STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345088	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Glen	**849 Waterworks Road , Winston-Salem, North Carolina, 27101**

(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 03/30/26 through 04/02/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 22C45E-H1.	E0000		04/21/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/30/26 through 04/02/26. Event ID #22C45E-H1. The following intakes were investigated: 852013, 852014, 2567635, 2656965, 2808756, and 2809047. 1 of the 11 complaint allegations resulted in deficiency.	F0000		04/21/2026
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 resident and staff interviews, the facility failed to provide care in a safe manner when Resident #4 rolled off the left side of her bed during incontinence care and required transfer to the hospital for medical evaluation. This was for 1 of 4 residents reviewed for accidents (Resident #4). Findings included: Resident #4 was admitted to the facility on 5/29/23.	F0689	Corrective Action for Affected Residents: On 3/26/26, Resident #4 was assessed by Nurse #1 after rolling off the left side of her bed during incontinence care. Resident #4 was transported to the hospital for medical evaluation. On 3/28/2026, the Administrator interviewed Resident #4 regarding her fall and the resident stated that she lost her balance when she had reached over to grab a chair and moved her leg to assist with her care and "gravity took over". On 3/28/2026 the Administrator educated Resident #4 on not utilizing a chair for balance and Resident #4 verbalized her understanding. Resident #4 has a BIMS of 14. On 03/28/2026 Resident #4 was also educated by the Administrator on ensuring her bed remained in the lowest position for safety and Resident #4 refused suggestion. On 4/2/2026, Nurse Aide #1 was educated on providing assistance according to resident care plans. Identifying other Residents having the Potential to be Affected: On 04/02/2026, the DON or designee conducted a review of care plans and care guides for residents requiring two-person assistance with bed mobility and incontinence care to ensure interventions were clearly documented and being followed by staff. Measures put into place or Systemic Changes: On	04/03/2026

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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F0689 SS = D	Continued from page 1 The resident's diagnoses included vascular dementia, left side paralysis following stroke, and muscle weakness. Resident #4's care plan last updated on 12/29/25 revealed a focus area of risk for falls related to left side weakness and paralysis. Interventions included two-person physical assistance with bed mobility and using a lift for transfers. Review of the care guide (a guide that explains to staff members what and how much assistance each resident requires) last reviewed on 3/6/26 showed Resident #4 was a two staff assist rolling left and right, bed to chair transfers and used an extra-large sling with the lift. A quarterly Minimum Data Set (MDS) dated 1/1/26 indicated Resident #4 was cognitively intact and had range of motion impairment on one side of her upper and lower extremities. The MDS also indicated Resident #4 was dependent rolling left and right. A review of Resident #4's quarterly Interdisciplinary Team (IDT) risk assessment dated 1/8/26 revealed she was at moderate risk for falls. A review of Resident #4's physical therapy evaluation dated 3/17/26 showed Resident #4 was dependent rolling left to right and was unable to sit on edge of bed unsupported. During an interview with the Rehabilitation Manager on 4/2/26 at 7:45am, she stated Resident #4 was recently reevaluated on 3/17/26 for a decline in strength and functional mobility. The Rehabilitation Manager stated Resident #4 was unable to support herself and was dependent on staff for bed mobility due to her left side paralysis and weakness. During an interview with Resident #4 on 3/31/26 at 10:34 am she stated on 3/26/26, she rolled off the left side of her bed onto the floor while Nurse Aide (NA) #1 was providing care. Resident #4 stated she usually had two nurse aides turning her in bed, but sometimes only one would come in. Resident #4 indicated that when there was only one nurse aide, she usually turned on her left side and reached over to the side chair with her right hand and steadied herself that way. Resident #4 stated, on the day she fell, she thought the chair may have moved causing her to lose her balance. Resident #4 reported she didn't hit her head on anything but did hurt her right knee when she landed on the floor. Resident #4 indicated she went to the hospital because her knee hurt but nothing was broken. Resident #4 reported	F0689	Continued from page 1 4/1/26, the DON or designee in-serviced Licensed nurses and Nurse Aides on the requirement to review and follow each resident's care plan and care guide prior to providing care, specifically regarding the level of assistance required for bed mobility and incontinence care. The in-service included clarification that staff must obtain assistance from another staff member when the care guide indicates two-person assistance is required, regardless of whether the staff member has previously cared for the resident independently. On 04/02/2026, the DON or designee reviewed and clarified care plans for residents requiring assistance with bed mobility to ensure the level of assistance needed was clearly documented. On 04/02/2026, the DON or designee implemented an audit tool to monitor staff compliance with care plan interventions for bed mobility. Plan to Monitor Performance: The DON or designee will observe 3 bed mobility assists weekly for 4 weeks, twice monthly for 2 months, and then monthly for 3 months using the audit tool to ensure staff are following care plan interventions and providing the appropriate level of assistance. The DON 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 the plan quarterly for two quarters.	04/03/2026

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F0689 SS = D	Continued from page 2 she had taken Tylenol for discomfort but had not needed anything else. During an interview with Nurse Aide #1 (NA #1) on 4/2/26 at 6:45am she stated on 3/26/26 during 3rd shift (7:00pm to 7:00am) at approximately 6:00am, she was providing incontinent care for Resident #4. NA #1 stated she usually worked on a different hall and had worked with Resident #4 a couple times prior. NA #1 stated she was aware that Resident #4 was dependent on staff for rolling left and right but she had cared for her by herself before by rolling Resident #4 on her left side and letting her hold onto the side chair with her right hand for support. NA #1 reported she could have asked the other nurse aide on the hall for assistance but thought the other nurse aide was already assisting another resident at that time. NA #1 stated she thought the side chair moved causing Resident #4 to lose her balance which allowed her to continue rolling left and off the left side of the bed onto the floor. NA #1 stated Resident #4 didn't hit her head and, initially, didn't complain of any pain anywhere. NA#1 stated she stepped out into the hallway and called for Nurse #1 to come help before returning to Resident #4. During an interview with Nurse #1 on 4/2/26 at 6:55am, she stated she was working 3rd shift on 3/26/26 and was near the nurse's station around 6:00am when NA #1 called out for assistance. Nurse #1 stated she arrived at Resident #4's room and found her lying face down on the left side of her bed. Nurse #1 reported that Resident #4 was alert and oriented and stated she didn't hit her head, and she was not complaining of any pain at that time. Nurse #1 stated she completed a full assessment, including vital signs, and found no abnormalities. Nurse #1 stated she and NA #1 used the lift to put Resident #4 back in her bed. Nurse #1 stated Resident #4 complained of some right knee pain after she was back in her bed, and she was transported to the hospital for evaluation. Nurse #1 indicated that Resident #4 was unable to support herself and needed two staff members to provide incontinence care. A review of an emergency department report dated 3/26/26 revealed Resident #4 was transported for evaluation following a witnessed fall at the facility. Resident #4 was alert and oriented and complained about right knee pain. Extensive imaging studies were performed to evaluate Resident #4 for any fractures. All these imaging studies were negative. Resident #4 was transported back to the facility on 3/26/26 with no new orders.	F0689		04/03/2026

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F0689 SS = D	Continued from page 3 During an interview with NA#2 on 3/31/26 at 10:50am, she stated that she usually worked first shift (7:00am to 7:00pm) and cared for Resident #4 frequently. NA#2 stated that Resident #4 was unable to help herself turn due to her weakness on her left side. NA#2 reported she always had assistance when providing incontinence care for Resident #4. During an interview with Nurse #2 on 3/31/26 at 11:00am, she stated she usually worked first shift and was assigned to Resident #4's hall often. Nurse #2 stated Resident #4 required two staff members to turn her in bed and provide incontinent care. During an interview with the Director of Nursing on 4/2/26 at 2:10pm, she stated it was the nurse aide's responsibility to check and follow the care guides for each resident they are assigned to prior to providing care. The DON reported that if the care guide stated Resident #4 was dependent and required two staff members, then the nurse aide should have gotten assistance from another staff member.	F0689		04/03/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F0756	Corrective Action for Affected Residents: On 04/02/2026, the Medical Director or designee reviewed the pharmacist recommendation dated 2/2/26 for Resident #14 and completed the recommended follow-up to determine appropriateness of aripiprazole taper versus initiation of psychiatric services consult. On 4/02/2026, Resident #14 received a psychiatric services consult with a recommendation to taper Resident #14's aripiprazole. On 04/03/2026 the Director of Nursing (DON) or designee ensured the order for the taper of the aripiprazole was completed. Identifying other Residents having the Potential to be Affected: On 04/10/2026, the DON or designee reviewed all pharmacist medication regimen review recommendations from January 2026, February 2026, and March 2026 to identify any other residents with outstanding recommendations that had not been acted upon by the attending physician or provider. No other missed recommendations were identified during this review. Measures put into place or Systemic Changes: On 04/17/2026 the Administrator or designee provided the Medical Director, Primary Nurse Practitioner, Psychiatric Nurse Practitioner, DON, and Assistant Director of Nursing (ADON) with a copy of the facility's medication regimen review policy and in-serviced them on new expectations including specific timeframes for provider response to pharmacist recommendations (maximum 14 days for	04/21/2026

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F0756 SS = D	Continued from page 4 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and Nurse Practitioner, Pharmacist and Medical Director interviews, the facility failed to act on a pharmacy medication regimen recommendation for a Resident taking aripiprazole; aripiprazole is an atypical antipsychotic medication that can be used to treat depression and for which possible side effects include tardive dyskinesia (uncontrollable abnormal movements of the face, tongue or other body parts and requires frequent assessment and monitoring). The deficient practice occurred in 1 of 5 residents reviewed for unnecessary medications (Resident #14). Findings included: Resident #14 was admitted to the facility on 9/19/25 with diagnoses including depression. Review of records revealed a 1/5/26 physician's order for aripiprazole 5 mg (milligrams) by mouth once a day for depression. Review of the Pharmacist's monthly Medication Regimen Review (MRR) dated 1/7/26 revealed an abnormal involuntary movement scale (AIMS) assessment which revealed no identified involuntary movements or medication issues and there were no new pharmacy recommendations. The Pharmacist's monthly MRR dated 2/2/26 included a recommendation to the provider to consider tapering Resident #14 off of aripiprazole and introducing a different medication to treat her depression if appropriate. The Medical Director's response on the recommendation was noted as "in agreement" with a handwritten note dated 2/24/26 that the Nurse Practitioner would follow up with	F0756	Continued from page 4 non-urgent recommendations and immediate for urgent recommendations) and a tracking system to monitor completion of pharmacist recommendations. On 04/21/2026 the DON or designee implemented a Pharmacist Recommendation Tracking Log to document date of pharmacist recommendation, date delivered to provider, provider name, date of provider response, and action taken. Plan to Monitor Performance: Beginning 04/21/2026, the ADON or designee will audit the Pharmacist Recommendation Tracking Log monthly for four months, then quarterly for two quarters to ensure pharmacist recommendations are delivered to providers and providers are documenting their review and action taken within established timeframes. The ADON or designee will review all pharmacist recommendations received during that month's audit period to verify provider documentation in the medical record shows the identified irregularity has been reviewed and action taken or rationale documented for no change. The DON 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 the plan quarterly for two quarters.	04/21/2026

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F0756 SS = D	Continued from page 5 regards to the medication taper or to initiate a psychiatric services consult for the recommended tapering of aripiprazole. An AIMS assessment dated 3/17/26 revealed a score of zero, which indicated no abnormal involuntary body movements. Review of Resident #14's medication administration records (MAR) for February 2026 and March 2026 revealed Resident #14 had continued to receive 5mg of aripiprazole daily per the 1/6/26 order with no taper attempts noted. Review of the April 2026 MAR revealed the aripiprazole was documented as administered on 4/1/26 and 4/2/26. Further review of Resident #14's medical record revealed no documentation by the provider regarding follow up of the pharmacist's recommendation on 2/2/26, no dose taper attempts or initiation of a psychiatry services referral. On 4/2/26 at 11:00 AM, an interview with the Primary Nurse Practitioner was conducted. The Primary Nurse Practitioner stated she was not the one responsible for performing follow-up on medication taper recommendations for antipsychotic medications as she only did Primary Care services. The Primary Nurse Practitioner indicated the Psychiatry Nurse Practitioner was the person to speak to for all psychiatric related questions. When asked if she was aware of the 2/2/26 pharmacy recommendation and the Medical Director's note of acknowledgement, the Primary Nurse Practitioner repeated that she was not the person to speak to about anything related to psychiatry or the medication taper. A telephone interview with the Psychiatric Nurse Practitioner was conducted on 4/2/26 11:20 AM. The Psychiatric Nurse Practitioner indicated she did not know Resident #14. The Psychiatric Nurse Practitioner stated she had never received a referral for Resident #14 and Resident #14 was not on her list of new residents to see or evaluate so she could not answer any questions. On 4/2/26 11:54 AM, a telephone interview with the Medical Director was conducted. The Medical Director stated she remembered the pharmacist's recommendation dated 2/2/26 but did not realize the follow up had not been completed. The Medical Director indicated she had delegated this task to the NP and did not know why the follow-up had not been completed but that it should have occurred sooner rather than later. The Medical Director said	F0756		04/21/2026

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F0756 SS = D	Continued from page 6 she had not been informed of any new issues with Resident #14's condition or her medications and wasn't sure where the breakdown had occurred. The Medical Director further stated that either herself or the Primary Nurse Practitioner could perform the recommended follow-up and then decide if a taper versus a psychiatric consult was appropriate. The Medical Director said she would ensure this would be done. An interview with the Director of Nursing (DON) was conducted on 4/2/26 at 12:00 PM. The DON stated anytime a pharmacist made a recommendation for the provider, the recommendations were emailed to the Assistant Director of Nursing (ADON) who then printed off the recommendations and gave them to the provider for review. The DON said there was no box or bin where these forms were placed for the providers to pick up but rather the forms were actually handed to the providers in person for their review, then the provider would carry out the recommendations as they deemed appropriate. On 4/2/26 at 12:10 PM, a follow up interview with the Primary Nurse Practitioner was conducted and included a review of Resident #14's medical record and the pharmacy recommendation dated 2/2/26 the Medical Director had documented on. The Primary Nurse Practitioner stated she had never seen the 2/2/26 pharmacy recommendation and did not know about it. The Primary Nurse Practitioner indicated she did not know there was a directive for her to follow up on the pharmacy recommendation for Resident #14 to ascertain if a medication taper versus a psychiatric referral was appropriate. The Primary Nurse Practitioner said that all referrals and/or pharmacy recommendations were given to either the Medical Director or herself, but she did not know about this particular recommendation. An interview was conducted with the ADON on 4/2/26 at 12:41 PM. The ADON said when the pharmacist made a medication regimen recommendation, the pharmacist emailed all their recommendations to her in a batch email. The ADON said she then reviewed every recommendation and printed them and hand delivered them to the providers, to either the Primary Nurse Practitioner or to the Medical Director, whoever was on site on the given day. The ADON said the provider then reviewed the recommendations and signed off on them and then returned them to her for scanning into the electronic medical record. The ADON said she monitored the recommendations to ensure the recommendations were actually acted upon. The ADON said she was aware of the recommendation	F0756		04/21/2026

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F0756 SS = D	Continued from page 7 dated 2/2/26 for Resident #14, had noticed no follow up had been conducted and re-delivered the recommendation in person to the Primary Nurse Practitioner for review and follow up. The ADON said she could not remember when she re-submitted the recommendation to the Primary Nurse Practitioner, but it was after she noticed that no apparent action had been taken. On 4/2/26 at 1:20 PM, a telephone interview with the Pharmacist was conducted. The Pharmacist stated that anytime she made a medication regimen recommendation, she would follow up on her recommendations to see if they were carried out. The Pharmacist indicated she was able to see all of her outstanding recommendations in their computer system as soon as she logged in. The Pharmacist noted follow ups were usually conducted by the providers within 30 to 45 days from the date of the recommendation but she sometimes allowed for a maximum of 60 days due to the schedules of the providers and not knowing the exact days the providers were onsite. The Pharmacist said if a recommendation was not acted upon within that timeframe, she would initiate a new recommendation to the provider. The Pharmacist further stated she would be coming to the facility next week for her next monthly visit and would follow up on the 2/2/26 recommendation for Resident #14 at that time. In an interview with the Administrator on 4/2/26 at 2:20 PM, the Administrator stated she did not know exactly where the breakdown had occurred with the pharmacy recommendation not yet being acted upon and her expectation was if a pharmacist made a medication regimen recommendation that the recommendation would be acted upon as soon as possible when the provider became aware of it to ensure the residents' medication needs were being addressed and met.	F0756		04/21/2026