STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345152	A. BUILDING _____ B. WING _____	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY VILLAGE	1265 21 STREET NE HICKORY, NC 28601

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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 interviews the facility failed to accurately code the minimum data set to reflect a hospice resident had a prognosis of 6 months or less to live for 1 of 1 residents reviewed for hospice services (Resident #73). The findings included: Resident #73 was readmitted to the facility on 02/15/18 with diagnoses that included: Alzheimer's disease, dementia, major depressive disorder, and others. Review of a physician order dated 02/16/18 read in part, admit to routine hospice for dementia. The order was signed the Medical Doctor (MD). Review of the hospice election statement dated 02/16/18 read in part, Resident #73 had been informed that hospice offers the hospice benefit program to those who have a terminal illness and meets the criteria for admission. The form was signed by Resident #73's family and the hospice staff. Review of the most recent quarterly minimum data set (MDS) dated 05/23/18 revealed that Resident #73 was severely cognitively impaired and required extensive assistance with activities of daily living. The MDS further revealed that Resident #73 was receiving hospice care but did not indicate that she had a prognosis of 6 months	F 641	1) Resident chart did not contain information from Hospice regarding resident's prognosis, and therefore, the MDS was not marked to reflect the resident had 6 months or less to live. 2) New procedure for ensuring accurate and timely notes will include the following: a)On day of admission, Hospice will leave a copy of the agreement signed by the family or responsible party. b)Trinity Village Medical Director and the Hospice physician will each sign an order to include language stating the resident has 6 months or less to live. c)MDS nurses were in-serviced on 7-9-18 by Barbara Arrowood, DON, on the new Hospice protocol. The in-service included the steps the staff should follow: -Staff will receive Hospice agreement for services -Supervisors will pull Hospice notes off of fax and give to Trinity Village Medical Director to sign -Medical Director will send to medical records to be scanned into the resident file. New staff members will be trained during orientation. d)A meeting was held with Hospice	7/9/18

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

Electronically Signed | 07/09/2018

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F 641	Continued From page 1 or less to live which is a requirement of hospice services. An interview was conducted with the MDS Nurse on 06/13/18 at 2:52 PM who stated that she had completed the MDS dated 05/23/18 and had coded hospice service but had not coded the prognosis of 6 months or less to live because she could not find the documentation it the medical record. The MDS Nurse indicated she reviewed a variety of things to complete the MDS like nurse's notes, physician orders, staff interviews, and any assessments that had been completed. She added that the hospice election statement had not been included in Resident #73's medical record and it should have been so she could have accurately coded the MDS. The MDS nurse further stated that she would make sure the appropriate documentation was available on Resident #73 and all the hospice patients that resided in the facility. She added that she would correct the MDS right away. An interview was conducted with the Director of Nursing (DON) on 06/14/18 at 10:44 AM. The DON stated that when Resident #73 readmitted under hospice her family requested a specific hospice agency that we did not have a contract with. She added that the whole process was a bit rushed to get the contract in place so Resident #73 could readmit under the hospice service that her family requested. The DON stated she expected the appropriate hospice information to be present in the medical record so that the MDS could be accurately coded.	F 641	Representatives (Cathy Lewis, Clinical Team Leader, and Lisa Bumgarner, RN)on 7-9-18 to educate them on Trinity Village's new protocol and expectations. The meeting was facilitated by Marcheta Campbell, Administrator. e)Hospice staff will be required to sign in when visiting a resident and will leave a written note of any changes to the plan of care in a designated notebook located in the central charting room. f) The facility will request Hospice notes within the first 24 hours of visit, but will be expected within 72 hours. 3) Debbie Bright, Medical Records Director, or designee will audit the medical records of residents receiving Hospice services weekly for required documentation of Hospice visits. 4)Barbara Arrowood, DON, or designee will oversee and audit all Hospice MDS assessments for accurate documentation as assessments come due. This will be done at the weekly staff meetings to ensure the MDS is completed accurately. The DON will implement the POC. 5)All in-services will be conducted and completed by 7-12-18. New procedures regarding Hospice will be reviewed and evaluated 1 X per quarter at the QAPI meetings for 12 months. All corrective action will be completed by 7-12-18.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		7/9/18

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F 677	Continued From page 2 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews the facility failed to provide showers as scheduled to a dependent resident for 1 of 2 residents sampled for activities of daily living (Resident #86). The findings included: Resident #86 was admitted to the facility on 05/18/18 with diagnoses that included: fracture trimalleolar (fracture of the ankle/lower leg), history of falls, osteoarthritis, diabetes, and others. Review of the most recent comprehensive minimum data set (MDS) dated 05/25/18 indicated Resident #86 was cognitively intact and required total assistance of 2 staff members with bathing. Review of the Nursing Assistant (NA) guidelines for daily care for Resident #86 indicated that her shower days were Sunday and Thursday on evening shift (3:00 PM to 11:00 PM). Review of the facility's bathing documentation for Resident #86 revealed the following: 05/20/18 Sunday: Shower given 05/24/18 Thursday: Shower given 05/27/18 Sunday: Bathing did not occur 05/31/18 Thursday: Shower given 06/03/18 Sunday: Bathing did not occur	F 677	1) CNA did not give bath to resident when requested. 2) The facility will introduce an updated bath sheet on 7-9-18 that will be signed off by the hall nurse and will become effective 7-10-18. CNAs must reference bath/shower on the sheet and then report to the hall nurse of any residents who refuse a shower on the schedule for the day. The CNA or nurse will then document in the resident chart if they refused a bath/shower or if a bath/shower was held due to sickness or a change in condition. CNAs will be educated by Claudia Freeman, SDC, during new hire orientation on person centered care and resident preferences. Mentors will teach new staff on where to find daily bath/shower schedule. Nursing staff will be in-service on 7-9-18 on bath schedules and documentation by Claudia Freeman, SDC. 3)Hall nurses will monitor and sign off on daily bath/shower sheets. 4)The DON, Barbara Arrowood, or designee will audit 3 bath/shower sheets 1 X per week for 4 weeks, 1 X monthly for 4 months and quarterly for 12 months. The DON will oversee the POC.	

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F 677	Continued From page 3 06/07/18 Thursday: Shower given 06/10/18 Sunday: Bathing did not occur 06/11/18 Monday: Shower given Further review of Resident #86's medical record revealed no documentation of a refusal of showers or reason why showers were not given on 05/27/18 or 06/03/18. An interview was conducted with Resident #86 on 06/12/18 at 8:35 AM. Resident #86 stated that when she admitted to the facility on 05/18/18 she was told she would get 2 showers a week and that was fine with her if they would do that. She stated that she had a shower on 06/11/18 and that was the first time in a while she had a shower. Resident #86 stated she had never refused a shower but the staff just did not come to assist her to shower because she was non-weight bearing on her right lower leg and could not get there by herself. An interview was conducted with Nursing Assistant (NA) #1 on 06/13/18 at 4:23 PM. NA #1 confirmed that she cared for Resident #86 on 06/03/18 on the 3:00 PM to 11:00 PM shift. NA #1 stated that she had only worked at the facility for about a month and the weekend of 06/02/08-06/03/18 was the first time she had worked by herself out of orientation. NA #1 confirmed that she had not showered Resident #86 on 06/03/18 because she did not know that the facility gave showers on Sundays. She added that since then she has learned that they do give showers on Sunday and she now checked the shower schedule each time she works so she is aware of who needs a shower. An interview was conducted with NA #2 on	F 677	5)All in-services and procedural updates will be completed by 7-12-18 and reviewed at the quarterly QAPI meetings for 12 months. All corrective action will be completed by 7-12-18.	

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F 677	Continued From page 4 06/13/18 at 5:14 PM. Na #2 confirmed that she cared for Resident #86 on 05/27/18 from 3:00 Pm to 11:00 PM and confirmed that she had not given her a shower on that day. NA #2 stated she could not recall why she did not shower her that day but stated it was entirely possible that her showers had not been added to the shower sheet from her admission. An interview was conducted with the Nursing Supervisor (NS) on 06/13/18 at 5:31 PM. The NS stated that when showers were given the NA's documented it in the medical record and if the resident refused it then it should be documented and reported to the nurse so another attempt could be made. The NS stated that he expected for showers to be given according to the shower sheet. An interview was conducted with the Director of Nursing (DON) on 06/14/18 at 10:50 AM. The DON stated that she expected showers to be given as scheduled and if the resident refused or the shower was not performed she would expect to see it documented in the medical record.	F 677		
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.	F 842		7/9/18

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F 842	Continued From page 5 §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 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	F 842		

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F 842	Continued From page 6 (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 record review, hospice nurse, and staff interviews the facility failed to maintain a complete and accurate medical record for 1 of 1 residents sampled for hospice services (Resident #73). The findings included: Resident #73 was readmitted to the facility on 02/15/18 with diagnoses that included: Alzheimer's disease, dementia, major depressive disorder, and others. Review of a physician order dated 02/16/18 read in part, admit to routine hospice for dementia. The order was signed the Medical Doctor (MD). Review of the most recent quarterly minimum data set (MDS) dated 05/23/18 revealed that Resident #73 was severely cognitively impaired and required extensive assistance with activities of daily living. The MDS further revealed that	F 842	1) Resident chart was incomplete as it was missing notes from Hospice. 2) New procedure for ensuring accurate and timely notes will include the following: a)On day of admission, Hospice will leave a copy of the agreement signed by the family or responsible party. b)Trinity Village Medical Director and Hospice physician will each sign an order to include language stating the resident has 6 months or less to live. c)Nurses were in-serviced on 7-9-18 on new Hospice protocol by Barbara Arrowood, DON. The in-service included the steps the staff should follow: -Staff will receive Hospice agreement for services -Supervisors will pull Hospice notes off of fax and give to Trinity Village Medical	

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F 842	Continued From page 7 Resident #73 was receiving hospice care. Review of the medical record revealed no documentation of routine hospice visits or care. An interview was conducted with the Hospice Nurse (HN) on 06/13/18 at 2:23 PM. The HN stated that she tried to visit Resident #73 at least weekly but had to see her at least every 14 days. She added that a Nursing Assistant (NA) visited 2 times a week, the chaplain visited once a week, and a social worker would visit once a month. The HN stated that when she visited Resident #73 she would assess for any decline in her status, medication changes, pain, anxiety, falls, or wounds and she generally obtained that information from Nurse #1 or the nurse that was on the unit. The HN stated that any new orders would be communicated to the facility staff. She stated that when she had finished her visit with Resident #73 she would make a visit note in her computer but did not document in Resident #73's medical record and she did not print her notes and leave them at the facility. She explained that Resident #73 was the first resident she had at the facility and this was a new process to her and she was not sure how the facility wanted her to document but she would find out. An interview was conducted with Nurse #1 on 06/14/18 at 11:46 AM. Nurse #1 confirmed that he routinely cared for Resident #73. He stated that when the hospice nurses come to the facility they generally would ask the facility staff if there were any changes with Resident #73 and if they changed any orders the hospice nurse would make us aware. Nurse #1 stated that the hospice nurse did not document in Resident #73 ' s medical record and she did not leave a copy of	F 842	Director to sign -Medical Director will send to medical records to be scanned into the resident file. New staff members will be trained during orientation and added to the nursing checklist. A meeting was held with Hospice Representatives (Cathy Lewis, Clinical Team Leader, and Lisa Bumgarner, RN)on 7-9-18 to educate them on Trinity Village's new protocol and expectations. The meeting was facilitated by Marcheta Campbell, Administrator. e)Hospice staff will be required to sign in when visiting a resident and leave a written note of any changes to the plan of care in a designated notebook located in the central charting room. 3) The facility will requests Hospice notes within the first 24 hours, but will be expected within 72 hours. If Hospice notes are not received within 72 hours, Debbie Bright, Medical Records Director or designee will notify Hospice to ensure records are received. Debbie Bright, Medical Records Director, will audit all Hospice charts for required documentation 1 X weekly for 4 weeks, 1 X monthly for 4 months, and quarterly for 12 months. 4)Barbara Arrowood, DON, or designee will oversee the POC. 5)All in-services will be conducted and completed by 7-9-18 by Barbara	

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F 842	Continued From page 8 her documentation that could be scanned into Residents #73's medical record. An interview was conducted with the Director of Nursing (DON) on 06/14/18 at 10:44 AM. The DON stated that when Resident #73 readmitted under hospice her family requested a specific hospice agency that we did not have a contract with. She added that the whole process was a bit rushed to get the contract in place so Resident #73 could readmit under the hospice service that her family requested. The DON stated she expected the appropriate hospice information to be present in the medical record and that she had just reached out to the HN and she would leave a copy of her notes that could be scanned into Resident #73's medical record for continuity of care.	F 842	Arrowood, DON. Hospice audits will be reviewed and evaluated at the quarterly QAPI meetings for 12 months. All corrective action will be completed by 7-12-18.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		7/9/18

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F 880	Continued From page 9	F 880		

staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 10 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and physician interviews, the facility failed to maintain infection control procedures by not changing gloves during dressing changes on the same residents with two different dressing sites for 2 of 2 residents (Resident #88 and Resident #85) reviewed for wound care. The findings included: A review of the facility's Wound Care policy and procedure revealed the proper steps for dressing changes; however, the procedure did not address multiple sites on the same resident. 1. An observation on 06/13/18 at 1:16 PM of Resident #88's dressing changes to coccyx and right buttocks revealed Nurse #2 performing the dressing changes. Nurse #2 washed his hands and donned his gloves. Nurse #2 proceeded to remove the old dressings from the 2 wound sites and discarded them in the trash. Nurse #2 cleansed the coccyx wound with normal saline (NS) and applied calcium alginate to the wound bed. The wound was then covered with a foam dressing and Nurse #2 signed and dated the dressing. Nurse #2 proceeded to the second wound which was the right buttock and cleaned it with NS, patted it dry with gauze, applied silver	F 880	1) Nurse did not change gloves between providing wound care on multiple sites on a resident. 2)The organizational policy was revised and updated to reflect the proper procedures for wound care on a resident with multiple wounds. Licensed nurses and CNA II staff were in-serviced on 7-9-18 by the Staff Development Coordinator (SDC), on the updated policy and infection control related to wound care. 3) SDC will audit one resident at random and will observe wound care by staff 1 X a week for 4 weeks, 1 X monthly for 4 months and quarterly for 12 months. 4) SDC, will oversee and implement the POC and provide audit forms to the facility Administrator. 5) All in-services will be completed by 7-9-18 and audits reviewed at the quarterly QAPI meetings for 12 months. All corrective action will be completed by 7-12-18. The POC will be implemented by the SDC.	

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(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 880	Continued From page 11	F 880		

alginate and packed the wound loosely with the use of a swab stick and then covered the wound with a foam dressing. Nurse #2 then signed and dated the second dressing. The wound care to both areas was done by Nurse #2 with the same gloves on during removal of old dressings and during both dressing changes.

An interview on 06/13/18 at 2:38 PM with the wound care physician revealed he would not expect the nurse to wash his/her hands and change gloves between wounds on the same resident. The physician stated he was not concerned about cross contamination because if a resident had 2 wounds it was likely that both wounds had the same contaminant (not infection) but contaminant. The wound physician stated her wound was improving and doing much better.

An interview on 06/13/18 at 3:46 PM with Nurse #2 revealed he forgot to change his gloves in between wounds and realized it after the wound care was done. Nurse #2 stated he should have doffed his gloves after the first dressing change, washed his hands and donned new gloves before moving to the second dressing change.

An interview on 06/14/18 at 11:42 AM with the Director of Nursing (DON) revealed she expected dressing changes to be done correctly and expected the nurses to wash their hands and don clean gloves in between wound sites. The DON stated she would change her policy to reflect the procedure for dressing changes of multiple sites on the same resident.

2. An observation on 06/13/18 at 11:13 AM revealed Nurse #2 and the wound care nurse providing wound care to Resident #85. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345152	A. BUILDING _____ B. WING _____	06/14/2018

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F 880	Continued From page 12	F 880		

wound care nurse and Nurse #2 washed their hands and donned clean gloves and the wound care nurse removed the toe and calf old dressings from the resident. Nurse #2 proceeded to cleanse the toe with wound cleanser, applied Santyl to the toe wound and wrapped with gauze and applied dressing. Nurse #2 then moved to the right calf wound and cleansed it with wound cleanser, applied Adaptic and plain Acquacel and wrapped in Kerlix and Tubigrip was applied over the Kerlix. The wound care to both areas was done by Nurse #2 with the same gloves on during removal of old dressings and during both dressing changes.

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