STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345554	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Grove	**631 Junction Creek Drive , Wilmington, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 09/15/25 through 09/18/25. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID # 1D6C90-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted at this facility from 09/15/25 to 09/18/25. Event ID #1D6C90-H1. The following intakes were investigated: 2615384, 2605492, 2581633, 886179. 2 of the 9 complaint allegations resulted in deficiency.	F0000		
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.	F0565		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0565 SS = E	Continued from page 1 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff and resident interviews, the facility failed to act upon concerns that were reported by the Resident Council and communicate the efforts to address concerns that were reported during Resident Council Meetings for 7 of 9 months reviewed (November 2024, March 2025, April 2025, May 2025, June 2025, July 2025 and August 2025). Findings included: a. The Resident Council Agenda dated 10/28/24 indicated in the notes section of the form that the following concerns were voiced: more sugar-free desserts, updated call bell system, and call bell response time. Staff in attendance at the meeting were Social Worker #1, the Director of Nursing and the Dietary Manager. b. The Resident Council Agenda dated 11/18/24 did not indicate that a response was provided to the council regarding the concerns that were voiced on 10/28/24 or any follow-up that the facility completed. Staff in attendance at the meeting were: Social Worker #1, the Administrator and the Dietary Manager. c. The Resident Council Agenda dated 2/24/25 indicated that the following concern was voiced: the dryer is broken in the laundry room. d. The Resident Council Agenda dated 3/24/25 indicated that the following new concerns were voiced: staffing	F0565		

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F0565 SS = E	Continued from page 2 concerns and staff not available to assist after meals are served. The March meeting minutes did not indicate that a response was provided to the council regarding the concerns that were expressed at the 2/24/25 meeting or any follow-up that the facility completed. Staff in attendance were Social Worker #1, the Administrator, Director of Nursing, and the Dietary Manager. e. The Resident Council Agenda dated 4/28/25 indicated the following new concerns were voiced: air conditioners not working in some resident rooms, staffing concerns, staff not available to assist after meals are served, and residents not offered choices for meals. The April meeting minutes did not indicate that a response was provided to the council regarding the concerns that were expressed at the 3/24/25 meeting or any follow-up that the facility completed. Staff in attendance were the Administrator, Dietary Manager, and Social Worker #1. f. The Resident Council Agenda dated 5/27/25 indicated the following concerns were voiced: air conditioning not working in some resident rooms and Nurse Aides sitting after serving meals and not assisting the residents when asked. The Agenda indicated that these concerns were voiced the previous month and the Administrator was to address. The May meeting minutes did not indicate that a response was provided to the council regarding the concerns that were expressed at the 4/28/25 meeting or any follow-up that the facility completed regarding air conditioning, staff not assisting after meals and not offered choices at meals. Staff in attendance was Social Worker #1. g. The Resident Council Agenda dated 6/30/25 indicated the following concerns were voiced: air conditioning not working in all rooms, Nurse Aides sitting after serving meals and not assisting residents when asked. The June meeting minutes did not indicate that a response was provided to the council regarding the concerns that were expressed at the 5/27/25 meeting or any follow-up that the facility completed regarding air conditioning, Nurse Aides sitting after serving meals and not getting up to help when asked. Staff in attendance were Social Worker #1 and the Administrator. h. The Resident Council Agenda dated 7/28/25 indicated the following concerns were voiced: air conditioning not working in all rooms, Nurse Aides sitting after serving the meals and not assisting residents when	F0565		

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F0565 SS = E	Continued from page 3 asked. The July meeting minutes did not indicate that a response was provided to the council regarding the concerns that were expressed at the 6/30/25 meeting or any follow-up that the facility completed regarding the air conditioning and Nurse Aides sitting after meals were served and not assisting residents when asked. Staff in attendance were Social Worker #1 and the Administrator. i. The Resident Council Agenda dated 8/25/25 indicated the following concerns were voiced: staffing. The August meeting minutes did not indicate that a response was provided to the council regarding the concerns that were expressed at the 7/28/25 meeting or any follow-up that the facility completed regarding the air conditioners and the Nurse Aides sitting after serving the meals and not assisting residents when asked. Staff in attendance were Social Worker #1, Dietary Manager and Administrator. During an interview with the Resident Council on 9/17/25 at 10:30 AM the residents stated that Resident Council meetings were held regularly but their concerns were not addressed. The residents stated they felt that their concerns “fell on deaf ears.” The residents stated that they were told " I'll look into it," when they expressed concerns, but nothing was ever done, and this made them feel like they did not make any difference. An interview was conducted with Resident #16 on 9/17/25 at 11:00 AM. Resident #16 stated that the council met monthly, and Social Worker (SW) #1 recorded the concerns that were expressed. Resident #16 indicated that nothing was done about the concerns that were expressed in the meetings. Resident #16 stated she attended all the Resident Council meetings and was frustrated with the lack of follow-up because she felt that management did not address the concerns of the council. She stated the council was not provided with a resolution to the concerns that were expressed each month. An interview with Social Worker #2 on 9/17/25 at 3:29 PM revealed that she was responsible for recording the grievances in the logbook and keeping the logbook with the forms, however it was Social Worker #1 that attended the Resident Council meetings. Social Worker #2 stated that Social Worker #1 should have written up grievances for the concerns that the Resident Council	F0565		

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F0565 SS = E	Continued from page 4 voiced each month at the meetings. The concerns that were expressed in the Resident Council meetings should have been given to the appropriate department manager to address, investigate and work on a resolution. SW #2 reviewed the logbook and indicated that there were no grievances completed from the Resident Council meetings. An interview with Social Worker #1 on 9/18/25 at 12:10 PM revealed that she conducted the monthly Resident Council meetings and recorded the minutes. Social Worker #1 stated that she had not been trained in how to oversee the Resident Council meetings and how to address grievances or concerns that were expressed during the meetings. SW #1 stated she did not complete grievance forms for each of the concerns expressed at the meetings and she did not review the grievances from the previous meeting or inform the Resident Council of the resolution. An interview with the Administrator on 9/18/25 at 10:16 AM revealed that there wasn't a formal process to address the grievances brought up by the Resident Council and they had not been discussing the resolution each month. The Administrator stated that they should address the grievances and provide a resolution at the next month's meeting. The Administrator acknowledged he should have implemented measures to address the concerns expressed by the Resident Council members and he explained that SW #1 who was responsible for conducting the meetings, was not in the position for long and was not aware of how to conduct the meetings.	F0565		
F0585 SS = B	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to	F0585		

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F0585 SS = B	Continued from page 5 resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State	F0585		

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F0585 SS = B	Continued from page 6 law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and Responsible Party (RP) and staff interviews, the facility failed to provide written grievance summaries for 1 of 1 resident (Resident #37). Findings included: Review of facility policy dated 08/01/23 titled "Guaranteed Fair Treatment Process" read in part: The Administrator, Executive Director or other individual designated to oversee the concern process will receive a copy of all written grievances for tracking purposes and will assist with investigations as necessary. The person filing the concern has the right to receive a written summary of a statement of the concern, the steps taken to investigate the concern, a summary of pertinent findings or conclusions, whether the concern was confirmed or not confirmed, and any corrective actions taken or to be taken by the facility. The Administrator, Executive Director will provide a written response within 3 working days, unless all parties are notified that additional time is needed. Resident #37 was admitted to the facility on 08/03/24.	F0585		

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F0585 SS = B	Continued from page 7 Resident #37's quarterly Minimum Data Set (MDS) dated 08/08/25 indicated that the resident was cognitively intact. A review of the facility's grievance log from 10/11/24 through 09/18/25 revealed one grievance from Resident #37's Responsible Party (RP) dated 07/06/25, for an air-conditioning thermostat not working properly in resident's room, with room temperature reading 76.8 F. On the response to concern section of the grievance form dated 07/09/25 read, "Removed room system from outdated computer system. Now, resident's room is constantly 70-71 degrees Fahrenheit (F.). The resident and RP expressed gratitude and verbally said "room is at the temperature they want". On the bottom page of the grievance form was dated 07/09/25, as resolved; but the grievance page summary and finding section was left blank. The section stating a copy of the grievance decision section was given to the individual was blank, along with the next line of the form stating the written notification was sent by email or postal mail to the individual was also left blank, without a signature or date. An interview was conducted on 09/18/25 at 8:10 AM with the Maintenance Director. He stated he was aware of one written grievance dated 07/06/25 from Resident #37's RP, regarding resident's air conditioning not working properly. The Maintenance Director did know of another grievance regarding laundry dryer #3 breaking down around the end of April/2025, but it was reported through his work order system and not from a resident or their family. The maintenance director stated Resident #37's written air conditioner thermostat grievance dated 07/06/25 was resolved the same day it was reported, which required resident's room thermostat being reprogramed and re-set. He stated he was not sure if a written grievance summary letter about the air conditioner was ever given to the residents or his RP. The Maintenance Director stated he received multiple work orders for the laundry's 3rd dryer breaking down, which were also repaired timely by their outside laundry repair vendor within a couple of days. He stated even with the 3rd dryer down; the facility's remaining 2-dryers were more than able to launder all of residents clothing timely. He stated he never received a written grievance about the down dryer from Resident #37 or his RP. He stated he received notifications of the down dryer always through their electronic work order system. He also stated he never heard of any residents not receiving their laundered clothing due to a dryer being down. An interview was conducted on 09/18/25 at 3:15 PM with	F0585		

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F0585 SS = B	Continued from page 8 Resident #37's RP. She stated she put in 6-grievances verbally or by email to the facility's administrative staff (Administrator, Director of Nursing, and Social Worker). She stated she had never received a written grievance summary from the facility for any of her 6 grievances. An interview was conducted on 09/18/25 at 9:00 AM with the Social Worker (SW). She stated Resident #37's RP never received a completed written grievance summary for any of RP's grievances, because the administrative staff deemed them to be concerns, not official grievances. Therefore, the administrative staff did not need to fill out a formal written grievance for Resident #37's or his RP, or provide a written summary to the complainant for RP's 6-verbal/emailed grievances: protein serving sizes were too small, mouthwash not provided timely, no staff were feeding the resident, facility's broken dryer resulted in the resident having no pants, and resident's room air-conditioning thermostat was not working properly. The Social Worker (SW) revealed that she did not know until today that she needed to provide a written grievance summary to grievance/concern complainants. She said she thought the verbal summary was okay. She said before today, she had only called, emailed, or spoken to complainants in person and verbally summarized the grievances, with nothing given to them in writing. She said she did not know she was required to provide a written grievance summary to every complainant. The SW said the resolution to Resident #37's six concerns/grievances were given to the complainant or his RP verbally, which included:1. Resident #37 gained greater than 5 lbs. in two months and had always received 3-5 ounces of protein per meal. 2. Resident's mouthwash was ordered on 07/30/25 and 1st evening dose was given to Resident #37 timely on 08/01/25. 3. Facility's third dryer was fixed by maintenance work order timely, and no residents were without dried clothing. 4. Resident had a Dycem meal plate place mat (a unique, durable polymeric material), a meal scoop plate, and a soup spoon for all meals, preferring to feed self, resulting in his gained weight. 5. Housekeeping had always mopped daily and cleaned resident's room. 6. Resident's air-conditioning thermostat was fixed and reprogrammed by maintenance director the same day it was reported malfunctioning. An interview on 09/18/25 at 3:30 PM with the Administrator revealed Resident #37's RP did not receive a written grievance summary for the 6 grievances she reported and should have. The Administrator stated he was not fully aware the complainant needed to receive a written summary of	F0585		

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F0585 SS = B	Continued from page 9 their grievance findings within 3 days, even if they were resolved verbally. An interview with the Director of Nursing (DON) or Assistant Director of Nursing (ADON) were not obtained due to being out of the facility for medical reasons or out of the country.	F0585		
F0600 SS = G	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 involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and staff, Power of Attorney, and Nurse Practitioner interview, the facility failed to protect a severely cognitively impaired resident (Resident #65) from the right to be free of physical abuse. On 08/29/25 at approximately 10:30 PM, when Nurse Aide (NA) #1 and NA #2 were providing care for Resident #65 who was agitated and combative, NA #2 struck the resident with an open hand on the left side of her face. This action would have caused a reasonable person psychosocial harm such as feelings of anger, fearfulness, humiliation, and helplessness. The deficient practice occurred for 1 of 3 residents reviewed for abuse (Resident #65). Findings included: Resident #65 was readmitted to the facility on 04/25/24 with diagnoses that included Alzheimer’s disease with late onset, dementia with unspecified severity and behavioral and mood disturbances, anxiety and chronic pain.	F0600		

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F0600 SS = G	Continued from page 10 Review of the care plan for Resident #65 revised on 06/05/2025 revealed the following focus areas:Impaired Functional Performance as evidenced by (AEB) requiring staff assistance to complete activities of daily living (ADL) secondary to impaired cognition, decreased mobility, and unsteady gait and balance. Resident #65 refused assistance and resisted care at times. Anticipate resident requiring increased assistance as her disease process progresses. The goals were that Resident #65 would continue to participate in ADL through the next review. Interventions included to always approach in a friendly, non-threatening manner, try to re-direct with refusals; and allow resident to calm down then have another staff member attempt or re-approach in a timely manner if resident is resisting care. Resident #65 has mood and behavior problems with episodes of pacing, rummaging, screaming, being short tempered, being easily annoyed, being verbally and physically abusive towards staff, setting off door alarms and will frequently remove pants secondary to Alzheimer's/dementia with mood and behavioral disturbance. Resident #65 will refuse taking her scheduled medications at times. She gets angry when there is a facility emergency and she's not allowed to assist, such as when another resident falls. The goal was for Resident #65 to continue to participate in decision making regarding her daily routine and not injure herself or others when being abusive by the review date. Interventions included to anticipate and meet the needs of Resident #65, stop and talk with her as passing by (resident enjoys looking at family photos, clipping coupons, flipping through newspapers and books, drinking coffee), encourage visitation from family for socialization and diversion, encourage out of room for meals and activities, attempt to keep a consistent routine, offer snacks or drinks (resident loves coffee) for diversion, intervene as necessary to protect the rights and safety of others, remove from the situation and take to an alternate location as needed, minimize the potential for the resident's disruptive behaviors by offering tasks which divert attention, monitor behavior episodes and attempt to determine underlying causes considering location, time of day, persons involved, and situations and document behavior and potential causes. Review of a quarterly Minimum Data Set (MDS) dated 08/28/25 documented that Resident #65 had short and long term memory problems and was rarely or never understood. She was aware of the location of her room, staff faces and names; but did not know the current season or that she was in a nursing home. She continuously presented inattention and disorganized thinking. Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing) occurred on 1 to 3 days.	F0600		

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(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
F0600 SS = G	Continued from page 11 Other behavioral symptoms not directed towards others (such as verbal or vocal symptoms like screaming) occurred on 1 to 3 days. The facility filed an Initial Allegation Report to the State on 08/30/25 at 12:37 AM for an allegation of abuse. The accused employee was NA #2. The facility became aware of the incident on 08/29/2025 at 10:30 PM. The allegation details were that the resident (Resident #65) became combative during care and was hitting and kicking the nurse aides. The resident hit NA #2 in the face and NA #2 swatted back at the resident. NA #2 was suspended pending an investigation, all residents were assessed with no new issues noted. Local law enforcement and DSS were notified on 08/30/25. The facility documented that the resident suffered no physical or mental harm. The facility Investigation Report was filed with the State on 09/08/25. The allegation was not substantiated by the facility because post investigation the Administrator determined that NA #2 did not swat at Resident #65 because there was no injury or mental anguish. The accused individual's employment (NA #2) was terminated related to the allegation on 09/04/25. In a telephone interview with NA #1 on 09/16/25 at 2:27 PM she stated she had asked NA #2 help her with an incontinent round for Resident #65 at approximately 10:30 PM on 08/29/25. She explained that it was the normal baseline behavior for Resident #65 to strike out at staff during incontinence care or showering. She explained that 2 aides were always needed when providing incontinent care to Resident #65. Staff often used chocolate to calm Resident #65 or would leave the room and re-approach Resident #65 later to give her time to calm down. She reported they had already successfully changed the resident's diaper and NA #2 was pulling up the resident's covers on her bed. Resident #65 told NA #2 that she didn't want the blanket and tried to swat NA #2 with her hand. NA #1 heard NA #2 tell Resident #65, "If you hit me, I'm gonna hit you back!". NA #1 heard Resident #65 tell NA #2 if she hit her she would report it. NA #2 continued to pull up the covers and NA #1 stated Resident #65 slapped NA #2. NA #1 stated she saw NA #2 slap Resident #65 with an open hand across the left cheek of her face, and it sounded like a loud clap. NA #1 explained she then tried to get herself and NA #2 out of the room as quickly as possible because she knew it was considered abuse to strike a resident. NA #1 noted when they left the room NA #2 was mingling around her and told her, "I didn't mean to do it-it was a reflex." NA #1 stated she was afraid to report NA #2 for abuse in	F0600		

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F0600 SS = G	Continued from page 12 NA #2's presence so she texted the nurse working on the Rehabilitation Hall and asked her to call her and Nurse #1 over to the Rehabilitation Hall so that she could tell Nurse #1 what happened, which she did. The Rehabilitation Nurse called the Administrator immediately and Nurse #1 returned to the memory care unit to monitor NA #2. NA #1 stayed on the Rehabilitation Hall because that is where she was originally scheduled to work on third shift and it was time to change shifts. NA #1 reiterated she had reported the abuse as quickly as she could after it happened. In a telephone interview with NA #2 on 09/17/25 at 9:55 AM she stated NA #1 had asked her to help with incontinence care for Resident #65. She noted she knew it was going to be chaotic because earlier in the shift after supper it took 3 nurse aides to put Resident #65 in bed because she was combative. NA #2 noted when she entered the resident's room at the end of the shift, the resident was already screaming, swinging her arms and kicking. She stated she went in the room to complete incontinence care because she was trained to care for residents who had dementia, and this was the resident's normal behavior. NA #2 explained after the incontinence care was done, she bent down to pull up the resident's bed sheet, and the resident slapped her on her face "really hard." NA #2 stated she backed up at that time but that she was all tangled up with the Resident #65 who had sat up in bed and had a grip on her. NA #2 noted at that time she was trying to push the resident down in the bed and her hand may have touched the resident's face in the struggle. She stated she was aware there was an allegation that she had slapped the resident but stated she had not. She noted she was also aware that there was an allegation that she told the resident that if the resident hit her she would hit her back and stated she had never said that. NA #2 also explained that law enforcement alleged to her that she had told the resident if the resident smacked her, then she would smack the resident. She stated she had not made either statement to hit or smack the resident. She noted there had been 2 aides on the memory care unit that night instead of 3, but she did not feel that the unit was short staffed. She recalled she had 11 residents on her assignment on 08/29/25 on second shift and explained she was able to complete her assignment during her shift. A telephone interview was conducted with Nurse #1 on 09/16/25 at 9:27 PM. He stated he was the nurse on duty in the memory care unit on 08/29/25 from 7:00 PM until 7:00 AM. He reported NA #1 and NA #2 went to change Resident #65's brief. When they came out of the	F0600		

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F0600 SS = G	Continued from page 13 resident's room, NA #2 told him that Resident #65 had hit her. He stated NA #1 was quiet. He explained he was called by Rehabilitation Hall Nurse who asked him to bring NA #1 to the Rehabilitation Hall. When he arrived at the Rehabilitation Hall with NA #1, NA #1 told him that Resident #65 had swatted at NA #2 while they were in the room providing care and that NA #2 had swatted back at Resident #65 and hit her on the left side of her cheek on her face. The Rehabilitation Hall Nurse tried to call the Director of Nursing but was unsuccessful, so she then called the Administrator to report alleged abuse. Nurse #1 stated the Administrator was present at the facility within 5 minutes. Nurse #1 explained that the Administrator took NA #2 off the memory care unit and told him (Nurse #1) to complete an assessment on Resident #65. Nurse #1 stated he noted Resident #65 had red dots on her left cheek when he assessed her. Nurse #1 explained that he could not determine that the discoloration on the resident's left cheek had been caused by a slap. Nurse #1 stated he completed skin checks on all the other resident's on the memory care unit. Nurse #1 commented that Resident #65 was normally combative during incontinence care, and the nurse aides were to stop care and re-approach later if a combative resident could not be calmed. Nurse #1 stated that NA #2 never told him that she had hit Resident #65 on the face. He reported that NA #2 was removed from the memory care unit by the Administrator on 08/29/25 and had not returned to work. A progress note written by Nurse Practitioner #1 on 09/02/25 at 10:45 AM documented that she assessed Resident #65 who was neurologically at baseline. She noted that she assessed Resident #65 to have multiple skin lesions and age-related changes on both sides of her face with a small area of petechiae on her left cheek. There was no pain, redness, bruising, or edema on her face. Resident #65 had no new complaints or distress noted. An interview was conducted with Resident #65's Power of Attorney (POA) on 09/16/25 at 3:10 PM. She stated she listened to her voice mail on Saturday morning (08/30/25) around 6:30 AM. She reported she called the facility and Nurse #1 told her that Resident #65 had been combative during care and when the resident swatted at a nurse aide the nurse aide hit her back. The POA stated she arrived at the facility that morning around 9:30 AM and took pictures of Resident #65's left side of her face. She stated she did see marks on Resident #65's left cheek. She reported when she was taking the pictures, Resident #65 asked her if someone had hit her. The POA found this unusual because Resident #65 had never said anything like that before.	F0600		

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F0600 SS = G	Continued from page 14 She asked Resident #65 if someone had hit her and the resident replied she did not know. The POA stated she had asked Nurse #1 for a report, and he told her the Administrator would call her. When the Administrator had not called her by noon, she googled what to do and called Adult Protective Services to file a complaint. She recalled the Administrator called her on 08/30/25 and told her he had had interviewed both of the nurse aides involved. He reported to her that he had escorted the accused nurse aide out of the building and suspended her. The POA stated Resident #65 had been at the facility for 6 years and that this was the first time anything like this had happened to her. She noted she had not visited Resident #65 on Friday (08/29/25) but had seen her the day before (Thursday) and the marks on her face were new. An observation of Resident #65 was made on entry (09/15/25) at lunchtime at 12:05 PM and again on 09/16/25 at 12:30 PM. No marks were visible on the left side of Resident #65's face. An attempt was made to interview Resident #65 on 09/17/25 at 3:05 PM, but Resident #65 was not able to understand the conversation. An interview was conducted with Nurse Practitioner #1 on 09/18/25 at 1:33 PM by telephone. She stated when she had assessed Resident #65 on 09/02/25 she had not found any frank marks or bruising on the resident's face. Nurse Practitioner #1 explained although she did observe 3 petechia dots on the resident's left facial cheek, she wouldn't call those marks a bruise. She noted the petechia could have just been due to the aging process and changes in the resident's skin. She stated Resident #65 was at baseline and was not able to tell her if anyone had hit her. An interview was conducted with the Administrator on 09/18/25 at 10:30 AM. He stated that he did not substantiate this allegation of abuse because when he talked to the local law enforcement officer who had responded to the incident, the information the office told him regarding staff interviews varied from the staff interviews that he had conducted himself. The Administrator explained he did not have a copy of the law enforcement report because when he had asked the officer for a copy of the report he was told the report had not been written yet and that the investigation was still open. The Administrator provided a Plan of Correction with an alleged completion date of 09/04/25, but it was not accepted because the plan did not include monitoring of staff to resident interactions or of care being	F0600		

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F0600 SS = G	Continued from page 15 provided.	F0600		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by	F0732		

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F0732 SS = C	Continued from page 16 State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to document accurate information on the daily nurse staffing sheets to include the census for 4 of 4 days of the survey (09/15/25, 09/16/25, 09/17/25, and 09/18/25). The findings include: A review of the daily posted nurse staffing information sheets for the 4-neiborhoods dated 09/15/25, 09/16/25, 09/17/25, and 09/18/25 revealed no entry in the areas of census for the 4- resident neighborhoods and for all shifts. The census number on 1st (7:00 AM – 3:00 PM), 2nd (3:00 PM - 11:00 PM), and 3rd (11:00 PM - 7:00 AM) shifts were left blank for the following days: 09/15/25, 09/16/25, 09/17/25, and 09/18/25. An interview on 09/18/25 at 11:00 AM was conducted with the facility's temporary scheduler. She verified that the census numbers for the facility's 4-neighborhoods on their daily nurse staffing sheets were all left blank. She stated she was not including facility census on daily nurse staffing sheets. Scheduler stated that the Administrator would work with her to ensure all the assignment sheets and daily nurse staffing posting reflects, daily census, and who was working the floor and when. An interview was conducted on 09/18/25 at 03:00 PM with the Administrator. He stated he was unaware the daily posted nurse staffing information sheets were not filled out completely to include census numbers for the 4- neighborhoods. Administrator said the facility's temporary scheduler was new to the position and that as the current Administrator he would take it upon himself to train the new scheduler in how to fill out the daily schedule forms correctly and would review the forms daily to ensure the daily posted nurse staffing information sheets are filled out completely to include census numbers.	F0732		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880		

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F0880 SS = E	Continued from page 17 §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; (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	F0880		

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F0880 SS = E	Continued from page 18 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 review, and staff interviews the facility failed to 1.) maintain clean technique (a strategy used during wound care to prevent or reduce the risk of transmission of microorganisms from one person to another or from one surface to another. This includes in part; maintaining a clean field (clean workspace) to prevent cross contamination) during wound care to a Stage III left heel pressure wound. Nurse #6 did not clean the work surface area or place a barrier prior to placing the wound care supplies that included a clean dressing onto the resident's dresser and did not place a barrier underneath the resident's (Resident #11) left heel during wound care which allowed the left heel to touch the floor and potentially contaminate the wound. 2.) implement the infection control policy and procedures for Enhanced Barrier Precautions (EBP) when providing direct care activities to residents with a Stage III pressure wound and an indwelling medical device (Resident #11 and Resident #100). This occurred for 3 of 3 staff members who were observed for infection control practices (Nurse #6, Nurse #5, Nurse Aide #6). Findings included: 1.) During an interview on 09/17/25 at 3:30 PM the Infection Control Preventionist Nurse stated there was	F0880		

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F0880 SS = E	Continued from page 19 no facility policy in place regarding the procedures to use when performing dressing changes. A wound care observation was conducted on 9/17/25 at 12:44 PM of Nurse # 6 providing wound care to Resident #11's Stage III left heel pressure wound. Resident #11 was oriented to person only and was observed in her room sitting up in a wheelchair during the wound care. Nurse #6 donned gloves and a gown and placed the wound care supplies on Resident #11's dresser without placing a barrier down or cleaning the work area. Nurse #6 removed Resident #11's shoe revealing no dressing covering the left heel wound. Nurse #11 did not place a barrier between Resident #11's left heel and the floor to prevent potential contamination of the wound. Resident #11's heel was left uncovered and resting on the floor while Nurse #6 retrieved the wound supplies. Nurse #6 returned and lifted the left heel, cleaned the wound with wound cleanser, then left the heel resting on the floor while she retrieved the wound medication. Nurse #6 then lifted the heel, applied the medication to the wound then left the heel resting on the floor again while she retrieved the new dressing. Nurse #6 then lifted the heel from the floor and applied the new dressing. During an interview on 09/17/25 at 1:00 PM Nurse #6 stated she had been a nurse less than one year. Nurse #6 stated the previous dressing must have fallen off and indicated she did not think to place a barrier under Resident #11's right heel prior to letting the heel rest on the floor to prevent possible contamination of the wound. Nurse #6 indicated she should have placed a barrier under Resident #11's heel and cleaned the dresser or placed a barrier down before placing the wound care supplies on it. She stated it was done in error, and she received infection control training upon hire to the facility. During an interview on 09/17/25 at 3:30 PM the Infection Control Preventionist Nurse stated Nurse #6 should have placed a clean barrier under Resident #11's heel for the dressing change to prevent the heel wound from touching the floor and cleaned the area or placed a barrier on the dresser before placing the new dressing supplies on it to reduce the risk of contaminating the wound. She stated Nurse #6 had received infection control training. 2.) The facility's Infection Control Policy revised	F0880		

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F0880 SS = E	Continued from page 20 4/3/25 revealed in part: Enhanced Barrier Precautions (EBP) were designed to reduce transmission of multidrug resistant organisms (MDRO) and employed targeted gown and glove use during high contact resident care activities. EBP was indicated for residents with wounds and/or indwelling medical devices even if the resident was not known to be infected or colonized with a MDRO. a. During an observation on 09/17/25 at 1:30 PM Nurse #5 was observed performing a peripherally inserted central catheter (PICC) line flush (a PICC line is a type of central venous catheter used to access the veins near the heart to deliver medications and other treatments. A PICC line flush is the process of injecting normal saline or heparin through the PICC line to keep it clear of blockages and to ensure it remains functional for the delivery of medications) for Resident #100. Nurse #5 was wearing gloves but no gown. An enhanced barrier precautions sign was observed on Resident #100's door. Personal Protective Equipment (PPE) supplies were inside of Resident #100's room at the doorway. During an interview on 09/17/25 at 1:35 PM Nurse #5 stated she was aware Resident #100 was on enhanced barrier precautions. Nurse #5 stated she knew she had to wear gloves but was not certain that she needed to wear a gown as well when providing direct care including flushing a PICC line. Nurse #5 stated she had received infection control training including training on enhanced barrier precautions. b. During an observation on 09/17/25 at 12:00 PM Nurse Aide #6 was observed in Resident #11's room in the bathroom preparing to assist Resident #11 to the toilet. Nurse Aide #6 was not wearing a gown or gloves. Resident #11 had a Stage III left heel pressure wound. Nurse Aide #6 picked up Resident #11's left heel without wearing gloves to observe for a heel wound. The left heel had no dressing in place. There was no sign on Resident #11's door indicating enhanced barrier precautions and no gowns were in the room, gloves were observed in a box on the wall inside of Resident #11's room. During an interview on 09/17/25 at 12:30 PM Nurse Aide #6 stated she had worked in the facility for two years and she knew Resident #11 had a heel wound but she was not aware Resident #11 should be on enhanced barrier precautions. Nurse Aide #6 stated there was no sign on	F0880		

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F0880 SS = E	Continued from page 21 the door to let staff know to wear gloves and a gown when providing care. She stated she had received training on infection control including enhanced barrier precautions. During an interview on 09/17/25 at 3:30 PM the Infection Control Preventionist Nurse stated Resident # 11 was on enhanced barrier precautions due to having a Stage III heel wound and a sign should have been placed on the residents door and supplies placed in or near Resident #11's room. She stated Resident #100 was on enhanced barrier precautions due to having a PICC line. She stated staff had been trained on infection control including enhanced barrier precautions and Nurse #5 and Nurse Aide #6 should have donned the appropriate PPE. The Infection Control Preventionist Nurse stated she and the Wound Nurse, along with the floor nurses, shared the responsibility of ensuring precaution signs were placed on the residents' doors when precautions were implemented and to ensure gloves and gowns were accessible to staff. During an interview on 09/17/25 at 4:13 PM the Wound Nurse stated she shared the responsibility for ensuring enhanced barrier precaution signs were placed on the residents' doors when indicated. The Wound Nurse stated Resident #11 had a Stage III pressure wound on the right heel that developed in August 2025 and should have had the enhanced barrier precaution sign placed sooner. She stated it was an oversight. During an interview on 9/18/25 at 2:00 PM the Administrator indicated staff received annual infection control training. He stated Nurse #6 should have followed the appropriate infection control measures when performing wound care and Nurse #5 and Nurse Aide #6 should have followed the facility policy on enhanced barrier precautions.	F0880		