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 05/09/2023

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
F 000	INITIAL COMMENTS A Complaint investigation survey was conducted from 05/08/23 through 05/09/23. Event ID# IKCH11. Intake # NC00201714 was investigated. 1 of the 1 complaint allegation did not result in deficiency.	F 000		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and	F 607		5/15/23

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

Electronically Signed | 05/19/2023

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F 607	Continued From page 1 (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their abuse policy for reporting and investigating abuse when Nurse Aide #1 failed to report allegations of staff (Nurse Aide #2) to resident abuse to facility management as soon as she observed or suspected incidents of resident abuse so that an investigation could have been conducted. This failure had the potential to affect residents in the facility. Findings included. The facility's policy titled "Abuse Investigation and Reporting for Senior Services" revised 09/19/22 revealed in part, it was the responsibility of all facility personnel to promptly report any incident or suspected incident of resident abuse or neglect to facility management. These reports may be made without fear of retaliation from this facility or staff. The person observing or suspecting incidents of resident abuse, neglect, or exploitation must report such knowledge or suspicion to the nursing supervisor or the department manager as soon as he or she is aware of an incident or potential incident. The Administrator or designee is responsible for ensuring a thorough investigation of the allegations is conducted. During a phone interview on 05/08/23 at 6:00 PM with Nurse Aide #1 she stated she was a new nurse aide and started working at this facility approximately 2 months ago in March 2023. She stated during the 2 months she worked at the facility she primarily worked the 3:00 PM to 11:00 PM shift on the locked memory care unit along	F 607	Beginning 5/8/23 all staff will be educated to LSC policy of Abuse Investigation and Reporting for Senior Services. No staff member will work after 5/15/23 without completing the education. Administrator, Director of Nursing, or Staff Development Coordinator will audit staff to ensure knowledge of Abuse Investigation and Reporting. Audit 5 employees per week for 2 weeks then 3 employees per week for 2 weeks then 5 employees per month until the next QAPI meeting on 7/20/23. Any needed re-education will happen immediatley. Administrator will report findings of audits at QAPI meeting on 7/20/23	

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F 607	Continued From page 2	F 607		

with Nurse Aide #2. She stated soon after starting on the memory care unit she became uncomfortable with the way Nurse Aide #2 provided care for the residents on the unit. She stated Nurse Aide #2 lacked patience with residents, was not gentle, and easily became frustrated with the residents. She stated she had witnessed Nurse Aide #2 rough handling residents specifically residents that required total care such as when putting residents to bed Nurse Aide #2 was very forceful with them and if a resident would try to get back up out of bed Nurse Aide #2 would push the residents back down on the bed. She stated she observed Nurse Aide #2 hold residents down by their arms and legs while in the bed and yell at the residents when she became frustrated. She stated she did not recall which residents were involved or when the incidents occurred, but these behaviors were directed at multiple residents on the memory care unit. She stated she was unaware if any residents on the memory care unit exhibited bruising or injuries resulting from Nurse Aide #2 and stated she wasn't sure if Nurse Aide #2's behaviors were intentional or not. Nurse Aide #1 stated this had been an ongoing concern and occurred frequently but stated she did not report any of this information to anyone in the facility. She stated she waited to report this information because she was a new nurse aide and didn't know if her observations were actual abuse, but then stated she realized her observations were abusive, so she reported this to someone not affiliated with the facility and that person notified Social Services of these allegations. She stated she didn't want to notify facility management because she thought there was no way Nurse Aide #2 had never been reported before. She stated she felt that Nurse Aide #2 must have been reported by

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other staff and facility management just didn't do anything about it. She stated she should not have made that assumption. She stated she had received abuse training upon hire that included recognizing signs of abuse, types of abuse, and reporting the suspicion of abuse immediately to a supervisor. She stated she should have notified the nurse on the unit, the Director of Nursing, or the Administrator of these allegations right away so that an investigation by management could have been done but stated she did not do that.

During an interview on 05/09/23 at 9:00 AM the Administrator along with the Director of Nursing (DON) each stated Nurse Aide #1 had not reported any suspicion of staff to resident abuse by Nurse Aide #2 or any staff member to either of them. The DON stated all staff received abuse training upon hire and at least annually regarding identifying, and reporting actual or suspected abuse and indicated staff were also made aware that reports of abuse may be made without fear of retaliation. The DON and Administrator both confirmed that Nurse Aide #2 had never been reported for allegations of resident abuse and they were not made aware of any suspected abuse by Nurse Aide #2. They each stated Nurse Aide #1 should have reported to either of them the suspected abuse allegations involving Nurse Aide #2 immediately so that an investigation could have be conducted.