STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Place	**24724 South Business 52 , Albemarle, North Carolina, 28001**

(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
F0000	INITIAL COMMENTS A complaint survey was conducted from 9/10/25 through 9/19/25. Event ID# 1D69B7-H1 The following intakes were investigated: 2608913 and 2612371. 2 of the 5 complaint allegations resulted in deficiency.	F0000		
F0689 SS = G	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, observation, and interviews with staff and a resident, the facility failed to provide a safe transfer. The resident was transferred manually by stand pivot (A technique for moving where a resident stands with assistance and pivots on their feet then sits. This technique requires the ability to bear most of their body weight.) and supported under her arm pits by Nursing Assistant (NA) #1. During transfer the resident's right knee had a popping sound and the resident reported immediate pain. The resident was transferred to the hospital for an evaluation and x-ray determined the resident had a non-displaced fracture (the bone fractured but did not move out of place) of the proximal tibia-fibula (fracture of the shin and calf bone just below the knee). The resident had a knee immobilizer placed. This deficient practice affected 1 of 4 residents reviewed for accidents (Resident #1).	F0689	"Past Noncompliance - no plan of correction required"	

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 = G	Continued from page 1 Findings included: Resident #1 was admitted to the facility on 7/3/24 with the diagnosis of stroke. The care plan dated 7/24/25 for Resident #1 documented she had an activity of daily living deficit. Transfers were total lift (mechanical lift). The quarterly Minimum Data Set (MDS) dated 7/28/25 documented Resident #1 had a severely impaired cognition. Her functional limitations were impaired upper body on one side and lower body no impairment. The resident required maximal assistance to roll and up to sit in her bed and lying to sitting and sitting to stand was not applicable. The resident was dependent during transfer. The resident had no pain and was not receiving therapy. On 9/10/25 at 1:40 pm NA #1 was interviewed. NA #1 stated she was assigned to Resident #1 on 9/2/15 evening shift. The resident required mechanical lift for transfer. NA# 1 requested NA #2 assist with the transfer of the resident using mechanical lift. The resident was sitting in a reclining wheelchair, and the sling was out of place. The NA moved the sling underneath the resident. When the resident was lifted, she was slipping out of the sling. The resident was then manually transferred, both NAs lifted and transferred the resident from her chair. NA #1 felt it was safer to manually transfer the resident to prevent a fall out of the sling. NA #1 went on to further state she placed the resident's arms over her shoulders for the transfer. The nurse was not informed the sling was in the wrong position and the resident was manually transferred. The resident complained her right leg was hurting after the transfer and the nurse was informed immediately. This type of transfer had not happened before the incident. On 9/10/25 at 1:20 pm an interview was conducted with NA #2. NA #2 stated she walked into Resident #1's room to assist NA #1 as the second person for the mechanical lift. The lift pad was up the resident's back and not underneath her. NA #1 stated to NA #2 how she was unable to reposition the sling. NA #1 had thought it would not be safe to use the lift pad/sling in its position; the resident could fall. NA #1 decided to transfer the resident without the lift. NA #1 used the stand pivot method with the resident's arms over the NAs shoulders and was holding her by her pants for support. NA #2 stated she observed the transfer and	F0689		

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F0689 SS = G	Continued from page 2 could not see the resident's legs. NA #2 stated "we heard a pop" as the transfer was done. NA #2 stated she would move the sling if not in the proper place before attempting to use the mechanical lift. NA #2 further stated she would never transfer a resident by standing when they needed a lift. The resident had not said anything about the type of transfer. The resident stated "my knee, my knee it hurt" during the stand pivot transfer. The resident was successfully transferred without falling. NA #2 indicated she made a concerned facial expression to NA #1 during transfer and NA #1 stated she had done this before transfer successfully but had not mentioned which resident. NA #2 stated she had not observed NA #1 manually transfer a resident that required a mechanical lift before. Nurses' note dated 9/3/25 written by Nurse #1 documented on 9/2/2025 at 10:25 pm NA #1 reported that while putting Resident #1 to bed with the lift, they heard a popping sound from her right knee. The knee appeared to be rotated to the right, and the resident complained of pain. On 9/10/25 at 1:32 pm an interview was conducted with Nurse #1. Nurse #1 stated she was at the nurses' station evening shift 9/2/25 when NA #1 and NA #2 informed Nurse #1 they had to rearrange the sling for the mechanical lift to transfer Resident #1 into her bed. The NAs thought the resident's bottom was going to come through the sling and rushed to put her in bed and heard something pop. Nurse #1 indicated she was informed by both NAs that the resident was on the sling for transfer. The sling was under the resident when her leg was assessed in her bed. The resident stated she heard a pop in her right leg, and it hurt. Nurse #1 further stated the resident had not mentioned anything about the transfer, and she was not asked. Tylenol was administered for pain, and the NP was notified. Nurses' note dated 9/2/25 at 9:15 pm written by Nurse #2 documented a discharge summary note that Resident #1 was sent to the hospital for evaluation of her right knee pain after transfer via Emergency Medical Services. The resident rated her pain at 10 out of 10 (10 worst pain and 1 minor pain). The resident's vital signs were stable. On 9/10/25 at 2:29 pm Nurse #2 was interviewed. Nurse #2 stated NA #1 and NA #2 came to the nurses' station 9/2/25 evening shift to inform nursing that while transferring Resident #1 with the mechanical lift, her bottom was sliding out of the sling. The NAs hurried and heard a pop of the resident's knee. It was not reported the resident had hit the lift during transfer.	F0689		

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F0689 SS = G	Continued from page 3 Nurse #2 was requested to evaluate Resident #1's knee. The resident was in her bed, and her knee was rotated out to the right. Nurse #2 had not seen the sling underneath the resident while in the bed. The resident stated the knee popped and it hurt. Resident #1 did not say anything about the type of transfer. The medical staff was notified and directed staff to send the resident to the hospital. The resident's pain was a 10 out of 10. Tylenol was the only medication ordered for pain and was administered. The NAs had not reported that the resident was transferred by stand pivot. Nurse #2 stated the resident had osteoporosis and prior history of fracture and the resident was not able to stand. Resident #1's hospital record documented she was seen in the Emergency Room on 9/2/25 for pain in her right knee. The x-ray report documented she had a non-displaced fracture of the proximal tibia-fibula. The resident had not required surgery. Orthopedic follow up outpatient was planned. The resident had a history of hip fracture and osteoporosis. The resident had a knee immobilizer placed. Resident #1 had an order dated 9/3/25 for Oxycodone 5-325 milligrams every 6 hours as needed for pain started at the facility. The Nurse Practitioner (NP) note dated 9/3/25 documented that the resident was sent to the Emergency Room (ER) for right knee pain. The resident was evaluated after her ER visit on 9/3/25. ER imaging diagnosed closed fracture of the right tibia-fibula nondisplaced. She returned with a knee immobilizer. During exam today she verbalized pain. ER orthopedic consultation concluded due to age avoiding an operation would be beneficial. The resident was discharged back to the facility with outpatient follow-up and nonoperative management. Nurses' note dated 9/3/25 at 1:00 pm written by Nurse #3 documented the facility received a call from the orthopedic office. The physician informed staff the resident would not need to be seen until one week. An appointment was made for 9/11/25. On 9/10/25 at 1:10 pm an interview was conducted with Nurse #3. Nurse #3 stated she was not present at the time of Resident #1's transfer 9/2/25 evening shift but was on shift the next morning. Nurse #3 stated NA #2 reported a lift was not used to transfer the Resident #1. NA #2 watched a stand pivot transfer of Resident #1 by NA #1. NA #2 had not said anything to NA #1 about not using a mechanical lift. The resident required	F0689		

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F0689 SS = G	Continued from page 4 transfer by mechanical lift. Nurse #3 indicated if a NA had a problem with transfer they were required to find a nurse. Resident #1 had a fractured end of her tibia-fibula and was wearing a whole leg immobilizer. The resident was being medicated for pain and was comfortable when not moving. Resident #1 was having pain with movement and care. The resident had grimacing and facial expression when moved. On 9/10/25 at 3:10 an interview was conducted with the Administrator. The Administrator stated she was aware of the incident with Resident #1 where NA #1 reported she tried to transfer the resident using the mechanical lift and was unable due to discomfort. NA #1 reported she decided to transfer Resident #1 by standing and supporting the resident. NA #1 informed the Administrator she heard a pop during transfer, and the resident had knee pain. The Administrator stated the resident was not able to stand; she was transferred with a mechanical lift. The resident was sent to the Emergency Department and an investigation was completed. The Administrator stated all nursing staff was required to complete education on safe transfer. The facility provided the following corrective action plan: 1) How will the corrective action be accomplished for those residents affected? At approximately 8:00 p.m. on 9/2/2025, Nurse Aide NA #1 and NA #2 attempted to transfer Resident #1 with a total mechanical lift, but during the transfer, Resident #1 indicated discomfort due to the position of the lift sling. NA #1 and NA #2 attempted to reposition the lift sling but could not get it to a different position since it was under Resident #1 in her reclining wheelchair. Since Resident #1 was expressing discomfort with the total mechanical lift transfer, NA #1 decided that a manual transfer by herself would be the best way to transfer Resident #1 to avoid discomfort. Resident #1 was transferred from the reclining wheelchair chair into her bed by NA #1. NA#1 initiated the transfer out of the reclining wheelchair NA #1 stood the resident by having placed her arms over the NA’s shoulders and holding the back of her pants. During the transfer from the reclining wheelchair to the bed, the nurse aides heard a "pop," after which the resident indicated right leg pain. NA #2 and NA #1 reported to Nurse #2 immediately. Nurse #2 called the residents daughter and left a message at 8:27 p.m. Nurse #2 used the medical director's standing orders, which state that in the event of an emergency, a	F0689		

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F0689 SS = G	Continued from page 5 resident should be sent to the emergency department; the medical director's triage line also states if calling with an emergency dial 911. Emergency Medical Services transported the resident to the Emergency Department at 9:15 p.m. An X-ray of the right knee revealed a fracture of the proximal tibia-fibula. Resident #1 returned to the facility on 9/3/2025 with orders for a mobilizer. On 9/3/25, the director of nursing began an investigation. Mechanical lift slings that are used for transfers are inspected by the nurse aide using the sling prior to each use. They are inspected per manufacturers recommendations to include: if any fraying or visible wear and tear, do not use, follow care instructions on wash tag and if illegible, do not use. Nurse Aide #1 and Nurse Aide #2 found no issues with the lift sling that was used with Resident #1 on 9/2/25. There was no issue with the lift sling; the resident expressed discomfort with the position of the lift sling and the nurse aides thought trying to reposition the sling in Resident #1's chair could cause further discomfort which led to the transfer without the lift. 2) How will corrective action be accomplished for those residents who have the potential to be affected? On 9/3/25, a root cause analysis was completed by the Administrator and the Director of Nursing. It was determined that the nurse aides did not notify a nurse when they felt they could not follow the resident's transfer status due to resident discomfort, so the nurse could assist with repositioning of the sling or provide other assistance. On 9/3/25, the Director of Nursing and Minimum Data Set nurse audited electronic health records for all residents requiring 2+ person assist transfers or higher. This audit included every resident who required more than one person to transfer. No issues noted and no residents reported concerns. Every resident requiring more than one person for transfers was assessed by the Director of Nursing, Staff Development Coordinator, and the MDS Nurse. No injuries were observed or reported. The audit included evaluation if any nursing staff had not followed the care plan and used the appropriate transfer status. On 9/3/25, the MDS nurse reviewed all special transfer instructions in the electronic health record. Special transfer instructions are what identify the transfer	F0689		

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F0689 SS = G	Continued from page 6 status for each resident in their chart. The transfer instructions were compared to care plans for all current residents to ensure consistency, and no discrepancies were noted. 3) What measures will be put into place to ensure that the deficient practice will not occur? Staff education for all nurses and nurse aides was conducted by broadcast text and in-person by the Staff Development Coordinator on 9/3/25, covering procedures for following transfer status according to care plans, on Lutheran Services Carolinas' transfer policy, on safe lift and transfer techniques including the requirement to get a nurse if there is any concern about following the resident's transfer status, and the abuse and neglect policy. Nursing staff received instruction on reporting instances of improper resident transfer, as well as how to reposition lift slings when necessary for residents seated in chairs. Nursing staff who have not completed the training on 9/3/25 will be educated prior to their next working shift by the Director of Nursing and/or Staff Development Coordinator. The Staff Development Coordinator is responsible for tracking all education, and education for all staff was initiated 9-3-25. No staff will work without receiving the education. New hires will be educated during new hire orientation by the Staff Development Coordinator. 4. How does the facility plan to monitor its performance to make sure that solutions are sustained? The charge nurses will conduct observations of five randomly selected resident transfers each week for eight weeks, commencing on 9/4/2025, and subsequently five resident transfers will be observed each month for an additional three months. These audits will include Residents transfer status, transfer performed correctly, ordered equipment used, lift sling inspection and staff member observed. These Audits will be completed on all shifts, including first shift, second shift and third shift. Audit findings will be presented by the Staff Development Coordinator and evaluated for effectiveness at the monthly QAPI meetings, and modifications will be implemented as needed to maintain compliance. The facility determined on 9/3/2025 that a corrective action plan was necessary. This plan became effective 9/3/2025 and no staff worked without education after 9/3/2025. The decision was made to monitor with a plan	F0689		

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F0689 SS = G	Continued from page 7 of correction on 9/3/25. The Administrator will be responsible for ensuring completion of the corrective action plan. Completion date for the corrective action plan: 9/4/25 Validation of the corrective action plan was completed on 9/12/25. Documentation reviewed of education sent out by broadcast text with confirmation that it was read and in person by signed roster for all current nursing employees that all mechanical lift transfers must be done with 2 staff, lift slings should be readjusted for appropriate positioning, manually transfer residents only in an emergency, and to report any staff that does not follow the policy. The Abuse and Neglect policy was also part of the required education. Documentation reviewed of skills fair observation that began on 9/11/25 of transfers including mechanical lift for all nursing staff which was ongoing. Staff could not return to work until the observation was completed. A review of the documented audits revealed the audits began on 9/3/25 for all residents that required a mechanical lift transfer. As part of the audit, residents that were oriented were interviewed. No other resident that required a mechanical lift transfer had a manual transfer identified. On 9/10/25 the Administrator and Director of Nursing were interviewed. Both stated audits of observed transfers had begun the week of 9/8/25. Interviews were completed with 4 NAs and 3 licensed nurses. All 7 staff interviewed participated in abuse and resident transfer education including the use of the mechanical lift. On 9/10/25 at 1:03 pm an observation of NA #3 and NA #4 transfer Resident #4 by mechanical lift from her wheelchair to her bed revealed no concerns with technique and safety. Resident #4 was interviewed and stated she had never been transferred without the lift and had no concerns. The corrective action plan's completion date of 9/4/25 was validated.	F0689		