STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345152	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Village	**1265 21 Street NE , Hickory, North Carolina, 28601**

(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 survey and complaint investigation was conducted on 03/09/2026 through 03/11/2026. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#1F2D33-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 03/09/2026 through 03/11/2026. Event ID# 1F2D33-H1. The following intake was investigated: #885477. 4 of the 4 complaint allegations did not result in deficiency.	F0000		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F0657	# PLAN OF CORRECTION **Tag: F657** **Corrective Action for Affected Residents:** On 03/11/26, the Director of Nursing or designee reviewed Resident #72's comprehensive care plan and updated the care plan to reflect the accurate level of assistance required for bed mobility, based on the Physical Therapy discharge summary dated 01/08/26 through 01/19/26, which indicated a need for two-person assistance for transfers and bed mobility. The care guide was revised on 03/11/26 to accurately reflect the assistance required for bed mobility. Licensed nursing staff were in-serviced on 03/11/26 regarding the updated care plan interventions for Resident #72, and Nurse Aides (NAs) assigned to Resident #72 were in-serviced on 03/11/26 regarding the accurate assistance required for bed mobility as documented in the revised care plan and care guide. **Identifying other Residents having the Potential to be Affected:** On 3/24/2026, the Director of Nursing or designee reviewed the comprehensive care plans of residents who received therapy services (physical therapy, occupational therapy, or speech therapy) and were discharged from such services within the past 90 days to ensure that care plans were revised to accurately	04/01/2026

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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F0657 SS = D	Continued from page 1 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to update and revise an individualized person-centered comprehensive care plan for 1 of 5 residents whose comprehensive care plans were reviewed (Resident #72). The findings included: Resident #72 was admitted to the facility on 11/04/24 with diagnoses which included non-traumatic brain dysfunction, Alzheimer's disease, non-Alzheimer's dementia, and seizure disorder. A quarterly Minimum Data Set (MDS) assessment dated 01/07/2026 revealed Resident #72 had severe cognitive impairment and required substantial/maximal assistance (helper does more than half the effort) with the ability to roll left and right while in bed. A Physical Therapy Discharge summary dated 01/08/26 through 01/19/26 revealed Resident #72's discharge recommendations was a two person assistance for transfers and gait. A Physical Therapy note dated 01/12/26 written by Physical Therapist #1 revealed Resident #72 required partial/moderate assistance (helper does less than half the effort) for rolling left and right in the bed. On 03/11/26 at 9:03 AM, an interview was conducted with Physical Therapist #1. During the interview, she stated Resident #72 required moderate to maximum assistance of two staff members with "everything." She stated Resident #72 required direction and verbal cues. Physical Therapist #1 stated when the resident was discharged from therapy services she required one-person assistance with bed mobility.	F0657	Continued from page 1 reflect the discharge recommendations and current functional abilities. Any identified discrepancies between therapy discharge recommendations and care plan interventions were corrected by 4/1/2026. The care guides for these residents were reviewed and updated by 4/1/2026 to ensure accuracy and consistency with the comprehensive care plans. **Measures put into place or Systemic Changes:** On 3/30/2026, the Director of Nursing or designee revised the facility procedure for care plan development and revision to include a process requiring that therapy discharge summaries and recommendations be communicated to the Minimum Data Set (MDS) Nurse or designee within one business day of discharge from therapy services. The revised procedure requires the MDS Nurse or designee to review therapy discharge summaries within two business days of receipt and update the comprehensive care plan and care guide to reflect current functional status and assistance required. On 3/30/2026, the DON or designee in-serviced the MDS Nurses, and therapy staff (Physical Therapists, Occupational Therapists, and Speech Therapists) on the revised procedure for communicating therapy discharge recommendations and updating care plans. Education will be provided to all newly hired nurses. On 3/30/2026, the Director of Nursing or designee implemented a process to document when therapy discharge summaries are provided to the MDS Nurse or designee, and when care plans and care guides are subsequently updated. **Plan to Monitor Performance:** Beginning 3/30/2026, the Director of Nursing or designee will conduct weekly audits of residents discharged from therapy services to verify that comprehensive care plans and care guides have been reviewed and revised within two business days of therapy discharge to accurately reflect current functional abilities and assistance required. The Director of Nursing or designee will review a sample of five residents discharged from therapy services each week, or 100% if fewer than five discharges occurred that week. The audit will include a review of the therapy discharge summary, the comprehensive care plan, and the care guide. The Director of Nursing or designee will interview Licensed nurses and NAs caring for sampled residents to verify that the care guide accurately reflects the assistance provided. Weekly audit results, including any identified deficiencies and corrective actions taken, will be documented using a monitoring tool. After three consecutive weeks of	

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F0657 SS = D	Continued from page 2 Review of Resident #72's care plan dated 01/16/26 revealed a focus area related to functional performance. Interventions included that Resident #72 was independent with bed mobility (rolling left and right), requiring only verbal cues and occasional hands-on prompting due to cognition. Review of Resident #72's care guide (a guide that explains to staff members what assistance each resident requires) on 03/10/26 revealed the following documentation: "Roll left and right independent." On 03/10/26 at 11:15 AM, an interview was conducted with Nurse Aide (NA) #1. During the interview she confirmed she was caring for Resident #72. She explained Resident #72 required assistance of one to two staff members with bed mobility depending on the day and how the resident was. NA #1 explained the first thing staff members were supposed to do was check the care guide in the morning, which came from the resident's care plan, to see how each resident transferred. NA #1 stated she knew Resident #72's care guide said she was independent; however, staff working with the resident on the floor knew that the information was incorrect but had not mentioned it to anyone. On 03/11/26 at 10:16 AM, an interview was conducted with Nurse #1. During the interview, she stated Resident #72 required assistance of one staff member for bed mobility. She explained it was the MDS Nurse who would alter the care plans and update the care guide. On 03/10/26 at 11:56 AM, an interview was conducted with MDS Nurse #1. During the interview, she stated she was responsible for the care plans for the facility. She explained that the Director of Nursing (DON) could also update the care plans and care guide. She stated the former DON had updated the care plan on 01/16/26 to show Resident #72 was independent for bed mobility. MDS Nurse #1 reviewed the Physical Therapy discharge summary then explained she had discussed Resident #72 with Physical Therapist #1 and the Nurse Aides who stated Resident #72 required at least one-person assistance for bed mobility. MDS Nurse #1 stated the care plan should not have indicated that Resident #72 was independent for bed mobility and it should have been correctly reflected in the care plan and care	F0657	Continued from page 2 100% compliance, the frequency of audits will be reduced to twice monthly for three consecutive audits. Upon achieving 100% compliance for three consecutive twice-monthly audits, the frequency will be reduced to monthly for three consecutive months. The Director of Nursing or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. **Date of Compliance:** 04/01/2026	

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F0657 SS = D	Continued from page 3 guide. She explained the typical process was for Therapy services to call her with any updates or changes with mobility status. She did not recall being informed of a status change but stated she should have seen the therapy note. On 03/11/26 at 1:10 PM, an interview was conducted with the Administrator, who stated that she expected all residents to have an accurate comprehensive care plan, and the care plan should reflect the resident's clinical condition and care needs.	F0657		
F0689 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 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 care in a safe manner when a resident was rolled out of bed hitting the floor face first during incontinence care. This deficient practice affected 1 of 3 residents reviewed for accidents (Resident #72). The findings included: Resident #72 was admitted to the facility on 11/04/24 with diagnoses that included non-traumatic brain dysfunction, Alzheimer's disease, non-Alzheimer's dementia, and seizure disorder. A quarterly Minimum Data Set (MDS) assessment dated 01/07/2026 revealed Resident #72 had severe cognitive impairment and required substantial to maximal assistance (helper does more than half the effort) with the ability to roll left and right while in bed. Review of Resident #72's Medication Administration Record (MAR) dated January 2026 revealed she had no orders for a anticoagulant medication.	F0689	# PLAN OF CORRECTION **Tag: F689** **Corrective Action for Affected Residents:** On 01/14/26, Resident #72 was immediately assessed by Nurse #1 following the fall incident. Vital signs were obtained and neurological checks were initiated due to head contact with the floor. An abrasion to the forehead was identified and monitored. Resident #72 was safely assisted back into her wheelchair using a gait belt with the assistance of two staff members. On 01/14/26, an assist rail was placed on the left side of Resident #72's bed to aid mobility and prevent future rolling incidents during care. The Director of Nursing or designee reviewed Resident #72's care plan on 03/13/2026 to ensure all interventions accurately reflect current functional status and bed mobility requirements, including the need for verbal cues and proper positioning techniques during incontinence care. **Identifying other Residents having the Potential to be Affected:** On 3/30/2026, the Director of Nursing or designee conducted a review of residents who received therapy services in the last 90 days to ensure that the recommended level of assistance from therapy was accurately reflected on the care plan and Kardex care guides for teammates. The Director of Nursing or designee reviewed care plans and care guides to ensure documentation accurately reflects the level of assistance required and that proper bed mobility techniques are identified for teammates. The Director of Nursing or designee will conduct a review of all other active residents in the facility to ensure that the appropriate level of assistance is accurately documented in care plans by 4/3/2026. **Measures put into place or Systemic Changes:** On 01/14/26, Nurse Aide #2 received immediate education	04/03/2026

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F0689 SS = D	Continued from page 4 A Physical Therapy note dated 01/12/26, written by Physical Therapist #1, revealed Resident #72 required partial to moderate assistance (helper does less than half the effort) for rolling left and right in bed. On 03/11/26 at 9:03 AM, an interview was conducted with Physical Therapist #1. During the interview, she stated Resident #72 required moderate to maximum assistance of two staff members with “everything.” She stated Resident #72 required direction and verbal cues. Physical Therapist #1 further stated that when the resident was discharged from therapy services, she required one-person assistance with bed mobility. A review of Resident #72’s care plan dated 01/16/26 revealed a focus area related to functional performance. Interventions included that Resident #72 was independent with bed mobility (rolling left and right), requiring only verbal cues and occasional hands-on prompting due to cognition. A review of Resident #72’s care guide (a guide that explains to staff members what assistance each resident requires) on 03/10/26 revealed the following documentation: “Roll left and right independent.” An observation conducted on 03/10/26 at 11:09 AM of Resident #72 revealed she was sitting in her wheelchair in the main common area of the locked unit. Resident #72 was observed smiling at the surveyor however was unable to communicate verbally. An incident report dated 01/14/26 at 7:15 AM, written by Nurse #1, revealed she was notified by a staff member (Nurse Aide #2) that Resident #72 was on the floor. Upon entering the room, the resident was observed lying face down on the floor next to her bed. Resident #72 had rolled off the bed while care was being provided. No injuries were initially observed. The detailed report revealed Resident #72 was a two-person assistance with transfers. On 01/14/26 at 7:15 AM, NA #2 was providing care for the resident when he attempted to roll her to change her brief. She continued to roll off the side of the bed and onto the floor. Resident #72 sustained an abrasion to her face, with no other injuries noted. Interventions following the fall included placing a side rail on the left side of the resident’s bed to aid in mobility while turning. A nursing progress note written by Nurse #1 dated 01/14/26 at 4:50 PM, recorded as a “post-fall evaluation,” revealed that at 7:15 AM Resident #72 had a witnessed fall. While staff were changing her brief,	F0689	Continued from page 4 from the Director of Nursing or designee regarding safe bed mobility techniques, specifically the requirement to roll residents toward the caregiver rather than away during incontinence care and other bed-related activities. Beginning on 3/27/2026, the Director of Nursing or designee in-serviced Licensed nurses and Nurse Aides on proper bed mobility techniques for residents including the importance of rolling residents toward the caregiver. On 3/30/2026, the Director of Nursing or designee implemented a process to ensure that care guides are updated within 48 hours of any changes to a resident's functional status or required level of assistance, and that teammates are notified of these changes. Each shift must check the Kardex for required care needs. All new hires will be educated on proper bed mobility and proper body mechanics during orientation. **Plan to Monitor Performance:** Beginning 3/30/2026, the Unit Manager or designee will conduct random observations of Nurse Aides providing bed mobility and incontinence care to residents with cognitive impairment requiring assistance with bed mobility, at a frequency of three times per week for four consecutive weeks, then weekly for four consecutive weeks, then monthly for three consecutive months. The Unit Manager or designee will utilize an audit tool to document whether staff are rolling residents toward themselves, providing appropriate verbal cues, and following care plan interventions. The Unit Manager or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. **Date of Compliance:** 04/03/2026	

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F0689 SS = D	Continued from page 5 the resident rolled out of bed. As a result, she sustained an abrasion to the right side of her forehead. On 03/10/26 at 11:29 AM, an interview was conducted with Nurse Aide (NA) #2. During the interview, he stated that on 01/14/26 around 7:10 AM, he entered Resident #72's room to provide incontinence care and assist her with dressing for the day. He explained that she was awake, and he informed her he was going to change her and roll her onto her side. NA #2 stated he picked up the bed pad underneath the resident and pulled it upward, placing the resident onto her left side. He further stated that as he lifted and her weight shifted toward the other side, she continued rolling and went off the bed onto the floor face first. NA #2 stated he attempted to catch her; however, he was unable to reach her because he was positioned across the bed. He stated he ran to the other side and observed the resident face down on the carpeted floor and called out for Nurse #1. He explained Resident #72 was non-verbal and was pointing to her forehead, where there was an abrasion. NA #2 stated Nurse #1 entered the room and assessed Resident #72, and the staff then used a gait belt to assist the resident back into her wheelchair. NA #2 stated the bed was in a low position at the time of the fall. NA #2 further stated that earlier that morning he had been informed during rounds that Resident #72 had changed to requiring a two-person assist with transfers, but not with bed mobility. He explained he had not worked with the resident since that update but acknowledged he should have rolled her toward him instead of away from him during care. On 03/11/26 at 10:16 AM, an interview was conducted with Nurse #1. During the interview, she stated that on 01/14/26 she remembered NA #2 calling out for assistance from the Resident's room. She stated that upon entering the room, she observed Resident #72 face down on the carpeted floor. Nurse #1 immediately assessed the resident and obtained vital signs. No major injuries were noted; however, an abrasion was present on her forehead. Resident #72 was placed on neurological checks due to hitting her head and was assisted back into her wheelchair using a gait belt with assistance from another staff member. Nurse #1 stated that NA #2 reported that while he was rolling Resident #72 in bed to provide incontinence care, he rolled her away from him using the bed pad, which resulted in her rolling off the bed onto the floor. The interview further revealed that staff were required to provide verbal cues to Resident #72, as she would not understand what to do without guidance due to cognitive impairment. Nurse #1 stated that NA #2 should have	F0689		

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F0689 SS = D	Continued from page 6 rolled the resident toward him during care rather than away from him. On 03/11/26 at 9:05 AM, an interview was conducted with the Director of Nursing (DON). During the interview, she stated she was the interim DON and was not in that role at the time of the incident. She explained that Resident #72 required verbal cues and assistance from at least one staff member with bed mobility. The DON stated that after reviewing the incident on 01/14/26, NA #2 should have rolled the resident toward him during incontinence care rather than away from him. She also stated she would have expected him to provide appropriate verbal cues prior to rolling the resident. On 03/11/26 at 1:06 PM, an interview was conducted with the Administrator. During the interview, she stated that appropriate positioning of Resident #72 would have included rolling her toward NA #2 during care rather than away from him.	F0689		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	# PLAN OF CORRECTION **Tag: F880** **Corrective Action for Affected Residents:** On 3/11/2026, the Wound Care Nurse was educated on proper hand hygiene and glove changing procedures between dirty and clean wound care tasks. On 03/13/26, the Wound Care Nurse, under direct supervision of the DON or designee, provided wound care to Resident #57 using proper hand hygiene and glove changing procedures between dirty and clean wound care tasks with no noted signs or symptoms of infection. Resident's insurance issued a discharge from Part A services 3/16/2026, resident was discharged home with appropriate services. **Identifying other Residents having the Potential to be Affected:** All residents receiving wound care services have the potential to be affected. On 03/31/2026, the DON or designee reviewed the wound care records of residents who received wound care from the Wound Care Nurse during the previous seven days to identify residents potentially exposed to improper hand hygiene practices during wound care procedures. All residents receiving wound care services were evaluated by the QSM Wound Care Provider on 3/18/2026 and again on 3/25/2026 to ensure no adverse reactions existed. **Measures put into place or Systemic Changes:** On 03/11/26, the DON or designee immediately in-serviced the Wound Care Nurse on the facility's Hand	04/01/2026

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F0880 SS = D	Continued from page 7 (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 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 follow their Hand Hygiene Policy when the Wound Care Nurse failed to doff her gloves, sanitize her hands, and don clean gloves	F0880	Continued from page 7 Hygiene Policy with emphasis on doffing gloves, sanitizing hands, and donning clean gloves when moving from contaminated body sites (cleaning wound and surrounding area) to clean body sites (applying sterile wound dressings). On 03/27/26 through 04/01/26, the DON or designee in-serviced Licensed nurses and wound care staff on proper hand hygiene procedures during wound care, specifically the requirement to doff gloves, sanitize hands, and don clean gloves when transitioning from dirty procedures to clean procedures during wound care. The Hand Hygiene policy and the Wound Care and Dressing Changes policy are provided on the Wound Care Nurse treatment cart for quick reference. All newly hired teammates will receive education at orientation and annually. **Plan to Monitor Performance:** Beginning 03/30/26, the IP or designee will conduct direct observations of wound care procedures performed by the Wound Care Nurse and Licensed nurses providing wound care using an audit tool that specifically monitors hand hygiene compliance when transitioning from dirty to clean procedures during wound care. Observations will be conducted weekly for four weeks, then bi-weekly for four weeks, then monthly for three months. The IP or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. **Date of Compliance:** 04/01/2026	

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F0880 SS = D	Continued from page 8 after cleaning Resident #57's sacral wound and surrounding area and prior to cutting and placing the alginate with silver (highly absorbent wound dressing) on his wound bed during wound care. The deficient practice occurred for 1 of 8 staff observed for infection control practices (Wound Care Nurse). The findings included: Review of the facility's policy entitled Hand Hygiene which is part of the Infection Control Policies and Procedures, last revised on 10/12/23 read in part, "Policy: Practicing hand hygiene is a simple yet effective way to prevent infections. Performing hand hygiene can prevent the spread of germs, including those that are resistant to antibiotics. All teammates are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of infections. Teammates are expected to follow hand hygiene procedures to help prevent the spread of infections to other staff members, residents and visitors. Procedures: 4. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations:Before donning gloves and after removing glovesBefore and after handling clean or soiled dressings, gauze pads, contaminated equipment, etc.Before moving from a contaminated body site to a clean body site during resident care.6. The use of gloves does not replace handwashing/hand hygiene." Review of Resident #57's electronic medical record (EMR) revealed wound care orders for an unstageable pressure ulcer to his sacrum. The wound orders dated 03/01/26 read, "cleanse with normal saline (NS), pat dry, apply alginate with silver and cover with dry dressing daily every day shift and as needed for protection." An observation was conducted on 03/11/26 at 10:12 AM of wound care being provided to Resident #57 for his sacral wound. The Wound Care Nurse with mask, gown, goggles, and gloves on cleansed the overbed table with a wipe and placed a barrier on the table and then her wound supplies. She doffed her gloves sanitized her hands and donned clean gloves and cleaned the wound bed of Resident #57's sacral wound. The Wound Care Nurse doffed her gloves, sanitized her hands, donned clean gloves and cleaned the outer wound area with NS-soaked	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345152	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Village	**1265 21 Street NE , Hickory, North Carolina, 28601**

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F0880 SS = D	Continued from page 9 gauze and patted the wound dry. She then, without doffing her gloves, sanitizing her hands and donning clean gloves, proceeded to cut the alginate with silver dressing and placed it on the wound bed to make sure it was covered. The Wound Care Nurse then doffed her gloves, sanitized her hands and donned clean gloves and placed a clean dressing on the wound over the alginate with silver. She doffed her gloves, washed her hands with soap and water, donned clean gloves and proceeded to Resident #57's heel wounds. After completing care to the heel wounds she gathered her trash, doffed her gloves, eye protection, gown and mask, washed her hands with soap and water, gathered her trash and left the room. An interview on 03/11/26 at 10:40 AM with the Infection Preventionist (IP) revealed the Wound Care Nurse should have doffed her gloves after cleaning the wound, sanitized her hands, donned clean gloves and then proceeded with cutting the alginate with silver dressing and applying it to the wound bed. An interview on 03/11/26 at 12:20 PM with the Wound Care Nurse and the Director of Nursing (DON) revealed that the Wound Care Nurse stated she was not aware that she had not doffed her gloves, sanitized her hands and donned clean gloves after cleansing the area around the wound bed and before cutting and applying the alginate with silver dressing to the wound bed. The Wound Care Nurse stated she should have cleansed the wound and surrounding area and then doffed her gloves, sanitized her hands, and donned new gloves prior to cutting and applying the alginate with silver dressing to the wound bed. The DON stated that she agreed that when moving from a dirty procedure (cleansing the wound and surrounding area) to a clean procedure (applying wound treatment) you should doff your gloves, sanitize your hands, and don clean gloves prior to the clean procedure. An interview on 03/11/26 at 2:15 PM with the Administrator revealed she would have expected the Wound Care Nurse to follow their Hand Hygiene policy and procedure while providing wound care.	F0880		