STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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 The survey team entered the facility on 2/17/25 to conduct a recertification and complaint investigation survey and exited on 2/18/25. The survey team was unable to return to the facility on 2/19/25 through 2/21/25 due to adverse weather of snow and unsafe travel conditions; therefore the survey was conducted remotely on 2/19/25 through 2/21/25. Additional information was obtained remotely on 2/24/25. Therefore, the exit date was changed to 2/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# YUOI11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 2/17/25 to conduct a recertification and complaint investigation survey and exited on 2/18/25. The survey team was unable to return to the facility on 2/19/25 through 2/21/25 due to adverse weather of snow and unsafe travel conditions; therefore the survey was conducted remotely on 2/19/25 through 2/21/25. Additional information was obtained remotely on 2/24/25. Therefore, the exit date was changed to 2/24/25. Event ID #YUOI11. The following intakes were investigated: NC00223438, NC00223303, NC00214066, NC00212383, NC00212300, and NC00210747. 4 of the 16 complaint allegations resulted in deficiency.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		3/6/25

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

Electronically Signed | 03/20/2025

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F 584	Continued From page 1	F 584		

comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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F 584	Continued From page 2 Based on observations, resident and staff interviews, the facility failed to maintain a clean shower room for 1 of 4 shower rooms reviewed for a safe, clean, comfortable, and homelike environment (The C-Hall shower room). The findings included: An interview with Resident #8 on 2/17/25 at 2:27 PM revealed the shower room on the C-Hall where she resides was "dirty" and there was "black mold" visible on the walls. Resident #8 stated she did not like using the shower room because it was "dirty", and she did not feel clean after her showers. An observation of the C-Hall shower room on 2/18/25 at 11:20 AM revealed there was a buildup of black grime observed around the shower fixtures, along the edges of the floor, and around areas on the wall where the paint was peeling. There was a buildup of black grime around a cabinet hanging on the wall and in the crevices around the cabinet doors. There was also a buildup of black grime observed on the feet of the shower chair and along the bottom of the shower curtain. An interview conducted with Housekeeper #1 on 2/18/25 at 12:30 PM revealed she was assigned the C-Hall shower room and cleaned it on Mondays, Wednesdays and Fridays. She indicated when she cleaned the shower room, she sprayed the walls, the floor, and the shower fixtures with a bleach solution, let it soak, and then wiped everything down. Housekeeper #1 stated she did not monitor the condition of the shower curtain, and the nursing staff were responsible for cleaning the shower chair. She	F 584	F-tag 584 □ Safe/Clean/Comfortable/Homelike Environment Facility failed to maintain a clean shower room for 1 of 4 shower rooms reviewed for as safe, clean, comfortable, and homelike environment (The C-Hall shower room). Corrective actions accomplished for those residents found to have been affected by deficient practice. No residents were directly affected. On 2/18/25 housekeeping staff deep cleaned the C-Hall shower room including spraying the fixtures, the walls and the floor with bleach solution, letting it soak, wiping everything down and mopping the floors. On 2/18/25 the Environmental Service Director (ESD) removed the dirty shower curtain and was changed. The cabinet was taken down and discarded. The walls around the shower curtain and behind the discarded cabinet were cleaned as well as the dirty shower chair. On 2/19/25 the Campus Maintenance Director (CMD) contacted a local contractor, to Prep, repair, prime and paint C-Hall shower room stall, walls and ceilings and to remove damaged caulking around tile, scrape and sand peeling paint from block walls and repair damaged drywall as needed. This was completed on 2/21/25. On 3/6/25, the tile in the bathroom was professionally steam cleaned by local contractor. Identified other residents who have the potential to be affected by the same	

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F 584	Continued From page 3 revealed she did not clean the C-Hall shower room on 2/10/25 (Monday), 2/12/25 (Wednesday), or 2/14/25 (Friday) but was unable to recall why. Housekeeper #1 stated she did not work on 2/17/25 (Monday). A phone interview was conducted with Housekeeper #2 on 2/19/25 at 4:15 PM. Housekeeper #2 revealed she covered for Housekeeper #1 on 2/17/25 (Monday) and was assigned to clean the C-Hall shower room. She stated she attempted to clean the shower room after lunch, but it was being used for a resident shower. Housekeeper #2 indicated she had other areas to clean and was unable to clean the shower room before her shift ended at 3:00 PM. An observation and interview was conducted in the C-Hall shower room with the Director of Housekeeping on 2/18/25 at 12:02 PM. He revealed Houskeeper #1 was assigned to the C-Hall shower room, and she was responsible for cleaning it daily including wiping down all surfaces with a disinfectant and mopping the floors. He further revealed Housekeeper #1 was responsible for deep cleaning the shower room on Mondays, Wednesdays and Fridays which included spraying the fixtures, the walls and the floor with a bleach solution, letting it soak, wiping everything down and mopping the floors. He stated the areas observed with a buildup of black grime on walls, around the fixtures and along the edge of the floor needed to be cleaned. The Director of Housekeeping observed the black grime on the cabinet, shower chair and shower curtain and stated Housekeeper #1 was responsible for monitoring these items and should have notified him they were in poor condition and needed to be replaced.	F 584	deficient practice and what corrective actions were taken. No residents were directly affected. On 2/18/25 housekeeping staff deep cleaned the C-Hall shower room including spraying the fixtures, the walls and the floor with bleach solution, letting it soak, wiping everything down and mopping the floors. On 2/18/25 the Environmental Service Director (ESD) removed the dirty shower curtain and was changed. The cabinet was taken down and discarded. The walls around the shower curtain and behind the discarded cabinet were cleaned as well as the dirty shower chair. On 2/19/25 the Campus Maintenance Director (CMD) contacted a local contractor, to Prep, repair, prime and paint C-Hall shower room stall, walls and ceilings and to remove damaged caulking around tile, scrape and sand peeling paint from block walls and repair damaged drywall as needed. This was completed on 2/21/25. On 3/6/25, the tile in the bathroom was professionally steam cleaned by local contractor. Measures/ systemic changes put in place to ensure the deficient practice does not recur. On 2/20/25, the ESD began re-educating the housekeeping staff on the proper way to deep clean shower rooms with the expectation that the deep cleaning of all shower rooms will occur on Monday, Wednesday, and Fridays. All housekeepers not present on 2/20/25 will complete their education before assuming their next assigned shift. All education was completed by 2/24/25. New housekeepers will receive training on the	

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F 584	Continued From page 4 A phone interview with the Administrator on 2/20/25 at 10:55 AM revealed the Director of Housekeeping managed the cleaning schedule for the shower rooms and the tasks to be completed when it was cleaned. He stated he was not aware there were several areas observed in the C-Hall shower room with a buildup of black grime or the condition of the cabinet, the shower chair or the shower curtain. The Administrator revealed the housekeepers should be cleaning the shower rooms as scheduled and if they observed equipment that was in poor condition they should report it to the Director of Housekeeping.	F 584	proper way to deep clean shower rooms during their orientation period from EVS. Monitoring of corrected actions to ensure the deficient practice will not recur. To ensure that all shower rooms are being properly deep cleaned, the EVS will audit all shower rooms using an auditing tool 1x daily for 1 month, then 1x per week for 2 months for compliance. The ESD will report the findings of audits to the Quality Assurance Performance improvement (QAPI) committee 1 x weekly for 3 months to ensure weekly compliance. The DON or Administrator will bring the results of the audits to the monthly QAPI Meeting to ensure ongoing compliance. The QAPI committee can make changes to ensure facility compliance of deficient practice.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		3/6/25

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F 600	Continued From page 5 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and staff and the Responsible Party (RP) interviews, the facility failed to protect a resident's right to be free from staff to resident abuse. While Nurse Aide (NA) #5 was providing care for a cognitively impaired resident, the resident became agitated, was whining and crying. NA #5 placed part of her hand over the resident's mouth and told the resident to "Hush, quit that whining." This deficient practice was found for 1 of 3 residents reviewed for abuse (Resident #16). The findings included: Resident #16 was admitted to the facility on 11/20/22 with diagnoses which included anxiety, cognitive communication deficit, muscle weakness, dementia, and generalized osteoarthritis. Review of the quarterly Minimum Data Set (MDS) dated 01/17/24 revealed Resident #16 was severely cognitively impaired and required extensive assistance transfers and toilet use. The MDS further revealed Resident #16 was not coded for any behaviors through the look back period. Review of Resident #16's care plan revised on 11/18/24 revealed the resident may have had altered behaviors, mood, or psychological wellbeing related to changes with health, functioning, and cognitive skills. Resident #16 had the potential or was at risk to be resistive to care, medicines, yelling out, crying and sadness, disrobing, attempting to get out of bed, difficulty to	F 600	F-tag 607 – Develop/implement Abuse/Neglect Policies “Facility failed to follow and implement abuse policies in the area of identification, protection, and reporting for 1 of 3 residents reviewed for abuse”. Corrective actions accomplished for those residents found to have been affected by deficient practice. On 1/18/24, the employee suspended pending investigation. All non-alert residents on the accused assignment were assessed for visible and mental signs of abuse. All interview able residents were asked about abuse without negative reports. Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken. On 1/18/24 the Staff Development Coordinator (SDC), unit managers and Department managers began Abuse Education with all staff using the facilities policy on abuse. Any staff not present at the time of education, were educated prior to the beginning of their shift. Measures/ systemic changes put in place to ensure the deficient practice does not recur. On 1/19/24 the Director of Nursing (DON), unit managers, and department managers educated all teammates on reporting abuse immediately to the supervisor. Then staff were educated on	

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F 600	Continued From page 6 redirect with agitation and anger. The goal was for Resident #16 to maintain comfort and dignity daily by a calm, relaxed manner, and a neat and clean appearance. Interventions included always approaching Resident #16 in a calm and relaxed manner, encouraged activity distraction, explaining all procedures and care before beginning to assist, and monitor and observe and report. Interventions also included when the resident becomes agitated staff would intervene before agitation escalate by guiding away from source of distress, engage calmly in conversation, and if response were aggressive staff would need to walk calmly away, and approach later. Review of the initial facility reported incident dated 01/18/24 at 5:30 PM revealed it was reported that a NA (Nurse Aide) mistreated a resident during care. The report further revealed the employee was suspended during the investigation. It was indicated that residents who were not alert and oriented on the unit of the incident were assessed for visible and mental signs of abuse and residents who were alert and oriented were interviewed. It was revealed Resident #16 showed no signs of physical or mental abuse found during the assessment on 1/18/24. Review of the investigation completed by the Administrator related to Resident #16's incident revealed the following: - Nurse Aide (NA) #5 statement undated read in part, "On Thursday 01/18/24 NA #5 was asked to assist to care for Resident #16 because she had tried to take her clothes off and smelled of urine. NA #5 revealed she and a Personal Care	F 600	the process of reporting the abuse event to the state within the 2-hour window. Monitoring of corrected actions to ensure the deficient practice will not recur. On 3/6/25, the DON, SDC and Unit Managers began abuse audits with 5 random staff members per week for 1 month, 2 random staff members per week for 2 weeks, and 5 random staff members a month for 1 month to ensure that staff understand the abuse policy. The DON or Administrator will bring the results of the audits to the weekly QAPI Meeting to ensure ongoing compliance. All findings will be taken to the Monthly QAPI meeting where the QAPI committee can make changes to ensure facility compliance of deficient practice.	

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Assistant (PCA) #1 took Resident #16 to her room and put her in the resident's bed to be changed. NA #5 further revealed she got the resident laid down in the bed and reassured the resident she was going to be okay once they changed her. NA #5 stated Resident #16 continued to cry while she got a washcloth and started to clean the resident and PCA #1 asked what was wrong with Resident #16. NA #5 indicated she continued to speak to Resident #16 that everything was going to be okay and to stop crying but Resident #16 continued to cry as PCA #1 continued to assist and NA #5 patted her mouth to get her to stop because they were unable to understand what the resident was saying but continued to reassure the resident that everything was okay. NA #5 revealed once care was completed on Resident #16 they got the resident in bed and comfortable to lay down and rest."

- Personal Care Assistant (PCA) #1 statement dated 01/18/22 read in part, "NA #5 put her hands over Resident #16's mouth while she was crying today and told her to be quiet around 2 PM."

A phone interview was conducted with Nurse Aide (NA) #5 on 02/17/25 at 2:50 PM and she revealed on 01/18/25 she and PCA #1 had gone into Resident #16's room and completed incontinence care. NA #5 stated when care began Resident #16 began whining and was agitated. NA #5 indicated throughout care the resident continued to be agitated and she consistently tried to calm the resident down. NA #5 stated halfway through care Resident #16 seemed upset and she took two fingers and tapped Resident #16 on the mouth three times and stated to the resident to "hush, quit that whining you are going to be fine".

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NA #5 indicated looking back she should have never tapped Resident #16 on the mouth. NA #5 revealed she was eventually let go by the facility. NA #5 stated "she was not trying to be mean to the resident but should not have tapped her on the mouth".

A phone interview conducted with PCA #1 on 02/18/25 at 12:00 PM revealed on 01/18/24 she and NA #5 went into Resident #16's room to give incontinence care. PCA #1 Resident #16 was often upset when staff changed her. PCA #1 further revealed the resident was cognitively impaired and she was unable to understand the resident. PCA #1 indicated Resident #16 started to whine and become agitated at the beginning of care. PCA #1 stated halfway through care NA #5 took her right hand and placed it over Resident #16's mouth and held it for almost 30 seconds and stated, "hush, quit that whining", in an aggressive tone. PCA #1 indicated Resident #16's eyes observed to become large in size and appeared to be "petrified". PCA #1 indicated she did not say anything to NA #5 and the care continued about 15 more minutes. PCA #1 revealed Resident #16 seemed agitated throughout the whole-time receiving care.

A phone interview conducted with Nurse #3 on 02/20/25 at 1:25 PM revealed on 01/18/24 around 5:00 PM it was reported to her by PCA #1 that NA #5 had put her hand over the resident's mouth during care and told the resident to be quiet. Nurse #3 indicated she notified the Administrator and completed an assessment on Resident #16 and found no issues or concerns during her assessment. Nurse #3 indicated Resident #16 was unable to recall any events that occurred that date.

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An interview conducted with Director of Nursing (DON) on 02/18/25 at 12:15 PM revealed on 01/18/24 she was not present in the facility but was notified there had been an incident with Resident #16 and NA #5 had put her hand over the resident's mouth and told her to hush and stop crying. The DON further revealed on 01/19/24 she spoke to PCA #1 who stated NA #5 had placed her hand over Resident #16's mouth and told the resident to "shhhhh", in an aggressive manner. The DON revealed she had completed NA #5's statement and NA #5 stated she admitted to tapping Resident #16 on the mouth three times. The DON indicated the next day skin assessments and interviews were conducted with alert and oriented residents on Resident #16's unit and no concerns were found. The DON indicated after their investigation that the facility did not feel like the incident was considered abuse due to conflicting stories by staff and there were no signs of abuse of the resident. The DON revealed Resident #16 was often confused and was resistive with care. The DON indicated NA #5 and PCA #1 should have walked away if Resident #16 was upset and agitated during care.

A phone interview conducted with the Responsible Party (RP) on 02/20/25 at 4:25 PM revealed they had not been notified of the incident that occurred on 01/18/24. The RP further revealed Resident #16 would have been very upset if she was alert and oriented and a facility staff had told her to be quiet or put their hands on her mouth.

An interview conducted with the Administrator on 02/20/25 at 1:55 PM revealed on 01/18/24 he was

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F 600	Continued From page 10 notified later during first shift around 5:00 PM that PCA #1 had observed NA #5 had spoken to Resident #16 harshly and put her hand over the residents' mouth during care. The Administrator revealed when he discussed the incident with NA #5 she denied holding her hand over the residents mouth but touched and patted the residents lips. The Administrator indicated a skin assessment was completed on Resident #16 and no concerns were found. It was revealed after the investigation that the facility did not substantiate the concern due to conflicting stories by staff and no signs of mental anguish.	F 600		
F 607 SS=D	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.	F 607		3/6/25

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F 607	Continued From page 11 §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 (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow and implement abuse policies in the area of identification, protection and reporting for 1 of 3 residents reviewed for abuse (Resident #16). While Resident # 16 was being abused, Personal Care Assistant (PCA) #1 did not stop Nurse Aide (NA) #5 or intervene and did not report the incident immediately to licensed nursing staff or administrative staff. As a result, NA #5 worked the rest of her shift putting other residents at risk for abuse. The findings included: A review of the facility policy and procedure titled "Abuse Investigation and Reporting for Senior Services", with a revised date of 04/26/22, read in part 1.) under Identification and Investigation "if the person(s) observing or suspecting incidents of resident abuse, neglect, exploitation or misappropriation of property must report such knowledge or suspicion to the nursing supervisor or his/her department manager as soon as he or she is aware of an incident or potential incident." Read in part 2.) Under Protection "while the investigation is pending, accused individuals employed by the facility will be suspended, pending the results of the investigation." Review of the investigation completed by the	F 607	F-tag 607 – Develop/implement Abuse/Neglect Policies “Facility failed to follow and implement abuse policies in the area of identification, protection, and reporting for 1 of 3 residents reviewed for abuse”. Corrective actions accomplished for those residents found to have been affected by deficient practice. On 1/18/24, the employee suspended pending investigation. All non-alert residents on the accused assignment were assessed for visible and mental signs of abuse. All interview able residents were asked about abuse without negative reports. Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken. On 1/18/24 the Staff Development Coordinator (SDC), unit managers and Department managers began Abuse Education with all staff using the facilities policy on abuse. Any staff not present at the time of education, were educated prior to the beginning of their shift. Measures/ systemic changes put in place	

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	345153	A. BUILDING _____ B. WING _____	C 02/24/2025

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F 607	Continued From page 12 Administrator related to Resident #16's incident revealed the following: - Nurse Aide (NA) #5 statement undated read in part, "On Thursday 01/18/24 NA #5 was asked to assist to care for Resident #16 because she had tried to take her clothes off and smelled of urine. NA #5 revealed she and a personal care assistant (PCA) #1 took Resident #16 to her room and put her in the residents bed to be changed. NA #5 further revealed she got the resident laid down in the bed and reassured the resident she was going to be okay once they changed her. NA #5 stated Resident #16 continued to cry while she got a washcloth and started to clean the resident and PCA #1 asked what was wrong with Resident #16. NA #5 indicated she continued to speak to Resident #16 that everything was going to be okay and to stop crying but Resident #16 continued to cry as PCA #1 continued to assist and NA #5 patted her mouth to get her to stop because they were unable to understand what the resident was saying but continued to reassure the resident that everything was okay. NA #5 revealed once care was completed on Resident #16 they got the resident in bed and comfortable to lay down and rest." - Personal Care Assistant (PCA) #1 statement dated 01/18/22 read in part, "NA #5 put her hands over Resident #16's mouth while she was crying today and told her to be quiet around 2 PM." A phone interview was conducted with NA #5 on 02/17/25 at 2:50 PM and she revealed on 01/18/25 she and PCA #1 had gone into Resident #16's room and completed incontinence care. NA #5 stated halfway through care Resident #16 seemed upset and she took two fingers and	F 607	to ensure the deficient practice does not recur. On 1/19/24 the Director of Nursing (DON), unit managers, and department managers educated all teammates on reporting abuse immediately to the supervisor. Then staff were educated on the process of reporting the abuse event to the state within the 2-hour window. Monitoring of corrected actions to ensure the deficient practice will not recur. On 3/6/25, the DON, SDC and Unit Managers began abuse audits with 5 random staff members per week for 1 month, 2 random staff members per week for 2 weeks, and 5 random staff members a month for 1 month to ensure that staff understand the abuse policy. The DON or Administrator will bring the results of the audits to the weekly QAPI Meeting to ensure ongoing compliance. All findings will be taken to the Monthly QAPI meeting where the QAPI committee can make changes to ensure facility compliance of deficient practice.	

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F 607	Continued From page 13	F 607		

tapped Resident #16 on the mouth three times and stated to the resident to "hush, quit that whining you are going to be fine". NA #5 indicated she worked the rest of the shift.

Review of NA #5's time card for 1/18/25 revealed she clocked in at 6:57 AM and clocked out at 3:39 PM.

A phone interview conducted with PCA #1 on 02/18/25 at 12:00 PM revealed on 01/18/24 at an estimated time of 2:00 PM she and NA #5 went into Resident #16's room to give incontinence care. PCA #1 Resident #16 was often upset when staff changed her. PCA #1 further revealed the resident was cognitively impaired and was unable to understand the resident. PCA #1 indicated Resident #16 started to whine and become agitated at the beginning of care. PCA #1 stated halfway through care NA #5 took her right hand and placed it over Resident #16's mouth and held it for almost 30 seconds and stated, "hush, quit that whining", in an aggressive tone. PCA #1 indicated Resident #16's eyes observed to become large in size and appeared to be "petrified". PCA #1 indicated she did not say anything to NA #5 and care continued for about 15 more minutes. PCA #1 revealed she failed to intervene and report the incident immediately due to being shocked. Once care ended PCA #1 did not report the incident she observed until between 5 to 5:30 PM to Nurse #3.

A phone interview conducted with Nurse #3 on 02/20/25 at 1:25 PM revealed on 01/18/24 around 5:00 PM it was reported to her by PCA #1 that NA #5 had put her hand over the residents' mouth during care and told the resident to be quiet. Nurse #3 indicated PCA #1 did not report the

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F 607	Continued From page 14 incident immediately and and she educated the PCA that she should have. An interview conducted with the Administrator on 02/20/25 at 1:55 PM revealed on 01/18/24 he was notified later during first shift, around 5:00 PM, that PCA #1 had observed NA #5 speaking to Resident #16 harshly and put her hand over the residents' mouth during care. The Administrator revealed he was aware PCA #1 had waited to report the incident and did not report immediately after the incident occurred. The Administrator indicated as soon as he was aware he suspended NA #5 pending the investigation.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		3/20/25

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F 609	Continued From page 15 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to include reported allegations in the initial report to the State Agency. Details were not accurately reflected for 1 of 3 residents reviewed for abuse (Resident #16). The findings included: Review of the initial facility reported incident dated 01/18/24 at 5:30 PM revealed it was reported that a Nurse Aide (NA) #5 mistreated a resident during care. It was revealed Resident #16 showed no signs of physical or mental abuse found during the assessment on 1/18/24. A phone interview conducted with Nurse #3 on 02/20/25 at 1:25 PM revealed on 01/18/24 around 5:00 PM it was reported to her by Personal Care Assistant (PCA) #1 that NA #5 had put her hand over the resident's mouth during care and told the resident to be quiet. Nurse #3 indicated she notified the administrator immediately what NA #5 had alleged. An interview conducted with the Administrator on 02/20/25 at 1:55 PM revealed he completed the initial report to the State Agency. The Administrator further revealed on 01/18/24 he was notified by Nurse #3 that NA #5 had put her hand over the resident's mouth during care and	F 609	F-tag 609 – Develop/implement Abuse/Neglect Policies “Facility failed to include reported allegations in the initial report to the state agency. Details were not accurately reflected for 1 of 3 residents reviewed for abuse”. Corrective actions accomplished for those residents found to have been affected by deficient practice. On 1/18/24 nurses assessed the resident for any signs of injury, abnormal discolorations, bruising or mental anguish outside of the resident’s normal baseline. The assessment revealed no signs of abnormal discolorations, bruising or mental anguish. The accused was suspended, and the facility began investigation. The Physician and RP were notified. Facility reported potential mistreatment to state based on initial findings. Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken. On 3/20/25, the administrator reviewed the last 6 months of reported incidents to ensure all details	

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F 609	Continued From page 16 told the resident to be quiet. The Administrator indicated he did not include the information on the initial State Agency report due to the staff statements were conflicting and did not think to add the alleged allegations.	F 609	were included in the initial and 5-day reports. 6 initial reports were reviewed and all included reported details of incidents. Measures/ systemic changes put in place to ensure the deficient practice does not recur. On 3/20/25, the Vice President of Senior Services for Lutheran Services Carolinas re-educated the administrator and Director of Nursing (DON) on Abuse Investigating and Reporting policy and reporting details on the initial and 5 day report. Monitoring of corrected actions to ensure the deficient practice will not recur. Beginning on 3/20/25, the administrator and DON will submit a draft of all initial and 5 day reports to the Vice President of Senor Services prior to submitting reports to the state agency to ensure that all details have been included in the reports. The will be completed for the next 3 months. The DON or Administrator will bring the results of the audits to the weekly QAPI Meeting to ensure ongoing compliance. All findings will be taken to the Monthly QAPI meeting where the QAPI committee can make changes to ensure facility compliance of deficient practice.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		3/14/25

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F 689	Continued From page 17 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a safe transfer for 1 of 6 residents (Resident #69) reviewed for accidents. The findings included: Resident #69 was admitted to the facility 1/07/25 with diagnoses including muscle weakness, abnormalities of gait and mobility, and mild cognitive impairment. The admission Minimum Data Set (MDS) dated 1/14/25 indicated Resident #69 was severely cognitively impaired and dependent on staff for transfers. The care plan dated 1/21/25 revealed Resident #69 required 2-person assistance for all transfers. An incident report dated 2/07/25 12:25 PM completed by Nurse #2 revealed Nurse Aide (NA) #1 was transferring Resident #69 from the wheelchair to a shower chair when Resident #69 was unable to support herself and NA #1 lowered her down to the floor. NA #1 was transferring Resident #69 without a second person and did not use a gait belt. Resident #69 was assessed, and no injuries were noted. A phone interview conducted with NA #1 on 2/19/25 at 2:38 PM indicated she was assigned to Resident #69 on 2/07/25. She revealed Resident	F 689	F-tag 689 □ Free of Accident Hazards/Supervision/Devices The facility failed to provide a safe transfer for 1 of 6 residents (Resident 69) reviewed for accidents. Address how corrective action will be accomplished for resident(s) found to have been affected: On 2/7/25, nurse immediately assessed resident for injuries with no injuries noted. The resident was transferred to shower chair by Certified Nursing Assistant (CNA) and nurse. The physician and resident representative were contacted at 12:43pm by the nurse. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: On 3/13/25, the Director of Nursing (DON) and unit managers audited transfer status on all residents. The audit started on 3/13/25, for all residents to ensure proper transfers status were correct. Audit completed by DON on 3/14/25 with 4 corrections made. Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future.	

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F 689	Continued From page 18 #69 was able to stand and pivot to transfer with 2-person assistance. NA #1 stated on 2/07/25 Resident #69's friend was coming to do her hair, and she needed to give Resident #69 a shower. She stated she was unable to find anyone to help her, so she attempted to transfer Resident #69 on her own. She stated she assisted Resident #69 to a standing position, but her legs started to give out. NA #1 revealed she lowered Resident #69 gently to the floor and called for assistance. She stated Nurse #2 and Nurse #3 responded, completed an assessment and Resident #69 was not injured. NA #1 indicated she knew that she should have waited until she was able to find someone to help, but she felt rushed, so she proceeded to transfer Resident #69 without a second person. An interview with Nurse #2 on 2/18/25 at 2:38 PM revealed she was not Resident #69's assigned nurse on 2/07/25 but she responded to assist when Resident #69 was lowered to the floor. She stated NA #1 was transferring Resident #69 by herself from the wheelchair to a shower chair when Resident #69's legs gave out and she had to lower her to the floor. She indicated Resident #69 was assessed and no injuries were noted. Nurse #2 revealed Resident #69 was able to stand and pivot to transfer with 2-person assistance. She indicated when she asked NA #1 why she transferred Resident #69 without a second person she stated she was unable to find anyone to help. Nurse #2 stated she was at the nurse's station with Nurse #3, and both were available to help, however NA #1 did not ask them for assistance. A phone interview with Nurse #3 on 2/19/25 at 4:01 PM revealed she was Resident #69's	F 689	On 3/3/25, the Staff Development Coordinator (SDC), DON, and unit managers re-educated the nurses, medication aides, and CNA□s on following proper transfer status and location of transfer status in resident Electronic Medical Record (EMR). All nurses, medication aides, and CNA□s not present on 3/3/25 will complete their education prior to beginning their shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. On 3/10/25, DON, SDC, and unit managers began audits of 5 transfers per week for 1 month and 10 transfers per 1 month for a quarter to ensure all transfers were occurring according to the care plan. All findings will be addressed in monthly QAPI.	

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F 689	Continued From page 19	F 689		

assigned nurse on 2/07/25. She stated NA #1 called for assistance from Resident #69's room and when she responded she found Resident #69 sitting on the floor. She stated NA #1 reported she was attempting to transfer Resident #69 by herself from her wheelchair to the shower chair when Reisdent #69's legs gave out and she had to lower her to the floor. She stated she assessed Resident #69, and no injuries were noted. Nurse #3 revealed Resident #69 was able to stand and pivot to transfer with 2-person assistance. She indicated NA #1 reported she was transferring Resident #69 without a second person because she was unable to find someone to assist her. Nurse #3 indicated she was at the nurse's station with Nurse #2 and available to help, however NA #1 did not ask them for assistance. Nurse #3 revealed she told NA #1 she should have asked them to assist her and that transferring Resident #69 on her own was unsafe.

A phone interview was conducted with the Director of Nursing (DON) on 2/19/25 at 2:11 PM. She revealed Resident #69 was able to stand and pivot to transfer with 2-person assistance. She stated on 2/07/25 NA #1 reported she was unable to find another staff member to assist, attempted to transfer Resident #69 by herself and had to lower her to the floor. The DON indicated Resident #69 was not injured. She revealed NA #1 stated she was aware that Resident #69 required two staff members for all transfers, and she should not have transferred her until she was able to find a second person to assist.

A phone interview was conducted with the Administrator on 2/20/25 at 10:55 AM. He stated if a resident was able to stand and pivot with

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F 689	Continued From page 20 2-person assistance to transfer then two staff members should be present during the transfer to ensure the resident was safe.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to secure medicated treatment supplies in a locked treatment cart for 1 of 1 treatment cart. Additionally, the facility failed to remove loose pills from a medication cart and	F 761	F-tag 761 □ Label/Store Drugs and Biologicals Facility failed to secure medicated treatment supplies in a locked treatment	3/13/25

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F 761	Continued From page 21 failed to label medications which were not stored in their pharmacy or manufacturer packaging for 1 of 3 medication carts reviewed for medication storage (Unit B medication cart). The findings included: 1. During wound care observation on 2/18/25 at 9:30 AM on the D hall, the treatment cart was observed to be in the hallway outside of room D5, unsecured. Residents were noted to be ambulating past the cart without any staff members present. Observation on 2/18/25 at 9:35 AM of the treatment cart revealed it consisted of three- 4 drawer plastic towers, two recycled bedside tabletops (one sitting on top of the plastic towers and one on the bottom) and it was held together by PVC (polyvinyl chloride) piping surrounding the perimeter. There was no locking mechanism on the cart. Observation of the items in the treatment cart drawers on 2/18/25 at 10:15 am with the wound nurse present revealed the following pertinent items: Plastic tower #1 1st drawer-iodine and skin prep pads 2nd drawer-triple antibiotic ointments 3rd drawer-boric acid solution, normal saline, and hydrogen peroxide bottles 4th drawer-resident specific prescription creams and ointments Plastic tower #3 2nd drawer-antibacterial petroleum gauze 3rd drawer-medicated/infused dressings and	F 761	cart for 1 of 1 treatment cart. Additionally, the facility failed to remove loose pills from a medication cart and failed to label medications which were not stored in their pharmacy or manufacturer packaging for 1 of 3 medication carts reviewed for medication storage (Unit B medication cart). Address how corrective action will be accomplished for resident (s) found to have been affected: On 2/18/25, facility made treatment cart was replaced with a new locking treatment cart on 2/18/25. On 2/18/25, three loose pills of various shapes, shapes, colors, and sizes were removed from bottom of Unit B medication cart. A white clear bag that contained two caplets were also removed from Unit B medication cart. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: All residents are at risk for deficient practice. On 2/18/25, Director of Nursing (DON) and Wound Care nurse purchased new locking treatment cart to replace facility made treatment cart. On 2/19/2025, all medication carts were checked for loose pills and medications not in appropriate packaging by the DON and Unit Managers (UM). Results of the audit revealed no loose pills and all medications were in appropriate packing. Address what measures will be put in place or systemic changes made to	

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F 761	Continued From page 22 collagen powders During an interview with the Wound Nurse on 2/18/25 at 10:15 am, she stated she had been in her position for several months. She reported she had used the facility-made treatment cart daily since she started. The Wound Nurse added that she did have the ability to partially lock the cart. She reported during the day, the cart would sit outside various residents' rooms throughout the facility and she would take the necessary items to perform wound care in the rooms with her. During an observation and interview with the Director of Nursing (DON) on 2/18/25 at 2:30 PM she stated she was unaware the treatment cart was unsecured throughout the day. She stated all drawers on the facility treatment cart should have the ability to be secured at all times when there wasn't a staff member present. 2. An observation of the Unit-B medication cart was conducted on 2/18/25 at 10:21 AM in the presence of Medication Aide (MA) 1 and Nurse #1. The medication cart contained 3 loose pills of various shapes, colors and sizes laying in the bottom of cart drawers. The medication cart contained two green caplets that were placed in a white clear bag that did not include the medication name, resident name, and/or dosage instructions. MA #1 was interviewed on 2/18/25 at 10:36 AM indicated that someone placed the two green caplets in the clear white bag and left them in the medication cart. MA #1 further stated that facility	F 761	ensure that the identified issue does not occur in the future. On 2/19/25, the Wound Care nurse placed all items that were on the facility made treatment cart in the new locking treatment cart and began using throughout facility. On 2/18/25, the Staff Development Coordinator (SDC), re-educated the licensed nursing staff and medication aides on proper medication storage process and process for cleaning medication carts. All nurses and medication aides not present on 2/18/25 will complete their education prior to beginning their shift. New nurses and medication aides will receive training on facility medication storage process and process for cleaning medication carts. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. On 3/11/25, the DON and unit managers began treatment cart audits with 4 days a week for 1 month, 2 days a week for 1 month, and 1 day a week for 1 month to ensure that the treatment cart is locked when left unattended. All findings will be addressed in monthly QAPI. On 2/24/25 the DON and unit managers began medication cart audits with 5 random unit carts per week for 1 month, 2 random unit carts per week for 1 month, and 1 random unit carts a month for 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 23 will usually place medications in the clear white bag for any over the counter medications that need to be given to residents who were being discharged home. Nurse #1 was interviewed on 2/18/25 at 10:40 AM and indicated each nurse assigned to the medication cart was responsible for cleaning the medication cart and ensuring each medication was labeled. An interview was conducted with the Director of Nursing (DON) on 2/18/25 at 11:11 AM. The DON indicated the medication carts were to be cleaned by the nurses on duty. The DON indicated each nurse should clean, organize the medication carts, and discard any loose pills. The DON indicated the nurses oversaw the medication aides. The DON further indicated each nurse and medication aide must use medication from a labeled container and after removing the medication from the original container, must administer the medication to residents immediately per physician orders.	F 761	month to ensure that staff understand the process on proper medication storage and cleaning medication carts. All findings will be addressed in monthly QAPI.	