Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		
		NH0068	B. WING		C 08/01/2019
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
TRINITY V	ILLAGE		STREET NE /, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
L 000	INITIAL COMMENTS		L 000		
	A complaint investigation of 29/19 through 08/0 allegation and it was to deficiencies were cite investigation. Event III	unsubstantiated. No d as a result of this			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/16/19

PRINTED: 08/22/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		345152	B. WING			08/	/01/2019
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				12	265 21 STREET NE		
TRINITY V	ILLAGE			Н	IICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	conducted from 07/29 faciltiy was in complia	complaint survey was 9/19 through 08/01/19. The ance with the requirements reparedness, Event ID					
F 000	INITIAL COMMENTS	;	F	000			
F 641 SS=D	four allegations inves substantiated and cite Accuracy of Assessm	was conducted from /19. There was a total of tigated and one was ed. Event ID# HQ1E11.	F	641			8/24/19
	resident's status. This REQUIREMENT by: Based on record rev facility failed to accurs status of a resident for sampled (Resident #9 The findings included Resident #92 was ad	is not met as evidenced iew and staff interview the ately code the discharge or 1 of 3 closed records 92).			Resident #92 was not affected due the deficient practice. MDS nurse immediately corrected the mistake whe was reported on 7/31/19 and resubmitt the MDS. All resident assessments have the potential to be entered incorrectly into MDS as human errors do occur. All	en it ed	
	mellitus, dementia, at disease, and others. discharged on 05/23/ Review of the Minimu	trial fibrillation, Parkinson's Resident #92 was 19. um Data Set (MDS)			residents who were discharged in the I- 30 days were audited for accuracy by Director of Quality Life & Care on 8/1/1 and no other submission errors were found.	Γhe	
	I .	5/23/19 revealed that verely cognitively impaired king and required limited			The MDS nurses were re-educated the importance of accurate MDS entries.		
L ABORATORY	-	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u> F		TITLE		(X6) DATE

Electronically Signed 08/21/2019

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 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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345152	B. WING			C	
NAME OF DE	ROVIDER OR SUPPLIER	04010Z	5:	STREET ADDRESS, CITY, STATE, ZIP CODE	08	/01/2019	
NAME OF PR	ROVIDER OR SUPPLIER						
TRINITY V	ILLAGE			1265 21 STREET NE			
				HICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 641	Continued From page	÷ 1	F 64	41			
		ties of daily living. The MDS Resident #92 was pital. The MDS was		by Marcheta Campbell, Administra 8/7/19. They have been instructed double check all information for ad before submitting the MDS.	I to		
	Resident #92 was dis	ote dated 05/23/19 read, charged to the dogwood and medical provider		4. The Director of Quality Life & C conduct random audits of dischargeresidents' MDS (1) x weekly for (4 and (1) x monthly for (6) months. I incorrect entries will be corrected	ged) weeks		
	on 08/01/19 at 11:48 confirmed that Reside assisted living and ha	ducted with MDS Nurse #2 AM. MDS Nurse #2 ent #92 had discharged to d not gone to the hospital led that MDS Nurse #1 was		immediately and resubmitted. Audresults will be reported to the QAF committee for (6) months for trend tracking purposes.	Pl		
		the facility. MDS Nurse #2 a data entry error and she or immediately.		All corrective action will be comple 8/24/19.	eted by		
	Administrator stated tone of the best MDS company and it was ju	1/19 at 12:25 PM. The hat MDS Nurse #1 was the nurses in the entire ust a data entry error. The stated she expected the					
F 656 SS=D	Clinical Services (DC- The DCS indicated th and the staff would co	ducted with the Director of S) on 08/01/19 at 2:45 PM. at it was a data entry error prrect the error.	F 6	56		8/24/19	
	implement a compreh	ensive Care Plans cility must develop and ensive person-centered sident, consistent with the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345152	B. WING		C 08/01/2019	
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2019	
				1265 21 STREET NE		
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F 656	Continued From page		F 65	6		
		th at §483.10(c)(2) and				
	§483.10(c)(3), that inc					
	•	ames to meet a resident's				
	-	mental and psychosocial				
		ied in the comprehensive				
		nprehensive care plan must				
	describe the following					
		re to be furnished to attain				
		ent's highest practicable				
		psychosocial well-being as 24, §483.25 or §483.40; and				
		would otherwise be required				
		25 or §483.40 but are not				
		esident's exercise of rights				
	·	ling the right to refuse				
	treatment under §483					
	(iii) Any specialized so					
	· · · · · · · · · · · · · · · · · · ·	the nursing facility will				
	provide as a result of	• •				
	·	a facility disagrees with the				
		RR, it must indicate its				
	rationale in the reside					
	(iv)In consultation with	h the resident and the				
	resident's representat					
	(A) The resident's goa	als for admission and				
	desired outcomes.					
	(B) The resident's pre	ference and potential for				
	future discharge. Faci	ilities must document				
		s desire to return to the				
	•	ssed and any referrals to				
		s and/or other appropriate				
	entities, for this purpo					
		n the comprehensive care				
		in accordance with the				
	•	n in paragraph (c) of this				
	section.					
		is not met as evidenced				
	by:	n managad mandanga arad		4. Decident #42 I		
	baseu on observation	n, record reviews and		1. Resident #13 no longer has pain		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
			A. BOILBING			С	
		345152	B. WING		0:	3/01/2019	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		5/01/2010	
				1265 21 STREET NE			
TRINITY V	ILLAGE			HICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	Continued From page	e 3	F 65	6			
	interviews the facility intervention that required transferred via two	failed implement a care plan ired a dependent resident to p-person assistance for 1 of for supervision to prevent		associated with the incident w place on 3/19/19. No futher incoccurred and her care plan relaccurate.	cidents have		
	The finding included: Resident #13 was admitted to the facility on 11/29/18 with diagnoses which included diabetes and left sided weakness.			All residents have the poter affected if the care plan is not nurses and CNAs were in-services.	followed. All viced by the		
				DON on 8/13/19 reiterating the expectation of following and recare plan for each resident. No also be educated on the expectation.	eading the ew staff will		
	Data Set (MDS) date cognition was intact, assistance via two pe MDS also indicated, steady with assistance a limitation in function	#13's quarterly Minimum d 02/27/19 revealed, her and she required extensive ersons for transfers. The Resident #13 was only be and was coded as having all range of motion to one oth upper and lower		during orientation by the SDC. 3. The DON in-serviced all CN 8/13/19 regarding the protocol following care plans. Changes plan, including transfer status, automatically transferred to the sheets. The shift supervisor w	IAs on for to the care are e CNA flow		
	side of her body in both upper and lower extremities. Review of Resident #13's Care Plan initiated 12/07/18 revealed, a potential for falls related to			ensure that any changes to the are communicated to the inter team so the care plan can be	e care plan disciplinary		
		which required interventions		4. Staff Development Coordinate observe (2) CNAs weekly for (1) then monthly for (2) months, a for (9) months. If during the ra	4) weeks, nd quarterly		
	and completed by Nu #13 self-reported a fa at approximately 6:30 transferred from her v (NA) #1. The immedi incident was that the pack for her right kne medication was offer in the right knee. The	t Report (IR) dated 03/19/19 urse #3 indicated, Resident all that occurred on 03/19/19 D AM when she was being wheelchair by Nurse Aide ate action taken post Resident was offered an ice where but was declined and pain ed and administered for pain a IR also indicated, the which is the second of the consible Party were notified.		observations, CNAs fail to pro the care plan, they will receive training and disciplinary action appropriate. Written results from audits will be reported to the Committee quarterly for (12) many All corrective action will be imputed by 8/24/19.	e additional i, as om the QAPI ionths.		

AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345152	B. WING			C 08/01/2019	
NAME OF PI	ROVIDER OR SUPPLIER	0.0.02		STREET ADDRESS, CITY, STATE, ZIP COI 1265 21 STREET NE HICKORY, NC 28601	DE	00/01/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From page		F	356			
	at 4:54 PM written by assessed Resident # knee pain the Resider was being transferred wheelchair that morn did not lock her whee rolled backwards whi down on the Residen underneath her. The assessment Residen slightly larger than he bruising or redness windicated, Resident # medication but later a medication which she Review of a written s 03/19/19 revealed, R of right knee pain and right knee the resider was helping her back the bathroom the who it rolled backwards w Resident down on the had bent backwards #13 continued to exp to go get help but she behind her and lifted and into the bed. Nurse #3 was not ava Review of Resident # 03/20/19 revealed, at knee.	ing around 6:30 AM, NA #1 elchair and the wheelchair ch caused the NA to sit her tt's right leg as it bent PN indicated, upon t #13's right knee was er left knee and that no vas visible. The PN also et13 initially refused pain agreed to take pain e already had an order for. Itatement by Nurse #3 dated esident #13 had complained d upon assessment of her not reported that when NA#1 is into bed after taking her to eelchair was not locked and which caused the NA to sit the ee Resident's right leg which underneath her. Resident lain, that she asked the NA ee didn't, and the NA got the Resident up off the floor					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345152	B. WING			C	
NAME OF PI	ROVIDER OR SUPPLIER	1 0.0.02		STREET ADDRESS, CITY, STATE, ZIP CODE 1265 21 STREET NE HICKORY, NC 28601		08/01/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	03/21/19 revealed, a to the right knee for a for edema. During an interview of 07/29/19 at 3:29 PM morning of the incide taken her to the bath her up to transfer he realized that she had her wheelchair. Resi explain, the wheelch and the Resident's right I asked the NA to get wouldn't and then go into the bed. The Re report the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be get anyone into trout NA #1 since the incident ur hurt later that day be ge	#13's Physician Orders dated in order for ice to be applied 20 minutes three times a day with Resident #13 on she indicated that on the ent (03/19/19) NA #1 had wroom and when the NA stood in back to bed, the NA if not locked the brakes on dent #13 continued to air started to roll backwards, ght knee started to bend in the compact of	F 6	,			
	(RCG) that included necessary to provide the RCG were updat interventions. NA#2	th Resident Care Guides specific interventions e care to the residents and red as needed with new 2 stated, that in order to er for Resident #13, she					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345152	B. WING			C / 01/2019
NAME OF PI	ROVIDER OR SUPPLIER	0.0.02		STREET ADDRESS, CITY, STATE, ZIP CODE 1265 21 STREET NE HICKORY, NC 28601	1 00	70 1720 19
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	required a two person An interview with the 1:05 PM revealed, the (who was currently or incident with Residen discovered that the N was NA #1. The DON followed the appropria intervention of a two p #13 and also NA #1 also did n Resident #13 reporte on 03/19/19. NA #1 won 03/20/19 and subs NA #1 was not available.	Administrator on 08/01/19 at e Director of Nursing (DON) in vacation) investigated the t #13 on 03/19/19 and A involved in the incident found that NA #1 had not ate care planned person transfer for Resident of report the incident until d the incident later that day as given a written reprimand sequently terminated.	F 65	56		
F 689 SS=D	interview. During a follow up into on 08/01/19 at 4:34 Presidents' safety was expected the staff to plan to assure the aputilized. Free of Accident Haza CFR(s): 483.25(d)(1)(1)(1)(1)(2)(1)(2)(2)(3)(1)(1)(2)(3)(2)(3)(1)(3)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	erview with the Administrator M she indicated, that the her utmost concern and she follow the Resident's care propriate lift status was ards/Supervision/Devices (2)	F 68	39		8/24/19

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345152	B. WING _				C / 01/2019
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	70172010
TOINITY	W. I. A.O.F.			126	65 21 STREET NE		
TRINITY V	ILLAGE			HIC	CKORY, NC 28601		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		COMPLETION DATE
F 689	Continued From page	e 7	F6	889			
	This REQUIREMENT by:	Γ is not met as evidenced					
	Based on record rev	iew, resident and staff			1. Resident #13 no longer has pain		
	-	failed to safely transfer a			associated with the incident which tool	(
		who needed the assistance of			place on 3/19/19 from the deficient		
		of three residents reviewed			practice related to the transfer. There		
	`	ent #13). One staff member 3 alone and did not lock the			have been no further incidents with		
		e transfer resulting in the			transferring resident #13 since 3/19/19	-	
		ckwards and causing the			2. All residents have the potential to be	2	
		nt on the Resident's leg as it			affected if the care plan is not followed		
		Resident #13 experienced			CNAs were in-serviced by the DON on		
	pain and swelling req	uiring pain medication and			8/13/19 reiterating the expectation of		
	ice pack but without f	fracture in her right knee.			following the CNA flow sheet which		
					references the transfer status for each		
	The findings included	1:			resident. New staff will also be educate		
	Desident #40 wee ed	locitto d to the c facility, as			on the expectation during orientation b	У	
		Imitted to the facility on ses which included diabetes			the SDC.		
	and left sided weakne				3. The DON in-serviced all CNAs on		
	and left sided weaking	C33.			8/13/19 regarding the policy for		
	Review of Resident #	‡13's quarterly Minimum			transferring residents. Effective		
		d 02/27/19 revealed, her			immediately, any CNA who transfers a		
	cognition was intact,	and she required extensive			resident incorrectly by not following the		
	assistance of two per	rsons for transfers. The MDS			care plan will receive additional training	g	
		ent #13 was only steady with			and disciplinary action as appropriate.		
		coded as having a limitation			Also, during the audits listed below in	# 4,	
		motion to one side of her			the SDC will check to make sure staff		
	body in both upper a				have the proper equipment/devices identified and are following the care plant the care plant to the ca	an.	
		#13's Care Plan initiated			4. Stoff Davidanment Coordinates will		
		potential for falls related to which required interventions			4. Staff Development Coordinator will observe (2)random transfers by CNAs		
	that included two per	•			weekly for (4) weeks, then monthly for	(2)	
	transfers.	SOLIS ASSISIALICE WILLI			months, and quarterly for (9) months.	(4)	
					Written results from the audits will be		
	Review of an Inciden	t Report (IR) dated 03/19/19			reported to the QAPI committee quarte	erly	
	and completed by Nu	urse #3 indicated, Resident			for (12) months.	,	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345152	B. WING _			C 08/01/2019	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1265 21 STREET NE HICKORY, NC 28601	CODE	05/01/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	transferred from her v (NA) #1. The immedia incident was that the declined an ice pack i medication was offere in the right knee. The Physician and Respo Review of a Progress at 4:54 PM written by assessed Resident # knee pain, the resident was being transferred wheelchair that morni did not lock her whee rolled backwards whice down on the Resident underneath her. The assessment Resident slightly larger than he bruising or redness w indicated, Resident # medication but later a medication which she Review of a written st 03/19/19 revealed, Re of right knee pain and right knee, the resident	AM when she was being wheelchair by Nurse Aide ate action taken post Resident was offered but for her knee and pain and administered for pain IR also indicated, the ensible Party were notified. Note (PN) dated 03/19/19 Nurse #3 revealed, as she 13 for a complaint of right ent reported that while she I to the bed from her eng around 6:30 AM, NA #1 Ichair and the wheelchair ch caused the NA to sit her the properties of the	F6		<u> </u>		
	the bathroom the whe it rolled backwards who Resident down on the had bent backwards u #13 continued to explore to go get help but she	eelchair was not locked and nich caused the NA to sit the Resident's right leg which underneath her. Resident ain, that she asked the NA e didn't, and the NA got the Resident up off the floor					

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		345152	B. WING _			C 08/01/2019	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From pag	e 9	F 6	889			
	Nurse #3 was not av	railable for interview.					
		#13's Physician Orders dated in order for x-ray of the right					
	Review of Resident 7 03/20/19 indicated, r	#13's x-ray report dated no acute fracture.					
	03/21/19 revealed, a	#13's Physician Orders dated in order for ice to be applied 20 minutes three times a day					
	07/29/19 at 3:29 PM required two persons but on the morning of #1 had taken her to the NA stood her up to the NA realized that she her wheelchair. Resi explain, the wheelch and the Resident's riwhich caused the NA the Resident's right I asked the NA to get wouldn't, then she go lifted her up into the she did not report the started to hurt later the want to get anyone in seen NA #1 since the Resident #13 also stright knee became streated with pain me	ated, that after the fall her wollen and painful and was dication and ice packs. The , her right knee had an x-ray					

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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1265 21 STREET NE HICKORY, NC 28601	1 00/01/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 689	AM with NA #2 who e provided the NAs with (RCG)s that included necessary to provide the RCGs were upda interventions. NA #2 provide a safe transfer required the assistant transfers. An interview with the 1:05 PM revealed, the (who was currently or incident with Residen discovered that the N was NA #1. The DON having followed the a two person transfer fold not report the incireported the incident NA #1 was given a wand subsequently wand was not availar.	ducted on 07/31/19 at 11:15 explained, the facility in Resident Care Guides specific interventions care to the residents and ted as needed with new stated, that in order to er for Resident #13, she ce of two persons for Administrator on 08/01/19 at the Director of Nursing (DON) in vacation) investigated the the #13 on 03/19/19 and A involved in the incident I found that along with not ppropriate lift status for a for Resident #13, NA #1 also dent until Resident #13 later that day on 03/19/19. ritten reprimand on 03/20/19 s terminated.	F 689			
F 761 SS=D	on 08/01/19 at 4:34 F residents' safety was expected the staff to a status to ensure the r Label/Store Drugs an	d Biologicals	F 76 ⁻	1	8/24/19	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345152	B. WING		C 08/01/2019
NAME OF PI	ROVIDER OR SUPPLIER	1 0,000		STREET ADDRESS, CITY, STATE, ZIP CODE 1265 21 STREET NE HICKORY, NC 28601	00/01/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 761	Drugs and biological labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of \$483.45(h)(1) In accessional laws, the fact biologicals in locked temperature controls personnel to have accessive control act of 1976 abuse, except when package drug distrib quantity storad is mile to ereadily detected. This REQUIREMEN by: Based on observation interview the facility medications from 2 cand 600 hall carts) a (central supply) revies storage. The findings included 1. Resident #254 was	of Drugs and Biologicals is used in the facility must be see with currently accepted es, and include the ry and cautionary expiration date when of Drugs and Biologicals ordance with State and stility must store all drugs and compartments under proper is, and permit only authorized coess to the keys. acility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and end other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can T is not met as evidenced ons, record review, and staff failed to remove expired of 3 medication carts (300 and 1 of 3 medication rooms ewed during medication d: as readmitted to the facility on sisted living facility with	F 76	1. No resident was directly affected duto the deficient practice. 2. All residents have the potential to be affected. All licensed nurses and medication aides were in-serviced on 8/13/19 by the DON regarding expired medications. All expired medications identified by surveyors were immediate removed from the carts and medication storage rooms on 8/1/19. All medication rooms, medication carts and treatments.	ely n

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBED:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345152	B. WING _			C 08/01 /2	2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	'	00/01//	2013	
			1265 21 STREET NE					
TRINITY V	ILLAGE			HICKORY, NC 28601				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	- I	(X5) OMPLETION DATE	
F 761	Continued From page	e 12	F 7	61				
		lux disorder, hyperlipidemia,		carts were audited for expired medications by the SDC. One medication was found and disc	-			
	Meloxicam 7.5 milligr day as needed for os An observation of the was made on 08/01/1 Nurse #2. In the top of and available for use prescribed for Reside mg 30 tablets. The bot contained a use beform the contained and the contained the	a 300-hall medication cart 19 at 10:52 AM along with drawer of the medication cart was a bottle of medication ent #254 of Meloxicam 7.5 bottle of Meloxicam 7.5 my re date of 07/25/19. ducted with Nurse #2 on 1. Nurse #2 stated that red to the 300-hall on isted living and the bottle of a her. Nurse #2 stated that re expiration date of the was moving it from the 300-hall within the facility. reach nurse was responsible here was no expired art and the night shift staff re medication carts and d medication. Nurse #2 dispose of the Meloxicam 7/25/19.		3. A new audit tracking tool was and implemented on 8/7/19. Al medication and treatment carts medication storage room will be weekly on 3rd shift by the facili supervisor using the newly creatool. This practice will be ongoi addition, a representative from organization's pharmacy will enurses and medication aides on the importance of identifying removing expired drugs. 4. Each week, starting 8/8/19, will randomly audit two carts ar medication storage room (1) x (4) weeks, then (1) x monthly from the and quarterly for (12) midentify trends requiring follow re-education. Written results from audits will be reported to the Q committee quarterly for (12) model.	s created I s and the e audited ty ated aud ing. In the ducate th n 8/23/19 g and the SDC nd the weekly fo or (2) nonths to up and om the API onths.	it ne e e e e		
	any expired medication them to the pharmacy	n carts and were to remove on they found and return y. The DS stated that the at expired on 07/25/19						

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED			
		345152	B. WING _			C 08/01/2019	
NAME OF PROVIDER OR SUPPLIER TRINITY VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1265 21 STREET NE HICKORY, NC 28601		1 00/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 761	Continued From pa	-	F 7	61			
		en on the medication cart and emoved and returned to the					
	Clinical Services (D The DCS stated that manufacture guideling She stated that the through the medical rooms and were to medication they four pharmacy visited the assisted with medical times as well. The Inght shift staff went	onducted with the Director of CS) on 08/01/19 at 11:42 AM. at the facility followed ines for expired medication. night shift nursing staff went tion carts and medication remove any expired nd. The DCS added that the e facility every 3 months and ation storage during those DCS stated that she knew the t through the medication carts e overlooked the Meloxicam on 07/25/19.					
	Administrator stated follow the protocol a medication. She ad mg that expired 07/ on the medication of	onducted with the //01/19 at 12:25 PM. The did that she expected the staff to and discard any expired ded that the Meloxicam 7.5 25/19 should not have been art available for use, it should it and returned to the					
	09/09/17 with diagn	s readmitted to the facility on oses that included atrial on, gastroesophageal reflux itis, and others.					
	1	an order dated 01/30/18 read, (mg) by mouth (po) every 6					
	An observation of the	ne 600-hall medication cart					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		345152	B. WING _			C 08/01/2019	
NAME OF PROVIDER OR SUPPLIER TRINITY VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1265 21 STREET NE HICKORY, NC 28601		1 00/01/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 761	Nurse #1. In the second discation cart and of Zofran 4 mg that of an expiration date of prescribed for Residual An interview was core 08/01/19 at 10:42 AN Zofran 4 mg that expite trash can, she ston the Zofran" anym. An interview was core Supervisor (DS) on ODS stated that the niresponsible for going rooms and medication any expired medication any expired medication them to the pharmacy tablets of Zofran 4 m should not have been repharmacy. An interview was core Clinical Services (DC The DCS stated that the nire pharmacy. An interview was core clinical Services (DC The DCS stated that manufacture guideling She stated that the nire pharmacy visited the assisted with medication they four pharmacy visited the assisted with medications as well. The D night shift staff went	19 at 10:39 AM along with cond large drawer of the available for use was a card contained 19 tablets and had 01/12/19 and was ent #80. Inducted with Nurse #1 on M. Nurse #1 took the card of ired 01/12/19 and threw in ated Resident #80 "was not ore. Inducted with the Day 18/01/19 at 11:14 AM. The ght shift nursing staff were in through the medication on carts and were to remove on they found and return y. The DS stated that the 19 g that expired 01/12/19 in on the medication cart and moved and returned to the onducted with the Director of CS) on 08/01/19 at 11:42 AM. The facility followed less for expired medication. In carts and medication carts and medication carts and medication.	F 7	61			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		345152	B. WING _			C 08/01/2019	
NAME OF PROVIDER OR SUPPLIER TRINITY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1265 21 STREET NE HICKORY, NC 28601		1 00/01/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 761	Continued From pag	ge 15	F 7	61			
	Administrator stated follow the protocol a medication. She add expired on 01/12/19 medication cart availabeen removed and r. 3. Resident #81 was 06/03/18 with diagnor disease and hyperter. Review of a physician DuoNeb 0.5 milligration every 6 hours and cough. An observation of the 08/01/19 at 11:14 AI Supervisor (DS) was of DuoNeb 0.5 mg/3 #81 that expired Decent An interview was cough of 08/01/19 at 11:14 AI night shift nursing stathrough the medicat carts and were to rethey found and return DS stated that the Double of the protocol o	o1/19 at 12:25 PM. The that she expected the staff to and discard any expired led that the Zofran 4 mg that should not have been on the lable for use, it should have eturned to the pharmacy. The readmitted to the facility on ease that included heart insion. The order dated 05/22/17 read, ms (mg)/3 milliliters (ml) ease that included heart insion. The Central Supply room on what along with the Day is made. There were 10 vials in prescribed for Resident ember 2018. The DS stated that the laff were responsible for going ion rooms and medication in them to the pharmacy. The luoNeb 0.5 mg/3 ml should is central supple and should					
		CS) on 08/01/19 at 11:42 AM.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345152	B. WING			C 8/04/2049	
NAME OF PROVIDER OR SUPPLIER TRINITY VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 1265 21 STREET NE HICKORY, NC 28601		08/01/2019 E			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 761	She stated that their through the medication coms and were to remedication they four pharmacy visited the assisted with medicatimes as well. The Dinight shift staff went rooms and they mus vials of DuoNeb 0.5 December 2018. An interview was con Administrator on 08/Administrator stated follow the protocol a medication. She add mit that expired December in the central sit should have been pharmacy. 4. Resident #91 was 07/18/18 with diagnor diabetes mellitus, and Review of a physicial Remeron 15 milligran night at bedtime for on Review of a physicial discontinue Remeron An observation of the made on 08/01/19 arof Remeron 7.5 mg 07/31/19 in the extra	nes for expired medication. hight shift nursing staff went on carts and medication emove any expired hid. The DCS added that the e facility every 3 months and ation storage during those CS stated that she knew the through the medication t have overlooked the 10 mg/3 ml that expired hiducted with the 01/19 at 12:25 PM. The that she expected the staff to hid discard any expired led that the DuoNeb 0.5 mg/3 ember 2018 should not have hupply room available for use, removed and returned to the readmitted to the facility on hoses that included anxiety, hid decreased appetite. In order dated 08/15/18 read, his (mg) by mouth every decreased appetite. In order dated 08/28/18 read, his order dated 08/28/18 read,	F 76	51			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345152	B. WING		C 08/01/2019
NAME OF PROVIDER OR SUPPLIER TRINITY VILLAGE		.	STREET ADDRESS, CITY, STATE, ZIP CODE 1265 21 STREET NE HICKORY, NC 28601	, 30.0.120.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 761	08/01/19 at 11:14 A night shift nursing s through the medicar carts and were to re they found and retu DS stated that the F on 07/31/19 should supply room and sh returned to the pharmacy returned to the pharmanufacture guideli. She stated that the through the medicar rooms and were to medication they four pharmacy visited the assisted with medicatimes as well. The Enight shift staff went rooms and they mure Remeron 7.5 mg the An interview was conditionally and the protocol of medication. She additionally returned to 17/3 the central supply returned to 17/3 the 17/4 the 17/	onducted with the DS on M. The DS stated that the taff were responsible for going tion rooms and medication remove any expired medication rn them to the pharmacy. The Remeron 7.5 mg that expired not have been in the central ould have been removed and rmacy. Inducted with the Director of CS) on 08/01/19 at 11:42 AM. It the facility followed the for expired medication. In the medication remove any expired medication remove any expired medication remove any expired medication storage during those DCS stated that she knew the through the medication st have overlooked the at expired on 07/31/19.	F 761		