STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345565	A. BUILDING _____ B. WING _____	03/31/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted 03/28/22 through 03/31/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 61GS11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertifiication survey was conducted on 03/28/2022 through 03/31/2022. Event ID 61GS11.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		4/20/22

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

Electronically Signed | 04/20/2022

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 690	Continued From page 1 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to maintain an indwelling urinary catheter bag and a nephrostomy bag off the floor. This was evident for 2 of 3 observations of Resident #25. Findings Included: Resident #25 was admitted to the facility on 9/1/15 and diagnoses included neuromuscular dysfunction of the bladder, urine retention and cerebral palsy. A quarterly minimum data set (MDS) dated 1/25/22 for Resident #25 identified he had an indwelling urinary catheter. A care plan dated 11/1/21 for Resident #25 revealed he had a catheter and bilateral nephrostomy tubes. Interventions included for the nurse to take care of his catheter and nephrostomy tubes and the aides to take care of his catheter equipment. An observation on 3/28/22 at 12:26 pm of Resident #25 revealed the resident ' s bed was in a lower position. The indwelling urinary catheter	F 690	1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Resident #25 was raised to a height that the catheter bag and nephrostomy bag would drain at bedside without touching the floor on 3/31/22. Staff was educated by SDC on 3/31/22 if bed is placed in lower position that basins are to be in place under catheter and nephrostomy bag to create a barrier between the floor and catheter bag. 2. How you will identify other residents having the potential to affect residents by the same deficient practice. -The Director of Nursing observed 6 residents on 3/31/22 that have catheters and/or nephrostomy tubes and all were placed in a position to allow draining and not touching the floor. 3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur;	

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F 690	Continued From page 2 bag and one nephrotomy tube bag were touching the floor. An observation on 3/29/22 at 10:00 am of Resident #25 revealed he was in bed being fed his breakfast and one nephrostomy tube bag was touching the floor. An interview on 3/30/22 at 11:42 pm with Medication Aide (MA) #1 revealed Resident #25 had a urinary catheter and a bag on each side that drained his kidneys. She stated the only thing she did was empty them and report his output to the nurse. MA #1 added the nurse was responsible for the rest of his care for the catheter and nephrostomy tubes. An interview on 3/30/22 at 12:10 pm with Nurse #1 revealed Resident #25 had an indwelling urinary catheter and bilateral nephrostomy tubes. She stated the resident ' s indwelling urinary catheter and nephrostomy tubes should be positioned so they can drain and should not be touching the floor. An interview on 3/31/22 at 11:05am with the Director of Nursing (DON) revealed Resident #25 ' s catheter should have been placed in a basin when the resident ' s bed was in a lower position, so the catheter bag was not touching the floor. She stated Resident #25 ' s nephrostomy tube bag should not have been touching the floor.	F 690	-The Director of Nursing, Infection Control Prevention RN, and Staff Development Nurse began educating on 3/31/22 on proper positioning of drainage of catheter and nephrostomy bags and placing a barrier between drainage bag and floor. Education continued thru 4/19/22. We used both in person training and our text em all system as a means to educate all clinical employees. All new residents admitted with any type of catheter will be observed for proper placement. 4.How the corrective actions will be monitored to make sure solutions are sustained. - The Director of Nursing and Staff Development nurse will observe all residents with catheter bags weekly times four (4) and then monthly times three (3) and then quarterly times (3) and will report to the Quality Assurance Committee. The audits began on 3/31/2022.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		4/20/22

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F 812	Continued From page 3 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to ensure opened foods were sealed, labeled and dated. This was evident for 1 of 1 kitchen observation. Findings Included: An observation of the kitchen on 3/28/22 at 10:50 am was conducted with the Assistant Food Service Director (AFSD). The following concerns were identified in the walk-in freezer: 1. A partial case of Salisbury steak patties that had been removed from the original packaging were not labeled and dated. 2. A partial case of breaded vegetable rounds were open and exposed to the air. 3. A partial case of pizza crusts were open and exposed to the air. 4. A partial case of French toast were open and exposed to the air.	F 812	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. A- The Assistant Food Director labeled and dated the steak patties on 3/28/22. B- The Assistant Food Director sealed the breaded vegetable rounds then labeled and dated on 3/28/22. C- The Assistant Food Director discarded the pizza crust on 3/28/22. D- The Assistant Food Director sealed, dated, and labeled the French Toast on 3/28/22. E- The Assistant Food Director sealed, dated, and labeled the pasta sheets on 3/28/22. 2.How you will identify other residents having the potential to affect residents by the same deficient practice. - The Assistant Food Director inspected all other food in the freezer to ensure that	

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F 812	Continued From page 4 5. A partial case of pasta sheets were open and exposed to the air. An interview with the AFSD revealed all these items should have been sealed, labeled and dated when opened. An interview on 3/31/22 at 11:15 am with the Administrator revealed she expected foods to be closed, labeled and dated when opened.	F 812	items were sealed, labeled, and dated on 3/28/22. 3.What Measures will be put into place or what systemic changes will you make to ensure that the deficient practice will not recur; - The Dietary Manager and Assistant Food Director completed an in-service for all dietary staff on the proper procedures of food safety (sealing, labeling, and dating). Staff educated on notifying Dietary Manager and Assistant Food Director of any items that are not stored properly during in person education by 4/15/22. 4.How the corrective actions will be monitored to make sure solutions are sustained. - Dietary Manager, Assistant Food Director, or cook supervisor will audit freezer three times a day to ensure compliance for 30 days, then two times weekly for the next 3 months to ensure compliance. New hires will be educated on food safety. Results from all audits will be reported to Quality Assurance Committee. These audits began March 28,2022.	