STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345106	A. BUILDING _____ B. WING _____	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY RIDGE	**2140 MEDICAL PARK DRIVE HICKORY, NC 28602**

(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 investigation survey was conducted on 11/27/23 through 11/29/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #M18211.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted on 11/27/23 through 11/29/23. Event ID #M18211. The following intake was investigated NC00206403. One (1) of one allegation did not result in a deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		

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

Electronically Signed | 12/15/2023

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to maintain the dignity of a cognitively impaired resident (Resident #43) when a Nurse Aide made an inappropriate sexual comment about the resident's son. A reasonable person would not want another person making inappropriate sexual comments about their family members. This was for 1 of 1 resident reviewed for dignity and respect. The findings included: Resident #43 was admitted to the facility on 02/23/22 with diagnoses that included Alzheimer's disease, dementia with behaviors, depression, and insomnia. A review of Resident #43's annual Minimum Data Set assessment dated 11/02/23 revealed resident was severely impaired with no psychosis,	F 550	Past noncompliance: no plan of correction required.	

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behaviors, rejection of care, or instances of wandering.

A review of Resident #43's care plan, last updated on 11/10/23 revealed a care plan for "I have cognitive deficits and do not consistently recognize my needs". Interventions included to use Resident #43's name, identify yourself at each interaction, face Resident #43 when speaking, and to make eye contact when speaking to her. Interventions also included to provide Resident #43 with necessary cues and to stop and return if agitated.

Review of a facility provided allegations of abuse, neglect, or misappropriation revealed Resident #43 was involved in an altercation with a nurse aide (Nurse Aide #1) in which Resident #43 used a racial slur directed towards NA #1 and in return, NA #1 got into Resident #43's face and told her she would have sex with Resident #43's son so Resident #43 would have interracial grandbabies. This interaction was reported to the facility by Resident #43's sitter (Sitter #1) several days after the interaction.

An interview with Sitter #1 on 11/29/23 at 1:38 PM revealed she was not the sitter who was present with Resident #43 at the time of the incident. She reported Sitter #2 was there and notified her of the interaction between NA #1 and Resident #43. Sitter #1 reported Resident #43 was "really bad" about using derogatory racial slurs towards persons of color and that it was her understanding that Resident #43 used a racial slur towards NA #1 and that NA #1 moved close to Resident #43's face and asked Resident #43 if she would like it if NA #1 had intercourse with Resident #43's son and had an interracial child.

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Sitter #1 reported Sitter #2 contacted her after the incident and asked her to come in early because Resident #43 was upset. Sitter #1 reported when she arrived at the facility, Resident #43 was still upset but Sitter #1 was able to get her to take a nap and when she awoke, Resident #43 had no recollection of the interaction with NA #1.

During an interview with Sitter #2 on 11/29/23 at 3:19 PM, she reported she had sat with Resident #43 for almost 4 years and that she remembered the incident well. Sitter #2 reported Resident #43 had been a little aggressive and disruptive that afternoon. She reported she and the staff decided to remove Resident #43 from the dining room as she was disrupting other residents and she, NA #1, and Restorative Aide #1 took Resident #43 back to her room. She reported once they got Resident #43 to her room, Resident #43 uttered a racial slur directed towards NA #1. She stated NA #1 retorted that she would have intercourse with Resident #43's son and have an interracial child. Sitter #2 reported she felt the interaction was inappropriate and it upset Resident #43. She also reported she ended up reporting the incident to Sitter #1 when she came to the facility. Sitter #2 verified she did not report the incident to any staff members.

During an interview with Restorative Aide #1 on 11/29/23 at 1:55 PM, he reported he remembered very little about the incident. He stated he believed that Resident #43 had been irritated and aggressive that day and he, NA #1, and Sitter #2 had removed Resident #43 from the dining room because she was disturbing other residents. Restorative Aide #1 reported when they got Resident #43 to her room, she directed a racial slur towards NA #1 who responded that she

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would go and try to date Resident #43's son and have an interracial child. Restorative Aide #1 stated Resident #43 became more agitated and upset after the interaction. He stated he reported the incident to the Assistant Director of Nursing (ADON).

An interview with the ADON on 11/29/23 at 3:42 PM, she reported she was made aware several days after the incident occurred when Sitter #1 informed her of the incident between Resident #43 and NA #1. She stated as soon as she was informed, she notified the Administrator. She reported NA #1 was also immediately suspended pending the results of the facility's investigation. She stated the facility investigated the incident as possible verbal abuse. She reported when she interviewed NA #1, she denied doing anything inappropriate even after being confronted with the statements from the other staff and visitors that were present at the time of the incident that verified the incident occurred. The ADON reported NA #1 was subsequently terminated and they completed education on the importance of ensuring interactions were respectful and appropriate. She also reported the incident was placed in the quality assurance plan and had been monitored.

During an interview with the DON on 11/29/23 at 4:50 PM, she reported she was made aware of the incident between Resident #43 and NA #1 after it occurred as she was out of the facility at the time. She stated it was her understanding that Resident #43 directed a racial slur towards NA #1 and NA #1 retorted, telling Resident #43 that she would have intercourse with Resident #43's son and have an interracial child. She reported she knew there was an investigation into

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the incident and that NA #1 was ultimately terminated. She also reported the administration provided education to all staff on the importance of ensuring all interactions with residents were appropriate, interviewed alert and oriented residents, and included the incident in the facility quality assurance process. The DON also stated the facility had been randomly monitoring interactions between staff and residents in the middle of provided care and would continue to randomly monitor the interactions for 3 months. The DON reported the interaction was completely unacceptable and she expected her staff to treat all residents with respect and dignity.

During an interview with the Administrator on 11/29/23 at 4:57 PM, she reported she was aware of an incident between NA #1 and Resident #43, where NA #1 told Resident #43 that she would have intercourse with her son and have an interracial child after Resident #43 directed a racial slur towards NA #1. The Administrator reported the facility investigated the incident and ultimately terminated NA #1. She also reported the incident was placed into the facility's quality assurance program and random interactions between staff and residents during care were being monitored. She also reported the facility administration completed education to the staff regarding appropriate interactions with residents and what to do if a resident is belligerent or aggressive in the facility and reported the incident to the state agency. She reported while the facility continued to monitor interactions between staff and residents, she felt the facility was back in compliance effective 08/21/23.

Multiple attempts to reach NA #1 via telephone were unsuccessful.

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F 550	Continued From page 6 Review of facility provided monitoring tools revealed the facility had completed a 24 hour and 5 working day report upon notification of the incident and completion of their investigation. The investigation revealed written statements from all parties involved, a termination notification for NA #1, education with sign-in sheets for all staff in the facility regarding appropriate interactions towards residents and what to do when a resident is agitated, interviews with alert and oriented residents, and finally monitoring tools for ongoing monitoring to ensure the issue was resolved with random observations of interactions between staff and residents during care. The facility indicated they were back in compliance on 08/21/23. While onsite during the recertification survey the plan of correction submitted by the facility was validated by interviews with staff who confirmed that they had received education regarding what to do when a resident is agitated and expectations of appropriate interactions towards residents at all times, review of skin checks and interviews, and monitoring tools. The facility date of compliance of 08/21/23 was validated.	F 550		