STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	**631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412**

(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 and complaint survey was conducted on 4/25/22 through 4/28/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # MH2T11.	E 000		
F 000	INITIAL COMMENTS A complaint investigation and recertification survey was conducted from 4/25/22 through 4/28/22. Event ID# MH2T11. The following intakes were investigated: NC00187751,NC00183503, and NC00181551. 1 of the 7 complaint allegations was substantiated resulting in deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		5/20/22

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

Electronically Signed | 05/19/2022

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F 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the Resident Representative of a significant change in condition following a seizure for 1 of 5 residents reviewed for a significant change, Resident #137. Findings included: Resident #137 was admitted to the facility on 01/05/22 with diagnoses that included unspecified	F 580	Resident discharged on 2/4/22 Beginning on 5/19/22, all licensed nursing staff will be re-educated on LSC Policy: Change in Resident□s Status or Condition, prior to next scheduled shift. In-service to include what is considered a significant change, notification of physician, internal reporting, expectations related to immediate notification of	

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F 580	Continued From page 2 convulsions. He was discharged to home with Hospice services on 02/04/22. Review of a physician progress note written on 02/03/22 documented, "Patient had a seizure at 5:30 AM today. He is now in bed. Very sleepy. (Resident Representative) arrived ...Patient very lethargic. Was not waking up and it was 6 hours since seizure." In an interview with the Director of Nursing (DON) on 04/27/22 at 7:25 AM she stated when she had arrived at work on 02/03/22 at 7:30 AM she overheard nurses reporting Resident #137 had a seizure earlier in the shift. At 10:30 AM she stated she became involved with the situation because the Resident Representative had arrived and was upset because no one had called her to tell her about the seizure. In an interview with Nurse #4 on 04/27/22 at 4:20 PM she stated she cared for Resident #137 the morning of 02/03/22 when he had a seizure. She reported she had been summoned to the room by the nurse aide. The resident was sitting on the side of the bed when she entered so she helped the nurse aide return the resident to bed. She recalled the seizure happened around 5:45 AM and she still had 20 or 30 residents to pass medications to before changing shifts. She stated his vital signs and blood sugar were good, so she continued to work but kept checking the resident. She reported she had called the physician who told her she was on her way and would see Resident #137 first. She concluded she had told the on-coming nurse she would call the family but something else happened on the unit that distracted her, and she forgot to call the family. She stated she knew she should have	F 580	family/representative, documentation, and other nursing protocols. Neighborhood Coordinators will check 24-hour report daily, Monday-Friday, to identify any resident with significant change. Neighborhood Coordinator will bring list of any identified residents with significant changes to daily clinical meeting for Director of Nursing or designee to review. Director of Nursing or designee will verify that timely notification of resident representative occurred and is documented in the EMR. If timely notification did not occur, Director of Nursing will re-educate the responsible Nurse and/or issue disciplinary action □ up to or including termination. Director of Nursing will monitor daily for 2 weeks, then weekly for 1 month and present results of audits in quarterly QAPI meeting on 7/28/22	

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F 580	Continued From page 3 called the family.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 585		5/19/22

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F 585	Continued From page 4	F 585		

can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions

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F 585	Continued From page 5 regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a written grievance summary for 2 of 2 residents (Resident #46 and Resident #79) reviewed for grievances. Findings included: 1. Resident #46 was admitted to the facility on 04/01/21 and discharged to the hospital on 04/23/22. The Minimum Data Set (MDS) annual assessment dated 03/15/22 revealed the resident was cognitively intact. A review of a Resident Concern Form dated 04/16/22 revealed Resident #46 reported he did not get his shower on 04/14/22 because the facility did not have time on second shift. A response to the concern form written by the Assistant Director of Nursing (ADON) revealed the Nursing Assistants (NAs) were educated	F 585	Administrator educated Social Workers on 5/19/22 on the LSC policy of guaranteed fair treatment Education included: definition of a grievance, investigation of grievance, how to complete a written summary of facility□s response to person who filed grievance, and timeliness of these notices. All grievances will be acknowledged by the department manager or designee within 24 hours of receipt and responded to within 3 working days, unless all parties are notified that additional time is needed. The person filing the grievance will receive a written summary of grievance, steps taken to investigate, conclusion, whether grievance confirmed or not confirmed, and any corrective action	

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F 585	Continued From page 6 about giving showers before working on their charting or preparing food menus. The Resident Concern Form for "written notification given" or notification sent by "Email or postal mail" was blank. An interview with Social Worker (SW) #2 on 04/28/22 at 3:30 PM revealed when she received the resident concern forms she would check to see what the concern was regarding, record the concern on the Resident Concern Form and Grievance Log, and then forwarded the concern to the appropriate department for them to address. SW #2 stated she did not do any kind of follow up to see if the grievance was taken care of or to ensure that written notification was given Resident #46. An interview with the ADON on 04/28/22 at 4:00 PM revealed that she investigated the grievance for Resident #46 but did not provide written notification to the resident because she thought SW #2 completed the process with the follow up and written notification. An interview was conducted with the Administrator on 04/28/22 at 4:30 PM. The Administrator stated he expected the staff to follow the company policy and provide the person filing the concern written notification regarding the outcome of the concern. The Administrator stated it was important to complete the process to ensure the person filing the concern was satisfied that their concern was addressed. 2. Resident #79 was admitted to the facility on 03/03/16. The MDS significant assessment dated 04/11/22 revealed Resident #79 was severely cognitively impaired.	F 585	taken. Administrator or Director of Nursing will verify that written summaries are provided for all grievances 1 time per week until next QAPI on 7/28/22. If in violation of LSC policy occurs reeducation will occur and/or disciplinary action-up to and including termination. Social Worker will provide summary of grievance and written notifications provided during quarterly QAPI report, ongoing.	

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F 585	Continued From page 7	F 585		

A Resident Concern Form written on 04/24/22 revealed Resident #79' s responsible party (RP) was unhappy with residents' care and stated the facility was too short staff to provide appropriate care. A response to the concern written by the ADON on 04/24/22 revealed the ADON spoke to the RP regarding other options for her to consider such as hospice care or taking Resident #79 to another facility, but the RP declined. The ADON addressed staffing at the facility and offered the RP to speak to the Administrator, but the RP declined. The Resident Concern Form for "written notification given" or notification sent by "Email or postal mail" was blank.

An interview with SW #2 on 04/28/22 at 3:30 PM revealed when she received the resident concern forms she would check to see what the concern was regarding, record the concern on the Resident Concern Form and Grievance Log, and then forwarded the concern to the appropriate department for them to address. SW #2 stated she did not do any kind of follow up to see if the grievance was taken care of or to ensure that written notification was given Resident #79' s responsible party.

An interview was conducted with the ADON on 04/28/22 at 4:00 PM. The ADON revealed she had spoken with the RP regarding her concerns and informed the RP that two staff members were assigned to Resident #79 daily to complete his care. The ADON stated she did not provide Resident #79' s RP a written notification regarding the outcome of the grievance. The ADON stated she thought SW #2 completed the process with the follow up and written notification.

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F 585	Continued From page 8 An interview was conducted with the Administrator on 04/28/22 at 4:30 PM. The Administrator stated he expected the staff to follow the company policy and provide the person filing the concern written notification regarding the outcome of the concern. The Administrator stated it was important to complete the process to ensure the person filing the concern was satisfied that their concern was addressed.	F 585		
F 641 SS=B	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 quarterly assessment to reflect a resident's (Resident #38) behaviors and refusal of care on one of 19 residents reviewed. Findings included: Resident #38 was admitted to the facility on 09/02/18. Diagnoses included, in part, dementia without behavioral disturbance. Review of the nursing progress notes revealed: On 03/08/22 a behavior note written at 6:04 AM revealed Resident #38 scratched Nursing Assistant during morning brief change and yelled loud enough to be heard down the hallway. On 03/08/22 at 9:03 AM a nursing progress note listed Resident #38 refused to take her scheduled morning medications.	F 641	MDS Nurse corrected quarterly MDS assessment and resubmitted on 4/25/22. Administrator educated Social Workers on 5/19/22 on expectation that all assessments must accurately reflect the resident□s status. MDS Nurse educated Social Workers on how to retrieve accurate information from the EMR. Social Workers can demonstrate proficiency in utilization of the EMR. MDS Nurse will audit 3 assessments per week for each Social Worker through 7/28/22 - ensuring accurate coding for moods, behaviors and any other entry. If inaccuracies are found, MDS will immediately report to Administrator and will ensure that corrections are made prior to submission of the assessment.	5/19/22

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F 641	Continued From page 9 On 03/09/22 a nursing progress note at 10:50 PM revealed Resident #38 refused to take scheduled at hour of sleep (HS) medications. On 03/10/22 a nursing progress note at 5:19 AM revealed Resident #38 refused to take her scheduled early morning medications. On 03/10/22 a nursing progress note written at 10:04 AM revealed Resident #38 refused to take her morning scheduled medications and stated, "Get out of here with those things." On 03/10/22 a nursing progress note written at 3:21 PM revealed Resident #38 refused to have her weekly skin check. The Minimum Data Set quarterly assessment dated 03/15/22 revealed the resident was severely cognitively impaired and demonstrated no behaviors. An interview was conducted with the Social Worker on 04/28/22 at 11:37 AM. The Social Worker reported she was responsible for completing sections C, D, E, Q in the MDS assessment. She stated section D was where she would record any behaviors she noted. The Social Worker stated she completed her assessment within 7 days of assessment reference date and checked the section for behaviors during the look back period. The Social Worker reviewed the notes she had access to in the computer under behaviors and stated she missed the note regarding the behavior on 03/09/22 of the resident scratching the nursing assistant and did not capture that on the MDS assessment during that look back	F 641	MDS Nurse will present a summary of findings to quarterly QAPI meeting 7/28/22.	

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F 641	Continued From page 10 period. During the interview, the Social Worker reported she did not have access to the nursing progress notes to capture that Resident #38 was refusing medications and care. An interview was conducted with the Executive Director (previous Administrator) on 04/28/21 at 4:30 PM and she reported the Social Worker was not aware she had access to the progress notes, but she did have access. The Administrator stated she was now aware of how to access the nursing progress notes and should have been aware prior. An interview with the present Administrator on 04/28/21 at 4:30 PM revealed his expectation of the Social Worker was to ensure she captured all behaviors in the MDS assessment including refusal of care so that the assessment reflected the resident's current care.	F 641		
F 885 SS=C	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of	F 885		5/19/22

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F 885	Continued From page 11 transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to notify residents, resident representatives, and families of a COVID-19 outbreak by 5pm the following calendar day. Findings included: Review of the facility COVID-19 testing log revealed one confirmed positive COVID-19 case on 04/18/22 in the building. In an interview conducted with the facility Executive Director on 04/25/22 at 1:19 PM she stated the facility did not send out any notifications to residents or family members regarding the 04/18/22 confirmed positive COVID case in the building. She commented only the resident, the resident's family and the county health department were notified. She noted in the past, the facility did use a mass texting/audio system to notify families and staff that there were positive COVID cases in the building, plus a sign was placed on the front door. She stated this was done in both January 2022 and February 2022 when they had confirmed positive COVID cases. She acknowledged that notifications should have been sent to residents, resident	F 885	On 4/25/22, Administrator notified all residents, resident representatives, and staff of one case of a COVID-19 positive resident detected on 4/18/22. Administrator and Director of Nursing have been re-educated on LSC policy regarding notification of families, residents, and staff regarding COVID-19 positive test results. Policy includes specific language about whom to report positive COVID-19 cases to and the time frame in which to report. This education was completed on 5/19/2022 by Executive Director of Trinity Landing and Trinity Grove. Administrator and Director of nursing will follow LSC policy and procedures regarding notification of positive COVID-19 test results to families, residents, and staff. COVID-19 notification checklist was developed 4/25/22 to confirm all steps are completed when a positive COVID-19 test result has been identified.	

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TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 885	Continued From page 12 representatives and staff within 72 hours of the identification of the positive case on 04/18/22. She reported they also usually put a sign on the front door indicating there was a positive case of COVID in the building but it was taken down after the last outbreak and they forgot to put one up this time. She concluded the facility would notify all residents, resident representatives, families and staff of the positive COVID case currently in the building and put a notice on the front door.	F 885	Administrator or Director of Nursing will ensure completion of COVID-19 positive test checklist with every positive resident case within Trinity Grove. Administrator or Director of Nursing will report findings to quarterly QAPI meeting on 7/28/22.	