COPD and frequent pneumonia with shortness of breath and cough. The goal was to provide breathing comfort and prevent dyspnea for three months. Interventions included to assess respiratory status, position to facilitate breathing, administer oxygen as ordered, assist with use of respiratory devices as ordered (nebulizer treatments), keep physician informed of signs	F 514	**PLAN OF CORRECTION TAG #483.75 F-514** **Continued From Page 2** resident regarding significance of this medication on this date. Director of Nursing, Staff Development Coordinator, Wound Care Nurse and Minimum Data Set Nurses completed an audit of all resident's medication administration records on 10-20-16 to ensure that documentation on medication administration records was accurate and complete. All licensed nurses and medication aides will be in serviced regarding the medication administration record audit to be reviewed after each medication pass to ensure that documentation on the medication administration record is accurate and complete. Nurses and Medication aides will also be in serviced that the physician/Nurse Practitioner is to be contacted regarding any areas not documented as administered or refused and/or refusals of vital medications greater than two times per policy. In services completed by Director of Nursing, Staff Development Coordinator, Wound Care Nurse and Minimum Data Set Nurses by 10-27-16.	

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F 514	Continued From page 3 and symptoms of infection. A review of the NP verbal order received on 07/27/2016 was to begin ipratropium- albuterol 0.5mg/3ml-2.5 (3) mg/3ml solution dose: (3ml) inhalation three times per day (TID) breakfast, afternoon, evening for bronchospasm. The medication administration record (MARs) included a code system which indicated that resident medication refusal was initialed in red and initialed in black for medication administered as ordered. The MARs reviewed for Resident # 78 dated from 07/27/2016 through 08/31/2016 were reviewed and revealed that ipratropium-albuterol inhalation was missing nurse administration initials for breakfast on 07/28/2016 and 08/30/2016 and initialed in red for breakfast on 07/29/2016 and 08/01/2016. Afternoon doses were missing nurse administration initials on 07/28/2016, 07/29/2016, 08/29/2016 and 08/30/2016 and initialed in red on 07/31/2016. Evening dose was missing nurse administration initials on 07/27/2016, 07/31/2016, 08/28/2016, 08/30/2016 and 08/31/2016. Red initials were noted for evening dose on 08/28/2016, 08/30/2016 and 08/31/2016. Review of nurse notes dated 07/29/2016 at 8:18AM, 07/31/2016 at 2:36 PM and 08/01/2016 at 2:51 PM revealed that ipratropium - albuterol was refused by Resident # 78. On 09/27/2016 at 2:01 PM an observation of Resident # 78 was conducted. Resident # 78 was lying in bed with the head of bed elevated. Resident # 78 was wearing oxygen via nasal cannula and Resident # 78 stated that she was tired and did not wish to be disturbed as she was going to nap. On 09/28/2016 at 10:43 AM an interview with Resident #78 was made and Resident # 78 stated that she did not wish to be interviewed to discuss her medication because	F 514	**PLAN OF CORRECTION TAG #483.75 F-514** Continued From Page 3 The medication administration record will be audited by Director of Nursing, Staff Development Coordinator, Wound Care Nurse and Nurse Unit managers and charge nurses to ensure that the medication record is accurate and complete and that physician/Nurse Practitioner has been notified per policy of greater than two refusals of vital medications and/or areas that have not been documented as administered or refused. This audit will be conducted daily times two weeks, then biweekly times two weeks, then weekly times six weeks then monthly times three months. This report will be reviewed and evaluated for effectiveness quarterly in Senior Leadership Team/Quality Assurance and Performance Improvement meetings.	

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F 514	Continued From page 4 she just wanted to rest. Resident #78 stated that her medications were fine. On 09/28/2016 at 3:20 PM an interview was conducted with MDS nurses. MDS nurse #1 stated that on 07/27/2016 the NP decreased the ipratropium - albuterol nebulizer medication from QID to TID. MDS nurse #1 confirmed that medication refusal should be documented in the nurse progress notes. During the interview of the nurse notes and the MARs for Resident #78 dated from 07/27/2016 through 08/02/2016 with MDS nurse #1 and MDS nurse #2 were unable to explain why nurse initials were absent or what red initials on the MARs signified. An interview conducted with the Director of Nursing (DON) on 09/29/2016 at 7:56 AM revealed that red initials on the MAR indicated that medication had been refused by the resident and that the red initials auto-populated a nurse note for the exact date, time, medication name with dose and reason for resident refusal. The DON stated that this was confirmed by the staff development nurse (SDC). On review of the MARs dated from 07/27/2016 through 08/31/2016, the DON stated that the blank administration boxes meant that the medication was not most likely given. The DON stated that the MD or NP were in the facility every day and the expectation was that notification of two missed or refused consecutive doses of medication to be reported to either the MD or NP as stated in the policy and that there was no evidence documented to indicate such notification was provided to the MD or NP for Resident #78. The DON was unable to explain why the MARs for Resident # 78 dated 07/27/2016 to 08/31/2016 contained omitted nurse initials. On 09/29/2016 at 10:10 AM an interview with the NP revealed that she had given an order on	F 514		

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F 514	Continued From page 5 07/27/2016 to decrease the ipratropium-albuterol nebulizer to be scheduled to TID (breakfast, afternoon and evening) from QID as requested by Resident #78 because Resident #78 did not want to be awakened during the night to receive medications. Review of the MARs for 07/27/2016-08/31/2016 was conducted with the NP. The NP stated that she had not been aware of the multiple refusals of nebulizer medication by Resident #78 after decrease of dose from QID to TID and if the nurse did not initial the medication as given or as refused, that a blank on the MAR with no corresponding nurse note would indicate that the medication was likely not given as ordered. NP also reviewed medication administration policy and procedure and stated that she was aware, after review that she should have been notified of 2 consecutive medication refusals and that had not happened. The NP stated that there was lack of documentation on the MARs or in nurse notes to explain the reason for the blanks observed on the MARs. An interview conducted with the SDC nurse on 09/29/2016 at 11:29 AM revealed that the facility had no method in place to monitor medication administration or MAR documentation at present as the facility was not aware of any concerns and that the facility would address the concern as part of the daily electronic chart audits that were completed by the SDC.	F 514		