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 03/27/2025

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 March 24, 2025 through March 27, 2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5T2811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from March 24, 2025 through March 27, 2025. Event ID # 5T2811. The following intakes were investigated NC00214521, NC00214508, NC00214594, NC00219700, and NC00224764. Seven (7) out of seven (7) allegations did not result in deficiency.	F 000		
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 a Medicare 5-day Minimum Data Set assessment for the use of antipsychotics for 1 of 5 residents reviewed for unnecessary medications (Resident #87). The findings included: Resident #87 was initially admitted to the facility on 01/16/25 with diagnoses that included dementia with behaviors and cognitive communication deficit. Resident #87 subsequently readmitted to the facility on 03/07/25 after a brief hospitalization.	F 641	Plan of Correction for Deficiency F641 1. Deficiency Identification Citation: F641 - Based on record review and staff interviews, the facility failed to accurately code a Medicare 5-day Minimum Data Set (MDS) assessment for the use of antipsychotics for 1 of 5 residents reviewed for unnecessary medications (Resident #87). 2. Corrective Action for Residents Affected and for Other Residents •Immediate Actions for Resident #87: •The MDS assessment for Resident	4/16/25

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

Electronically Signed | 04/16/2025

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F 641	Continued From page 1 Review of Resident #87's Medicare 5 day Minimum Data Set (MDS) assessment dated 03/14/25 revealed he was not receiving antipsychotic medications. Review of Resident #87's physician orders revealed an order dated 03/07/25 for Seroquel Oral tablet (antipsychotic medication) 25 milligrams (mg). The order was for Resident #87 to take ½ of a tablet, one time a day for mood disorder. Review of Resident #87's medication administration record revealed he received Seroquel 25mg starting on 03/07/25. During an interview with MDS Nurse #1 on 03/27/25 at 11:09 AM, she reported when she completed Minimum Data Set assessments, she reviewed residents' medication administration records and physician orders. She stated she was aware that Resident #87 was taking Seroquel at the time she completed the Minimum Data Set assessment and must have miscoded it in error. An interview with the Director of Nursing, on 03/27/25 at 11:22 AM, revealed Resident #87 had discharged from the facility and when he returned, he came back with a new physician order for Seroquel. She reported MDS nurses typically reviewed all of a resident's medications when they complete the Minimum Data Set assessments. She indicated that Resident #87's Minimum Data Set assessment dated 03/14/25 should have accurately represented his current use of an antipsychotic medication.	F 641	#87 was immediately reviewed and corrected to accurately reflect the use of antipsychotics. •The care plan for Resident #87 was reviewed and updated accordingly. •Actions for Other Residents: •A comprehensive audit of all current residents receiving antipsychotic medications was conducted to identify any other inaccuracies in MDS coding. •Any discrepancies found were corrected immediately, and care plans updated accordingly. 3. Systemic Changes •Policy/Procedure Updates: •The facility's internal procedure on MDS coding was revised to include a mandatory double-check process for accuracy, specifically focusing on the coding of antipsychotic medication use. This is tracked by MDS coordinators utilizing a tracking log for antipsychotic MDS coding. •Training: •All MDS Coordinators received education on accurate MDS coding practices, with an emphasis on the documentation and coding of antipsychotic medications. 4. Monitoring and Quality Assurance •Regular Audits: •Monthly audits of MDS assessments will be conducted by the Quality Assurance (QA) team to ensure ongoing accuracy in coding, with a focus on antipsychotic medication use. Frequency as follows: •10 MDS Per Month for 1 Quarter •8 MDS Per Month for 1 Quarter	

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F 641	Continued From page 2 During an interview with the Administrator on 03/27/25 at 12:03 PM, she indicated she expected resident Minimum Data Set assessments to accurately reflect the individual resident and their care needs and that included the medications that particular resident was currently taking.	F 641	•6 MDS Per Month for 1 Quarter •4 MDS Per Month for 1 Quarter •Quality Assurance Activities: •Quarterly QA meetings will include a review of audit findings and discussion of any necessary adjustments to policies or training programs. 5. Responsible Parties •Director of Nursing •Administrator •MDS Coordinator •Quality Assurance Designee 6. Compliance Date The facility will be in full compliance with the corrective actions by 4/16/2025	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, manufacturer's instructions, and staff and Consultant Pharmacist interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 28 opportunities, resulting in a medication error rate of 7.14% for 1 of 5 residents observed during the medication administration (Residents #25). The findings included: The manufacturer's instructions for prefilled	F 759	Plan of Correction for Deficiency F759 1. Deficiency Identification Deficiency Identifier: F759 Regulation/Standard Not Met: The facility failed to maintain a medication error rate of less than 5%, as evidenced by 2 medication errors out of 28 opportunities, resulting in a medication error rate of 7.14% for 1 of 5 residents observed during medication administration (Resident #25).	4/17/25

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F 759	Continued From page 3 Lantus insulin pen indicated that priming the insulin pen each time was an important step to ensure there were no air bubbles in the insulin and the full dose of insulin was given. Priming the insulin pen: 1. Dial up 2 units: turn the dose selector dial to 2 units, 2. Prime the pen: Press the injection button to let out any air bubbles and ensure the insulin is flowing correctly, 3. Check for a drop of insulin: you should see a drop of insulin on the tip of the needle, 4. Repeat if necessary. Resident #28 was admitted to the facility on 09/04/20 with diagnoses that included diabetes mellitus. Review of Resident #28's physician orders revealed an order dated 06/24/25 for Lantus insulin Pen injector, inject 85 units subcutaneously one time a day for diabetes mellitus. On 03/26/25 at 9:08 AM an observation was made of Nurse #1 as she removed a Lantus prefilled insulin pen from the medication cart, placed a needle on the pen and turned the dose selector to 30 units in preparation for the injection. The Nurse removed another needle from the medication cart and explained that she would need to inject Resident #28 twice because her total dose of insulin was 85 units and that was too much to inject all 85 units at one time. The Surveyor accompanied Nurse #1 to Resident #28's room where the Nurse injected the Resident with the Lantus insulin without priming the insulin pen per the manufacturer's instructions. Nurse #1 then removed the needle from the prefilled insulin pen and applied the other needle then turned the dose selector to 55	F 759	2. Corrective Action for Residents Affected and for Other Residents "Immediate Actions for Affected Residents: "Resident #25 was immediately assessed by the nursing staff to ensure no adverse effects resulted from the medication errors. The resident's physician was notified, and appropriate clinical interventions were implemented as needed. "Steps for Identifying and Protecting Other Residents: "Implemented immediate re-education sessions for all nursing staff on proper medication administration procedures, specifically focusing on priming the insulin pen appropriately before administration, and the importance of adhering to the "Five Rights" of medication administration (right patient, right drug, right dose, right route, right time). 3. Systemic Changes "Policy/Process Changes: "Introduced a new protocol requiring all nursing staff to complete a competency assessment on medication administration annually with a specific focus on insulin administration. "Implemented a standardized checklist for medication administration to ensure compliance with the "Five Rights." "Implemented Unit of Use Product Guide at each medication cart for detailed	

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F 759	Continued From page 4 units and proceeded to inject Resident #28 with the second dose of insulin again without priming the insulin pen. An interview was conducted with the Consultant Pharmacist on 03/27/25 at 12:08 PM. The Pharmacist explained that it was important to prime the insulin pen before every injection so that air bubbles were removed to ensure the total amount of insulin was delivered. The Pharmacist indicated that air bubbles can take up space that could prevent the correct dosage of insulin from being administered. Multiple attempts were made to interview Nurse #1, but the attempts were unsuccessful. Interviews were conducted with the Director of Nursing (DON) and the Administrator on 03/27/25 at 12:50 PM. The DON explained that Nurse #1 had attended the skills training which included how to utilize insulin pens therefore she could not address why Nurse #1 did not prime the insulin pen each time she gave the injection. The DON stated it was important that insulin pens be primed before injecting to remove the air bubbles and ensure all the ordered insulin dose was given to the resident.	F 759	guidance on insulin administration provided by LSA Pharmacy. "Training and Education: "Scheduled quarterly in-service training sessions on medication administration best practices and error prevention strategies for all nursing staff. 4. Monitoring and Quality Assurance "Regular Audits: "SDC or designee will conduct weekly audits of insulin administration for the next three months to monitor compliance and identify any recurring issues. "4 Per Week for 1 Month "2 Per Week for 1 Month "1 Per Week for 1 Month "Data Collection: "Track and analyze medication error rates monthly to identify trends and areas for improvement. 5. Responsible Parties "Director of Nursing (DON): Oversees the implementation of corrective actions and ensures compliance with medication administration standards. "Administrator: Provides support and resources necessary for the successful implementation of systemic changes. "Designee (e.g., Nurse Educator): Conducts training sessions and competency assessments for nursing staff.	

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F 759	Continued From page 5	F 759	6. Compliance Date The facility will be in full compliance with the corrective actions outlined in this plan by 4/17/2025	
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, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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;	F 880		4/16/25

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F 880	Continued From page 6 (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. §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 and staff interviews, the facility failed to follow their Hand Hygiene policy and procedure when the Director of Nursing did not perform hand hygiene after	F 880	Plan of Correction for Deficiency F880 1. Deficiency Identification Citation: F880 - Infection Control Regulation/Standard Not Met: The facility	

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F 880	Continued From page 7 removing gloves and donning a clean pair of gloves while providing wound care to Resident #71 and Nurse #2 did not perform hand hygiene after removing gloves and donning a clean pair of gloves while providing wound care to Resident #62 for 2 of 3 staff members observed for infection control practices (Director of Nursing and Nurse #2). The findings included: A review of the facility's Hand Hygiene policy and procedure last revised 10/12/23 revealed in part: Hand Hygiene: Policy: Practicing hand hygiene is a simple yet effective way to prevent infections. Performing hand hygiene can prevent the spread of germs, including those that are resistant to antibiotics. All teammates are trained and regularly inserviced on the importance of hand hygiene in preventing the transmission of infections. Teammates are expected to follow hand hygiene procedures to help prevent the spread of infections to other staff members, residents, and visitors. Note: Hand Hygiene means cleaning hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e., alcohol-based hand sanitizer including foaming or gel), or surgical hand antisepsis. Procedures: 4. Before donning gloves and after removing gloves. 1. On 03/25/25 at 11:25 AM an observation was made of the Director of Nursing (DON) providing wound care to Resident #71 who had a stage 3 pressure ulcer on his coccyx. The Resident was	F 880	failed to adhere to the Hand Hygiene policy and procedure, as evidenced by the Director of Nursing and Nurse #2 not performing hand hygiene after removing gloves and before donning a clean pair of gloves during wound care for Residents #71 and #62, respectively. 2. Corrective Action for Residents Affected and for Other Residents •Immediate Actions for Affected Residents: •Resident #71 and Resident #62 were immediately assessed for any signs of infection. No signs of infection were noted. •Steps for Identifying and Protecting Other Residents: •Conducted a review of all residents receiving wound care to ensure compliance with hand hygiene protocols. •Implemented immediate re-education for all staff involved in direct resident care on the importance of hand hygiene, specifically focusing on glove use and handwashing between glove changes. 3. Systemic Changes •Policy Updates: •Reviewed the Hand Hygiene policy to include specific steps and reminders for hand hygiene between glove changes. •Process Changes: •Introduced a mandatory hand hygiene competency check for all nursing staff, to be completed	

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F 880	Continued From page 8 positioned on his right side in preparation for the treatment and the previous wound dressing had been removed. The DON washed her hands and donned clean gloves and gown. The DON cleansed the pressure ulcer with wound cleanser-soaked gauze from the inside of the wound outward, then doffed her gloves and without sanitizing her hands donned a clean pair of gloves. The DON then applied and sealed the ordered dressing with an island dressing and doffed her gloves and gown, washed her hands with soap and water, gathered her supplies and trash and left the room. Interviews were conducted with the Director of Nursing (DON) and the Administrator simultaneously on 03/27/25 at 1:42 PM. The DON explained she did not realize that she did not sanitize her hands between glove changes and stated she should have sanitized her hands after doffing her gloves and prior to donning clean gloves. 2. On 03/26/25 at 11:40 AM an observation was made of Nurse #2 providing wound care to Resident #62 with the Director of Nursing (DON) assisting. Resident #62 had a stage 4 pressure ulcer on her right foot. Nurse #2 sanitized her hands and donned a clean gown and gloves and removed the dressing from the right foot ulcer and threw the old dressing in the trash can. Nurse #2 then proceeded to doff her gloves and without sanitizing her hands donned clean gloves and cleansed the pressure ulcer with wound cleanser-soaked gauze from the inside outward and applied the ordered dressing followed by an island dressing. Nurse #2 then covered the right foot with an ABD pad and wrapped it with gauze. Nurse #2 then doffed her gloves and washed her	F 880	quarterly. 4. Monitoring and Quality Assurance •Regular Audits: •Conduct weekly audits of hand hygiene practices during wound care procedures for the next three months, then monthly thereafter. •6 Residents Per Week for 1 Month •4 Residents Per Week for 1 Month •2 Residents Per Week for 1 Month •1 Resident Per Month for 9 Months •Utilize a checklist to ensure compliance with hand hygiene protocols during audits. •Data Collection: •Track and analyze data from audits to identify trends or areas needing improvement. •Report findings to the Quality Assurance and Performance Improvement (QAPI) committee monthly. •Ongoing Quality Assurance Activities: •Conduct random spot checks by infection control staff to ensure adherence to hand hygiene protocols. •Provide immediate feedback and retraining if non-compliance is observed. 5. Responsible Parties •Director of Nursing •Administrator •Infection Control Nurse (Designee) 6. Compliance Date The facility will be in full compliance with the corrective actions by 4/16/2025	

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F 880	Continued From page 9	F 880		

hands before donning clean gloves. The Director of Nursing removed the dressing from Resident #62's (2) stage 3 sacral pressure ulcers then doffed her gloves and washed her hands with soap and water after the end of the treatment. Nurse #2 cleansed the pressure ulcers with wound cleanser-soaked gauze from the inside outward and then doffed her gloves and without sanitizing her hands, donned clean gloves. Nurse #2 then applied the ordered dressing and an island dressing then doffed her gown and gloves and washed her hands with soap and water, gathered her supplies and trash and left the room.

Multiple attempts were made to interview Nurse #2 but the attempts were not successful.

Interviews were conducted with the Director of Nursing (DON) and the Administrator simultaneously on 03/27/25 at 1:42 PM. The DON explained she did not realize that Nurse #2 did not sanitize her hands between glove changes and stated she should have sanitized her hands after doffing her gloves and prior to donning clean gloves.