STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
E 000	Initial Comments An unannounced, onsite recertification and complaint investigation survey were conducted 10/23/2023 to 10/26/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event # SF5L11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 10/23/2023 to 10/26/2023. Event ID # SF5L11. The following intakes were investigated: NC00206255, NC00206690, and NC00206927. 1 of 3 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		10/26/23

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

Electronically Signed | 11/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to maintain a resident's dignity when a nurse used a loud voice directed toward 1 of 1 resident reviewed for dignity (Resident #38). Findings included: Resident #38 was admitted to the facility on 03/02/ 23. A quarterly Minimum Data Set (MDS) assessment dated 08/02/23 revealed Resident #38 had no cognitive impairment. An initial allegation report dated 08/14/23 at 8:45AM documented Resident #38 reported Nurse #11 spoke to her disrespectfully. Nurse #11	F 550	F-tag 550 □ Residents Rights/Exercise of Rights Facility failed to maintain a resident□s dignity when a nurse used a loud voice directed toward resident #38. Corrective actions accomplished for those residents found to have been affected by deficient practice: On 8/14/2023 the nurse in question was immediately suspended pending investigation and after investigation was completed on 8/17/2023, nurse in question was terminated due to speaking to the resident in an unprofessional manner. Identified other residents who have the potential to be affected by the same deficient practice and what corrective	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 550	Continued From page 2 was suspended from the facility during the investigation. The 5- day investigative report dated 08/17/23 documented the facility investigation into the incident revealed the exchange between Nurse #11 and Resident #38 was inappropriate and disrespected the Resident. The Administrator interviewed Resident #38 on 08/14/23 and Resident #38 revealed Nurse #11 had been disrespectful and hurt her feelings. Resident #38 felt safe at the facility. Nurse #11 was terminated from employment on 08/17/23. Resident #38 was interviewed on 10/24/23 at 8:42AM. Resident #38 revealed Nurse #11 had taken care of her in the past and Resident #38 believed she and Nurse #11 were friends and Nurse #11 hurt her feelings and was disrespectful when Resident #38 asked her for a full oxygen tank and to please charge the cell phone belonging to Resident #38.Resident #38 revealed Nurse #11 spoke loudly to her in the hall and told her to go to her room because Nurse #11 was busy and Resident #38 would have to wait her turn. Resident #38 revealed her feelings were hurt and Nurse #11 did not listen to her. Resident #38 revealed she called the DON and left a message about her feelings. On 10/25/23 at 10:16 AM Nurse #11 was interviewed. Nurse #11 revealed on she worked on 08/13/23,and Resident #38 requested a new oxygen tank, but Nurse #11 was busy administering medications to other residents. Nurse #11 revealed she told Resident #38 she needed to wait a few minutes and to go back to her room because she needed to wait her turn.	F 550	actions were taken: On 8/14/2023 Administrator and Social Services interviewed all residents that resided on the same hall that resident #38 resided on and the nurse in question worked on the day of the event. There were no further complaints from the nurse in question speaking to them in an unprofessional manner from interviewed residents regarding this incident. Measures/ systemic changes put in place to ensure the deficient practice does not reoccur: Beginning 8/18/2023 all staff were re-educated on Abuse, Neglect and Exploitation in the Elder Care Setting and Preventing, Recognizing, and Reporting Abuse. 100% of all staff were re-educated by 9/14/2023. Beginning 11/13/2023, the Director of Nursing (DON) and Staff Development Coordinator (SDC) will observe 5 staff/resident interactions weekly for 1 month, 10 interactions per month for 1 quarter using the Staff Interaction Audit Form. Monitoring of corrected actions to ensure the deficient practice will not reoccur: The DON will submit the Staff Interactions Audit form to the administrator for review each month. The DON will present findings at the quarterly Quality Assurance and Performance Improvement (QAPI). The QAPI committee can make changes to ensure facility compliance of deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 550	Continued From page 3 On 10/25/23 at 10:31 AM Nurse # 12 was interviewed. Nurse #12 recalled on 08/13/23 Nurse #11 was assigned to Resident #38 and when Resident #38 came into the hall near the medication cart of Nurse #11 she heard Nurse #11 speaking in a loud voice to Resident #38. Nurse #12 revealed she had not heard the conversation but observed Resident #38 upset and tearful. Nurse #12 explained Resident #38 approached her in the hall and told Nurse #12 she was going to report Nurse #11 for being disrespectful to her and not listening to her. Nurse #12 assisted Resident #38 to get a new oxygen tank and charge her cell phone as requested. On 10/26/23 at 10:59 AM an interview with the Administrator and DON revealed the investigation was thorough and Nurse #11 was terminated based on investigation results from 08/14/23 through 08/17/23 and in the best interest of residents and staff that Nurse #11 was terminated for her disrespect and undignified behavior toward residents and staff.	F 550		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 690	Continued From page 4 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews and record review, the facility failed to obtain a physician order for a suprapubic catheter size and balloon size (Resident #82) and failed to keep a catheter drainage bag and tubing from touching the floor to reduce the risk of infection or injury (Resident #246) for 2 of 3 sampled residents reviewed for the use of an indwelling urinary catheter. The findings included: 1. Resident #82 was readmitted to the facility on 1/9/2023 with obstructive and reflux uropathy and retention of urine.	F 690	F-tag 690 □ Bowel-Bladder Incontinence, UTI Facility failed to obtain a physician order for a suprapubic catheter size and balloon size for resident #82 and failed to keep a catheter drainage bag and tubing from touching the floor to reduce the risk of infection or injury for the use of an indwelling urinary catheter for resident #246. Corrective actions accomplished for those residents found to have been affected by deficient practice: On 10/24/23 the facility nurse immediately changed the indwelling	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 690	Continued From page 5 A urology visit note dated 2/2/2023 documented the consultation for the insertion of a suprapubic indwelling urinary catheter. The note specified Resident #82 was to return to the urologist on 2/14/2023 for the procedure. A urology visit note dated 2/14/2023 documented the insertion of a suprapubic indwelling urinary catheter. The note documented Resident #82 was to return to the urologist on 3/15/2023 to have the suprapubic catheter charged by the urologist. The size of the suprapubic catheter and balloon was not noted in the documentation. A visit note dated 3/17/2023 documented the suprapubic catheter change at the urologist office. The size of the catheter and balloon was not noted in the documentation. A physician order dated 7/10/2023 specified the suprapubic indwelling urinary catheter was to be changed during the day shift on the 1st of the month starting 8/1/2023. The order did not include the size of the catheter or the balloon size. The significant change Minimum Data Set assessment dated 9/6/2023 assessed Resident #82 to be cognitively intact and to have an indwelling urinary catheter. A review of the Treatment Administration Record (TAR) for August 2023 revealed that Resident #82's indwelling suprapubic catheter was changed on 8/1/2023 by evidence of the nurse initials. The TAR did not document the size of the suprapubic catheter or the balloon size.	F 690	urine catheter for resident #246 when discovered on the floor. On 10/26/23 the facility nurse contacted physician to obtain order on catheter balloon size for resident # 82 Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken: On 10/24/23 Unit Manager (UM) reviewed all 9 residents with indwelling catheters for catheter and balloon sizes in physician□s orders. All 8 remaining residents had catheter and balloon sizes in orders on Electronic Medical Records (EMR). On 10/24/23, UM and Director of Nursing (DON) ensured that all indwelling catheters were correctly positioned on bedframe below resident bladder. Beginning on 11/9/23, the DON in-serviced all nurses on accurately documenting Indwelling Catheter balloon sizes and correct positioning of catheter bag on bedframe. Any nurses not educated on 11/9/2023 were in-serviced before beginning their next shift. Measures/ systemic changes put in place to ensure the deficient practice does not reoccur: All indwelling catheters will be audited positioning 4x week for 1 month, then 2x per week for 2 months by DON, UM, and Staff Development Coordinator (SDC) using the Catheter Positioning Audit Tool.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 690	Continued From page 6 A review of the TAR for September 2023 revealed on 9/1/2023 the indwelling suprapubic catheter was changed for Resident #82by evidence of the nurse's initials. A nursing note dated 9/1/2023 documented the suprapubic indwelling catheter was changed using a 20 French catheter with a 30-cubic centimeter balloon. A review of the TAR for October 2023 revealed no documentation for the changing of the indwelling suprapubic catheter. Resident #82 was observed on 10/24/20230 at 10:37 AM. Resident #82 reported he had a suprapubic catheter because he "couldn't urinate". Resident #82 declined to have the size of the catheter observed. The catheter bag was noted to have a privacy cover and was positioned below the bladder and was not noted to be on the floor. An interview was conducted with Nurse #5 on 10/24/2023 at 4:23 PM. Nurse #5 reported he was assigned to provide care to Resident #82 on Sunday, 10/1/2023 and he did not change the indwelling suprapubic catheter on that date. Nurse #5 explained that Nurse # 6 came in at 3:00 PM on the weekends and she would perform treatments for the facility, including changing catheters as needed. Nurse #5 reported he remembered he had asked Nurse #6 to change Resident #82's suprapubic catheter. Nurse #6 was interviewed by phone on 10/25/2023 at 12:52 PM. Nurse #6 reported she worked on 10/1/2023 and she did change Resident #82's catheter. Nurse #6 reported she used the same size catheter that Resident #82 had previously inserted. Nurse #6 reported the	F 690	All residents with indwelling catheters will be audited 1x per week x 2 months, then 1x monthly for 3 months by DON, UM and SDC to ensure accurate documentation on changing indwelling urinary catheters using the Catheter Care and Catheter Bags Audit Tool. All new admissions and readmissions with indwelling catheters will be added to the audit and reviewed. Monitoring of corrected actions to ensure the deficient practice will not reoccur: The DON will bring the results of both audits to the Monthly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee can make changes to ensure facility compliance of deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 690	Continued From page 7	F 690		

suprapubic catheter supplies had been gathered for her and she used the package with Resident #82's name on it.

During an interview with Nurse #7 on 10/26/2023 at 9:14 AM, she explained the orders to change an indwelling urinary catheter should include the size of the catheter and the size of the balloon. Nurse #7 reported she would review nursing progress notes to determine the size to use if there was not an order in the electronic medical record.

The Unit Manager (UM) was interviewed on 10/26/2023 at 10:01 AM. The UM reported she was not aware Resident #82 did not have orders for the indwelling suprapubic catheter size or balloon size. The UM indicated the physician should have been contacted to clarify the orders for Resident #82.

The physician (MD) was interviewed on 10/26/2023 at 1:57 PM. The MD reported indwelling catheter orders should include the size of the catheter and the balloon size.

The Director of Nursing (DON) was interviewed on 10/26/2023 at 3:20 Pm. The DON explained that Resident #82 had been going to a urologist to have his catheter changed and it became too physically difficult for him to go there once a month and his family opted to have the suprapubic catheter changed at the facility. The DON reported the size of the catheter and balloon should have been part of the order to change the catheter monthly and she expected all catheter orders to include the size of the catheter and balloon.

2. The facility's Catheter Drainage Bag and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 690	Continued From page 8	F 690		

Tubing policy, revised 7/30/23, documented in part, to "always attach the drainage bag to the bedframe, keep the drainage bag and tubing off the floor at all times to prevent contamination and damage."

Resident #246 was admitted to the facility on 10/20/23. Diagnoses included retention of urine, fitting and adjustment of urinary device, traumatic subdural hemorrhage with loss of consciousness, cerebral infarction, transient ischemic attack, displaced fracture of second cervical vertebra and dementia, among others.

A nurse admission assessment dated 10/20/23 recorded on admission, Resident #246 was assessed with a catheter that was patent and draining yellow urine.

A physician order dated 10/20/23 recorded Resident #246 had a catheter for urinary retention.

A care plan dated 10/20/23 indicated Resident #246 was at risk for complications related to the presence of an indwelling catheter, recent urinary tract infection (UTI) and the use of a prophylactic supplement. The goal was to remain free from catheter-related trauma with no signs of a UTI and interventions that included securing the tubing to prevent injury.

An admission Minimum Data Set assessment was in progress and assessed her cognition as severely impaired.

Resident #246 was observed on 10/24/23 at 12:30 PM, 1:09 PM and 1:30 PM in her room in her recliner with her feet elevated, positioned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 690	Continued From page 9	F 690		

the left, hanging off the footrest. During each observation, the catheter drainage bag, hook, and tubing were lying on the floor on the left side of the recliner. The catheter drainage bag was not in a privacy bag but was also not visible from the doorway. There were approximately 1200 milliliters of dark yellow urine in the catheter drainage bag and tubing. Resident #246 was nonverbal with each observation.

An observation of Resident #246 in her room receiving care from Nurse #1, Nurse #2, Nurse Aide (NA) #1 and NA #2 occurred on 10/24/23 at 1:45 PM. Resident #246 was seated in a recliner chair in her room with an indwelling catheter draining dark yellow urine into a catheter drainage bag that was attached to the footrest of the recliner chair. During the observation, Resident #246 was transferred via a mechanical lift to her bed.

Nurse #1 stated in an interview on 10/24/23 at 1:48 PM that she just arrived at 1:00 PM, and that she had not observed Resident #246 prior. Nurse #1 stated that catheter drainage bag and tubing were not to be left on the floor due to the risk of injury and infection to the resident.

Nurse #2 stated in an interview on 10/24/23 at 1:49 PM that she was not the assigned Nurse for Resident #246 and just entered the room to assist with her care. Nurse #2 stated when she entered the room the catheter was attached to the footrest of the recliner.

NA #1 stated in an interview on 10/24/23 at 1:50 PM that she just entered the room to assist NA #2 to care for Resident #246 and when she entered the room, the catheter drainage bag was attached

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 690	Continued From page 10	F 690		

to the footrest of the recliner.

NA #2 stated in an interview on 10/24/23 at 1:51 PM that she entered the room of Resident #246 after 1:30 PM and emptied her catheter drainage bag. When asked twice where the catheter drainage bag was located when she entered the Resident's room, she stated "it was not on the floor."

During an interview with Nurse #3, the assigned Nurse for Resident #246, on 10/24/23 at 1:50 PM, she stated that she last medicated Resident #246 around 10:30 AM that day and the catheter drainage bag was attached to the footrest of the recliner.

The Director of Nursing (DON)/Infection Preventionist (ICP) was interviewed on 10/24/23 at 3:30 PM. She stated that per the facility policy and training provided to staff, catheter drainage bags were to be positioned below the resident's bladder and not on the floor. She stated when catheter drainage bags and tubing were left on the floor, this increased the risk of infection to the resident from bacteria that may be on the floor or to other residents due to possible urine spillage on the floor. The DON/ICP stated it was better to position the resident close to the bed and secure the catheter drainage bag to the bed frame to keep it off the floor, rather than on the footrest of a recliner.

An interview with the physician occurred on 10/26/23 at 2:20 PM and he stated that Resident #246 was at increased risk of infection due to the use of an indwelling catheter and that the catheter should not be on the floor to prevent contamination and infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide an enteral product (liquid nutrition fed via a tube) continuous per physician order and record the date and time the enteral product was initially opened. This occurred for 1 of 2 sampled residents reviewed for nutrition from tube feedings. The findings included: The facility policy Enteral Nutrition, revised 6/5/23, recorded in part, Continuous feeding is	F 693	F-tag 693 □ Tube Feeding Mgmt./Restore Eating Skills Facility failed to provide an enteral product continuous per physician order and record the date and time the enteral product was initially opened for resident #246. Corrective actions accomplished for those residents found to have been affected by deficient practice: On 10/24/23 Facility Registered Nurse (RN) immediately restarted CONTINUOUS Tube feedings for resident #246. On 10/24/23 the physician was notified of Tube Feeding	10/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 693	Continued From page 12 the uninterrupted administration of enteral formula over extended periods of time. Ensure the administration of enteral nutrition is consistent with and follows the practitioner's orders. Document pertinent information such as date and time the procedure was performed. Manufacture recommendations for Isosource 1.5 calories oral liquid nutrition recorded for tube feeding, once opened, the enteral product should be consumed within 24 hours. Resident #246 was admitted to the facility on 10/20/23. Diagnoses included dysphagia, gastrostomy status, traumatic subdural hemorrhage with loss of consciousness, cerebral infarction, transient ischemic attack, displaced fracture of second cervical vertebra and dementia, among others. A nurse admission assessment dated 10/20/23 recorded on admission, Resident #246 was alert and oriented to herself only, and her speech was "jumbled." She was assessed with a PEG (percutaneous endoscopic gastrostomy) tube with an abdominal binder (waist belt used to secure enteral feeding tubes) in place. A physician order dated 10/20/23 recorded may turn off PEG-tube for activities. A physician order dated 10/22/23, recorded give Isosource 1.5 calories oral liquid nutrition 45 ml (milliliters) per hour via PEG-tube every shift for nutrition replacement/tube feedings and a regular pureed diet by mouth with thickened liquids. An Admission Nutrition/Enteral Review dated 10/22/23 was completed by the Registered	F 693	being turned off by nurse. No new orders were received. Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken: On 10/24/2023 Director of Nursing (DON) and Unit Manager (UM) assessed all other residents with Tube Feedings and their orders to ensure Tube Feedings were being delivered per physician□s order. Facility has 3 residents on tube feedings including resident #246 at the time of the audit and the other 2 residents were nocturnal feedings and were getting bolus feedings as ordered by physician. Beginning on 10/24/2023 the DON and UM in-serviced all nurses on the facilities policy entitled, Enteral Nutrition. All nurses not educated on 10/24/23 were in-serviced before beginning their next shift. Measures/ systemic changes put in place to ensure the deficient practice does not reoccur: All tube feedings will be audited 3x weekly for 1 month and then 2X per week for 2 months by DON, UM, and Staff Development Coordinator (SDC) using the facilities Treatment Administration Record (TAR). Monitoring of corrected actions to ensure the deficient practice will not reoccur: The Plan of Correction (POC) and its audits will be monitored by Administrator and DON during weekly QA Meetings to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 693	Continued From page 13 Dietitian (RD) Consultant. The RD documented that Resident #246 currently received a regular, pureed diet with thickened liquids in addition to the enteral nutrition. The RD documented Resident #246 had minimal oral intake noted with six recorded meals, eating 0-25% regarding a traumatic brain injury and dependent on staff for 100% of feeding/eating. The RD documented the addition of an enteral product for nutritional support to run continuously for 22 hours, and off for nursing care. The RD documented no intolerance to the enteral product noted. The RD recommended continued monitoring of oral intake, fluids, and enteral product for the need to increase/decrease the enteral order. A care plan revised 10/23/23 indicated Resident #246 had a PEG tube placed, dependent on PEG tube nutrition and required substantial, maximal staff assistance with eating. Dietary staff would also provide a regular, pureed textured diet with nectar thickened liquids as ordered that honored her preferences. A physician order dated 10/24/23 was clarified and recorded, regular diet, pureed texture, liquids nectar/mildly thick consistency. An admission Minimum Data Set assessment was in progress and incomplete. A review of nurse progress notes dated 10/23/23 and 10/24/23 revealed no documentation of problems with enteral product intolerance or that the enteral product was held. Resident #246 was observed on 10/23/23 at 3:00 PM in a low bed, head of bed elevated and with a cervical collar for neck support. Isosource 1.5	F 693	ensure audits are complete per POC. The DON will report its findings to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee can make changes to ensure facility compliance of deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 693	Continued From page 14	F 693		

enteral product infused at 45 ml per hour via intravenous (IV) pump with approximately 300 ml of enteral product in the dispensing the bag. The dispensing bag did not include a label with the date and time the enteral product was initially opened.

Resident #246 was observed on 10/24/23 at 10:21 AM in her recliner, the head of the recliner was elevated, and she had on a cervical collar for neck support. Speech Therapy (ST) #1 was observed providing cognitive services. A 1000 ml prefilled dispensing bag of Isosource 1.5 enteral product hung from the IV pump, the label recorded 10/23/23, 6:00 PM. The IV pump was off, and approximately 1000 ml of enteral product remained. The tubing was hooked to the IV pump but was not connected to Resident #246. An observation of the same occurred on 10/24/23 at 10:28 AM.

ST #1 was interviewed on 10/24/23 at 3:30 PM, she stated she provided ST for cognitive services to Resident #246 that morning around 10:00 AM until about 10:30 AM, she did not recall if the enteral product was infusing at the time, but that she did not request to suspend the enteral product for Resident #246 to provide ST services.

Resident #246 was observed again on 10/24/23 at 1:09 PM in her recliner, the head of the recliner was elevated, and she had a cervical collar on for neck support. She was alone in her room and not engaged in any activity or nursing care. A 1000 ml bag of Isosource 1.5 enteral product hung from the IV pump, the label recorded 10/23/23, 6:00 PM. The pump was off, approximately 1000 ml of enteral product remained, and the enteral product had a thickened appearance. The tubing was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 693	Continued From page 15	F 693		

hooked on the IV pump but was not connected to Resident #246. An observation of the same occurred on 10/24/23 at 1:30 PM and 1:45 PM.

The October 2023 Medication Administration Record (MAR) for Resident #246 recorded the initials of Nurse #3 on day shift for 10/23/23 and Nurse #4 on day shift for 10/24/23 for the physician order to provide Isosource 1.5 calories at 45 ml per hour continuous oral nutritional supplement.

An interview with Nurse #1 occurred on 10/24/23 at 1:35 PM. Nurse #1 stated she was the hall nurse; she came in at 1:00 PM to help because one of the nurses had to leave. Nurse #1 reviewed physician orders and stated Resident #246 had an order for a continuous enteral product, but that the feeding could be turned off for activities, like nursing care or if she came out of her room to attend an activity and to resume the feeding once the activity was over.

Resident #246 was observed in her room with Nurse #1, Nurse #2, and Nurse #3 on 10/24/23 at 1:45 PM. Resident #246 was in a recliner, the IV pump was off, the enteral product was hung and labeled 10/23/23 6:00 PM, approximately 1000 ml of product remained and had a thickened appearance. Nurse #1 removed the bag of enteral product and discarded it. Nurse #1 stated she discarded the enteral product because the product was thickened and there was sediment in the bottom of the bag which could increase the risk of clogging the tube. Nurse #1 confirmed that Resident #246 should have enteral product infusing continuously.

Nurse #2 was interviewed on 10/25/23 at 10:10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 693	Continued From page 16	F 693		

AM. Nurse #2 stated the "COTA" (certified occupational therapy assistant) asked her to disconnect the enteral product for Resident #246 on the morning of 10/24/23 before the COTA assisted the Resident with morning care. Nurse #2 stated she did not recall the time. Nurse #2 stated she was not the assigned nurse, but she came in, the enteral product was attached to the PEG site and infusing, so she disconnected the tubing from the Resident, and after therapy finished, she came back and connected the tubing back to the resident and turned the IV pump on, but she did not recall the time. Nurse #2 stated when she returned to the room that same day (10/24/23) around 1:30 pm, the tubing was not connected to the Resident, and she was not sure who disconnected it.

An interview with COTA #1 occurred on 10/25/23 at 9:37 AM. The COTA stated that on 10/23/23 "sometime before breakfast, about 8:00 or 8:30 AM" Nurse #2 came in and turned the enteral product off for Resident #246 so that therapy could work with her. The COTA stated that she provided occupational therapy (OT) services to Resident #246, assisted her with hygiene, dressing and a transfer via a mechanical lift from the bed to the recliner. The COTA stated Resident #246 was not connected to the IV pump and her enteral product was not infusing at the time. The COTA stated Nurse Aide (NA) #2 came in to feed her breakfast when the COTA completed services and the COTA reported to Nurse #2 that she had finished working with Resident #246.

An interview with NA #2 on 10/24/23 at 3:17 PM revealed she came to work at 8:00 AM that morning (10/24/23) and when she arrived,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 693	Continued From page 17	F 693		

Resident #246 was already up and dressed. NA #2 stated Resident #246 received OT services which included morning care, a bed bath, and dressed her. NA #2 stated she fed Resident #246 breakfast, "after 8:30 AM," and described that the Resident "ate a few bites of her grits and drank some of her fluids, she ate less than 25% and received a pureed breakfast with thickened beverages." NA #2 stated Nurse #4 turned her pump off that morning to give her medication and it remained off while NA #2 fed her breakfast. NA #2 stated she reported to Nurse #4 when she finished feeding Resident #246 her breakfast. NA #2 stated she checked on Resident #246 throughout the morning and stated, "I do not recall seeing her tube feeding going the times I checked her, and I checked her several times." NA #2 stated Resident #246 was in her recliner until NA #2 came to lie her down around 1:00 PM and when NA #2 arrived to lie her down, the tube feeding was not on.

Nurse #4 stated in a phone interview on 10/24/23 at 3:04 PM that she came on shift at 7:00 AM and worked 4 hours. She received shift to shift report that Resident #246 had no problems on the previous shift. Nurse #4 stated she medicated Resident #246 that morning and provided a water flush that was due at 8:00 AM. Nurse #4 stated "I think the tube feeding was infusing, but I am not 100% certain, if it was infusing, I would have turned it off and disconnected the tubing before I did the flush." Nurse #4 stated she did not recall how much enteral product remained in the bag that was hanging, but she documented her initials on the MAR for day shift that day (10/24/23) and when asked if the enteral product was infusing, Nurse #4 stated, "I thought it was." Nurse #4 stated that Nurse #3 medicated Resident #246

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 693	Continued From page 18	F 693		

later that morning and Nurse #4 saw Resident #246 again when she repositioned her in her recliner as she described "right before lunch." Nurse #4 stated she was not asked to turn the enteral product off that morning for staff to give her care. Nurse #4 stated Resident #246 did not have concerns with product intolerance or residuals that morning (10/24/23).

Nurse #3 was interviewed during an observation of Resident #246 on 10/24/23 at 1:50 PM. Nurse #3 stated she was one of the assigned nurses for Resident #246 that morning and last saw the Resident around 10:25 AM, when she medicated her. Nurse #3 confirmed that at the time of the interview, the enteral product was not infusing, the pump was turned off and the tubing was not connected to the Resident. Nurse #3 stated "I did not turn it off," she stated that she completed a flush and medicated Resident #246 via the PEG tube at 10:25 AM, but that "I did not mess with the tube feeding, I did not turn it on or off, I assumed it was infusing by the nurse who had her at 7:00 AM, I think I would have noticed if it was not infusing." Nurse #3 stated "I just went in and medicated her at 10:25 AM and did the flush at the same time, speech therapy was in the room working with her." Nurse #3 was asked if she recalled if she turned the enteral product off to medicate and give a water flush, she stated "I have been passing meds all day, sorry I just don't remember, I just know I did not mess with her tube feeding pump." Nurse #3 stated Resident #246 did not have any problems with enteral product intolerance or residuals on 10/24/23 and assumed her enteral product was infusing. She stated that she recorded her initials on the MAR on the 7AM - 3PM shift on 10/23/23 but could not recall if she initiated the enteral product that day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 693	Continued From page 19	F 693		

or if it was already dispensing when she arrived on shift. She stated her practice was to label the enteral product dispensing bag with the date and time she initiated the product.

NA #1 was interviewed on 10/24/23 at 2:08 PM and stated she fed Resident #246 her lunch meal that day after 12:30 PM and Resident #246 ate about 25% of her pureed meal, ate 50% of her pudding and drank all the thickened tea. NA #1 stated "I don't recall seeing her tube feeding connected or her pump on, I would not turn it off, I would ask the nurse to do that, but I did not ask the nurse to turn the pump off when I fed her lunch."

An interview with the Director of Nursing (DON) on 10/24/23 at 3:30 PM revealed, Resident #246 had a physician order to receive Isosource 1.5 at 45 ml per hour, continuous, for nutritional support. The DON stated her nutritional support could not be maintained with her pureed diet due to a neck fracture which made eating too painful for her to meet her nutritional needs. The DON stated her enteral product should be provided continuously, and because the Resident ate less than 25% of her meals, the pump did not have to be turned off during meals. The DON stated the order for continuous feeding should be followed and enteral feedings should be provided per facility policy unless Resident #246 displayed signs/symptoms of intolerance and then the Nurse would need to notify the Physician to obtain an order to hold the enteral product. The DON stated once an enteral product was dispensed, the dispensing bag should record the date/time to ensure the product did not infuse for more than 24 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 693	Continued From page 20	F 693		

A phone interview with the Registered Dietitian (RD) Consultant occurred on 10/24/23 at 4:52 PM. The RD stated she consulted at the facility monthly and reviewed all high-risk residents which included residents who received enteral products. The RD stated she assessed product tolerance, weight fluctuations, and that she typically calculated calorie needs based on 22 hours for residents with a physician order for a continuous product to allow time for the product to be turned off for care or activities. The RD stated Resident #246 had a physician order for a continuous enteral product. The RD further stated, "In a perfect world if Resident #246 tolerates the product as ordered that's what we would expect, but since I don't know if there were concerns with residuals or intolerance, I think the nurse would hold the product if there were any concerns with intolerance, otherwise we expect the product to be provided as ordered, but I am not there so I don't know what occurred with this resident."

The Physician was interviewed on 10/26/23 at 2:20 PM and stated Resident #246 received nocturnal enteral feedings in the hospital, but he was concerned that this would not meet her nutritional needs, so he changed the order to continuous feedings with meals to supplement her intake. The Physician stated that he did not know the circumstances surrounding Resident #246 and her enteral product on 10/24/23, but if the enteral product was held, he would expect the Nurses to get a clarification order to hold the enteral product and not make that decision on their own. The Physician stated that the order was for continuous enteral feeding and the order and facility policy should be followed to meet her nutritional needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to discard expired insulin injection pens in 1 of 3 medication rooms (Medication room on A/B Hall) and in 1 of 5 medication carts (the secured unit medication cart) and monitor the temperature daily in 1 of 3 medication refrigerators (the C/D Hall medication refrigerator). The findings included:	F 761	F-tag 761 □ Label/Store Drugs and Biologicals Facility failed to discard expired insulin injection pens in A/B Medication room, VCC medication cart and monitor temperature daily in C/D Hall Medication Refrigerator. Corrective actions accomplished for those residents found to have been affected by deficient practice. On 10/25/23, Both	11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 761	Continued From page 22 1. A. The medication room on the A/B side of the facility was observed on 10/25/2023 at 9:21 AM with Nurse #9. A basket with insulin pens was noted to be in the medication room and Nurse #9 explained that she was going to take the insulin pens with her to the medication cart to administer insulin. Two insulin pens were noted with an open date of 9/18/2023 and a discard date of 10/16/2023. Nurse #9 admitted she had not noticed the expiration dates on either insulin pen. B. The medication cart on the secured unit was observed on 10/25/2023 at 12:05 PM. An insulin pen with an open date of 9/23/2023 and a discard date of 10/21/2023 was noted on the medication cart. Nurse #8 was interviewed at the time of the observation. Nurse #8 reported she had not noticed the discard date on the insulin, and she felt it was human error it was not discarded. The DON was interviewed on 10/26/2023 at 3:23 PM and she expressed the insulin pens should have been discarded on the date written on the pens. 2. The medication refrigerator on the C/D hall was observed on 10/26/2023 at 10:45 AM. No temperature had been recorded on 10/8, 10/9, 10/16, 10/17, 10/21, 10/22, 10/23, and 10/24/2023. Inside the refrigerator were multiple medications, including vaccines and intravenous antibiotics. The Unit Manager was interviewed at the time of the observation, and she reported that the night shift (11:00 PM to 7:00 AM) was responsible for checking the medication refrigerator temperature every night. The UM explained an agency nurse	F 761	expired insulin pens observed were removed immediately from medication room on A/B. On 10/25/23, the expired insulin pen noted on the VCC medication cart was removed immediately. On 10/26/23 the temperature was recorded for the C/D hall medication refrigerator. Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken. All residents are at risk for deficient practice. On 11/8/2023 medication storage areas were checked for expired medications by the Director of Nursing (DON) and the Unity Manager (UM). On 11/10/23, all medication refrigerator temp logs were checked by the DON to ensure all temps were recorded. The DON also checked all medication carts on 11/10/2023 for expired medications. Results of the audit revealed no other expired medications and all refrigerators□ dates were up to date. Measures/ systemic changes put in place to ensure the deficient practice does not reoccur. Beginning 11/8/2023, DON, UM, Staff Development Coordinator (SDC,) re-educated the licensed nursing staff on the proper medication storage process and recording medication room refrigerator temps daily. All medication storage procedures, including the process for monitoring expiration dates. and that daily temperature readings must be recorded for all Medication Room Refrigerators. All nurses not present on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 761	Continued From page 23 worked on those dates, and she may not have been aware to check and document the medication refrigerator temperature. The DON was interviewed on 10/26/2023 at 3:23 PM and she reported the medication refrigerator should have the temperature checked and documented each day.	F 761	11/8/2023 will complete their education before assuming their next assigned shift. New nurses will receive training on facility medication storage procedures including the process for monitoring expiration dates in orientation form SDC. Monitoring of corrected actions to ensure the deficient practice will not reoccur. To ensure that medications are properly stored and locked in the medication carts and/ or medication rooms when unattended and that Medication Room Refrigerator temps are being checked and recorded daily. The DON, UM, and SDC will audit using an auditing tool 3x per week for 1 month and 2x per week for 2 months for compliance. The DON will report findings of audits to the Quality Assurance Performance improvement (QAPI) committee meeting monthly x3 months. The DON will bring results of the audits to the monthly QAPI Meeting to ensure ongoing compliance. The QAPI committee can make changes to ensure facility compliance of deficient practice.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		11/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 812	Continued From page 24 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to 1) remove expired foods/foods with signs of spoilage, 2) record a label on refrigerated and frozen foods that included date of opening and use by date, and 3) store foods in sealed containers. This failure had the potential to affect all residents who received food from the dietary department. The findings included: The "Use by Date Storage Chart" posted on the walk-in refrigerator, recorded "All food items must be properly dated and labeled and must be stored in either containers with lids, foil/film wrappers, sealed food storage bags, or their original container." A continuous observation with the Assistant Dietary Manager (ADM) of the walk-in refrigerator, cook's reach in refrigerator, the freezer and the dry storage occurred on 10/23/23 from 10:25 AM until 11:15 AM and revealed the following concerns:	F 812	F-tag 812 □ Food Procurement, Store/Prepare/Serve-Sanitary Facility failed to remove expired food/foods with signs of spoilage, record a label on refrigerated and frozen foods that included date of opening and use by date, and store foods in sealed containers. Corrective actions accomplished for those residents found to have been affected by deficient practice: No residents were directly involved with this citation because none of the expired food was served. On 10/23/23 from the reach in refrigerator the Assistant Dietary Manager (ADM) discarded the four-pound container of pimento cheese. On 10/23/23, from the walk-in refrigerator, the ADM discarded the twelve celery stalks and the Swiss cheese. On 10/23/23, from the freezer, the ADM discarded the plastic bag of unlabeled meat, the 10 pieces of breaded chicken	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 812	Continued From page 25 1a. The cook's reach in refrigerator was observed at 10:25 AM with the following concerns: - An opened four-pound container of pimento cheese did not record the date opened. 1b. The walk-in refrigerator was observed at 10:40 AM with the following concerns: - Twelve celery stalks that were cut and wrapped in plastic film, were observed brown, discolored, and with a mushy texture. The label recorded an open date of 10/11/23. The "Use by Date Storage Chart" recorded "Use cut/prepared fruits/vegetables, within 7 days or by expiration date (whichever is the soonest)." - A plastic package of Swiss cheese with four slices remaining, did not record the date opened. 1c. The freezer was observed at 10:55 AM with the following concerns: - One plastic bag of meat, was unlabeled, identified by the ADM as "beef tips", was opened and secured with a twist tie but did not record the date opened. - A torn plastic bag with 10 pieces of breaded meat, was unlabeled, identified by the ADM as "chicken tenders", the bag was tied in knot, but did not have a label to record date opened. The contents were exposed to air. - A plastic bag wrapped in plastic film with approximately 22 pieces of meat, was unlabeled, identified by the ADM as "chicken livers" recorded an open date of 7/2/23, but did not record a label with the use by date. This food item was stored past 90 days. - A torn plastic bag with 6 pieces of meat, was unlabeled, identified by the ADM as "boneless chicken breast" was exposed to air with discolored pieces.	F 812	tenders, the 22 pieces of chicken livers, 6 pieces f boneless chicken breasts, 1bag of hash brown rounds, 16 pieces of garlic bread, and4 garlic sticks. On 10/23/23, from the Dry storage room, the ADM discarded seven containers of caramel sauce. Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken: On 10/23/23 the ADM checked the reach in refrigerator, the walk-in refrigerator, the freezer, and the dry storage areas to ensure that all items had opened dates, contained se by dates and had not expired. No further items were found to be deficient. On 11/9/2023, the administrator in-serviced the Dietary Manager (DM) and ADM on proper labeling, with Open and use by dates, all foods that do not have pre-stamped use by dates on the product container and discarding food by the use by / expiration date using the facilities policy and procedures titled, Date Marking Foods, and Food Storage. On 11/9/2023) The DM and ADM began in-servicing all dietary staff on proper labeling, with Open and use by dates, all foods that do not have pre-stamped use by dates on the product container and discarding food by the use by / expiration date using the facilities policy and procedures titled, Date Marking Foods, and Food Storage. Any staff not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 812	Continued From page 26 - One plastic bag of brown circular food pieces, was unlabeled, identified by the ADM as "hash brown rounds", was opened and tied in a knot but did not record the date opened. - A plastic bag with a zipped closure had a label that recorded "garlic bread" with 16 pieces of garlic bread remaining, did not record the date opened or a date to use by/discard. The "Use by Date Storage Chart" did not record a use by date for garlic bread. - A plastic bag with a zipped closure, had a label that recorded "garlic sticks" with 4 garlic sticks remaining, recorded a date opened as 10/1/23, but did not record a date to use by/discard. The "Use by Date Storage Chart" did not record a use by date for garlic sticks. 1d. The dry storage was observed with the ADM at 11:10 AM with the following concerns: - A box of seven, 12-ounce containers of caramel sauce, recorded a received date of 5/30/22, and a manufacturer expiration date of 8/27/23. This food item was stored past the manufacturer expiration date. During the continuous observation, the ADM stated that all staff were responsible to monitor food storage daily for expired foods, packaging and labels that included the date of opening, expiration and/or use by dates. The ADM stated that it had been two weeks since he checked cold storage for expired, labeled, and dated items and he checked dry storage for expired foods, about 1 week ago, saw the box of expired caramel sauce, but forgot to discard it. A phone interview occurred with the Certified Dietary Manager (CDM) on 10/24/23 at 4:18 PM. The CDM stated that she had been in her role at	F 812	in-serviced on this date will be in-serviced prior to working their shift. All future dietary employees will be educated on these policies during their orientation training. Measures/ systemic changes put in place to ensure the deficient practice does not reoccur: The DM and ADM will conduct Food Service and Safety Audits 5x weekly for 1 month, then 2x weekly for 1 month, then 1x weekly for 1 month to ensure that all items in the reach in refrigerator, the walk-in refrigerator, the freezer, and the dry storage areas have opened dates, contained use by dates and had not expired. The Consultant Dietician (CD) will conduct Food Service and Safety Audits 1 x monthly to ensure that all items in the reach in refrigerator, the walk-in refrigerator, the freezer, and the dry storage areas have opened dates, contained use by dates and had not expired. Monitoring of corrected actions to ensure the deficient practice will not reoccur: DM will bring Food Service and Safety Audit sheets to weekly Quality Assurance (QA) meetings and review all findings. The Quality Assurance and Performance Improvement (QAPI) Committee will be responsible for ongoing compliance. The QAPI committee can make changes to ensure facility compliance of deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 812	Continued From page 27 the facility for 2 years. The CDM stated that all dietary staff were responsible for monitoring dry and cold storage areas for items labeled, dated, and expired. The CDM stated she and the ADM conducted storage rounds at least twice weekly for monitoring and in her absence, the ADM was responsible to conduct monitoring rounds of storage areas. The CDM stated she conducted monitoring rounds on the storage areas last week but may have missed some items. The CDM stated that for frequently used food items, staff just recorded the date of opening, but that all items should be labeled with the date of opening, and date to use by. The CDM further stated that if items were removed from the original package, staff should place a label with the date of storage, date opened, and the expiration or use by date. The CDM stated that if staff find something expired or the package was torn and open to air, staff should discard it, she stated "we should discard any items that are not properly sealed." The Administrator confirmed in an interview on 10/26/23 at 11:27 AM that all foods should be labeled, dated, stored in sealed containers, and discarded according to manufacture expiration dates or use by dates. He stated that all opened frozen foods should be discarded if not used within 90 days of opening.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to remove trash and	F 814	F-tag 814 □ Dispose Garbage and Refuse Properly	11/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 814	Continued From page 28 debris on the ground around a commercial trash compactor and 3 of 3 commercial trash receptacles and maintain the commercial trash receptacle door closed. The findings included: During a continuous observation with the Assistant Dietary Manager (ADM) on 10/26/23 from 09:45 AM until 10:00 AM of three commercial trash receptacles and one commercial trash compactor, the door of one commercial trash receptacle was observed open, the receptacle was odorous, with multiple flies observed and the trash inside the receptacle was exposed. Further observation of the grounds around the commercial trash receptacles and the commercial trash compactor included the following: - Multiple articles of trash and debris - One used blue glove, inverted. - Four empty cardboard boxes - One mattress - One broken broom - One white polyvinyl chloride pipe - Two storage carts, one filled with multiple empty plastic bottles. - A motorized wheelchair. - One empty storage bin - One storage bin filled with table linen. - Three empty buckets - One uncovered small trashcan full of trash (fast food bags and paper cups with straws) - Three concrete pavers - One broken brick During the continuous observation on 10/26/23	F 814	Facility failed to remove trash and debris on the ground around a commercial trash compactor and commercial trash receptacles and maintain the commercial trash receptacle door closed. Corrective actions accomplished for those residents found to have been affected by deficient practice: On 10/26/23, the door to the commercial trash receptable was closed by the Assistant Dietary Manager (ADM). Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken: On 10/26/23 the door to the noted commercial trash receptacle was closed by the ADM. On 10/26/23 all items, articles of trash and other debris observed on the grounds around the commercial trash receptacles and the commercial trash compactor were immediately removed by administrator, ADM, Housekeeping Director (HD), Maintenance Personnel (MP), and Floor Tech (FT). On 11/10/23 the Administrator in-serviced DM, ADM, HD, MP on making sure that areas around commercial trash receptacles and receiving areas of building are free of articles of trash or other debris and that doors to all commercial trash receptacles are closed. On 11/10/23 the Dietary Manager (DM), ADM, HD, MP began in-servicing all housekeeping staff, dietary staff, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 814	Continued From page 29 from 09:45 AM until 10:00 AM, the ADM stated that he was responsible to monitor the grounds around the commercial trash receptacles for trash and debris and to keep the doors to the receptacles closed. He stated that he checked the grounds daily and when he checked the trash receptacles yesterday (10/25/23), a used glove, one of the empty cardboard boxes and the mattress were not there, but that he did not put the remaining items that were on the ground inside the trash receptacles. The Environmental Director (EVD) was interviewed on 10/26/23 at 10:00 AM during the continuous observation of the trash receptacles. The EVD stated that he was in this role for 3 years and was responsible, collectively with the Dietary Manager (DM) and the Maintenance Director, to monitor the commercial trash receptacles and grounds for trash. He stated that the motorized wheelchair was placed outside about one week ago, the cardboard boxes were outside for a few days, a staff member was scheduled to pick up the storage bin with linen, but he did not know how long the remaining items were left on the ground. He stated he knew the trash was left outside, but he did not place the trash in trash receptacles. The Maintenance Director was interviewed on 10/26/23 at 10:11 AM. He stated he was in this role for three weeks and that he shared the responsibility of monitoring the trash receptacles. He stated that when he arrived there were multiple pallets and large trash items left on the grounds, that he was working to get removed and placed in trash bins. He stated the facility had a construction receptacle that large trash items like storage carts and mattress could be placed in. He	F 814	Maintenance staff on making sure that areas around commercial trash receptacles and receiving areas of building are free of articles of trash or other debris and that doors to all commercial trash receptacles are closed. The education was completed on 11/17/23. Measures/systemic changes put in place to ensure the deficient practice does not reoccur: Beginning 11/13/2023 Ground Rounds will be made 5x weekly for 1 month, then 2x weekly for 1 month, then 1x weekly for 1 month by DM, ADM, Maintenance to ensure that there are no articles of trash and other debris observed on the grounds around the commercial trash receptacles, commercial trash compactor, and receiving area of the building. The Consultant Dietician (CD) will conduct General Sanitation Audits 1 x monthly to ensure that commercial dumpsters doors are closed, and the area around them is clean and clear of articles of trash and other debris. Monitoring of corrected actions to ensure the deficient practice will not reoccur: The DM will bring Ground Rounds Audit sheets to weekly Quality Assurance (QA) meetings to ensure grounds are debris free with the Quality Assurance and Performance Improvement (QAPI) Committee responsible for ongoing compliance. The QAPI committee can make changes to ensure facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 814	Continued From page 30 stated he was aware that trash should not be left on the ground and that he would continue to work with the DM and the EVD to get the grounds around the commercial receptacles cleared of trash. The Administrator stated during an observation of the commercial trash receptacles on 10/26/23 at 9:48 AM the cardboard boxes and the mattress were discarded yesterday (10/25/23) when a resident's mattress was replaced, he was not sure how long the remaining items were left on the ground, and he was not sure why the trash had not been placed in the receptacles. The Administrator also stated that the commercial vendor emptied the trash receptacles two or three times weekly, and the last pick up was Monday, 10/23/23. The Administrator stated that the grounds were monitored collectively by the EVD, the Maintenance Director and the DM and that trash should not be left on the ground.	F 814	compliance of deficient practice.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		11/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 842	Continued From page 31	F 842		

that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 842	Continued From page 32 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews, the facility failed to accurately document changing an indwelling suprapubic urinary catheter for 1 of 3 residents reviewed for urinary catheter documentation (Resident #82). The findings included: Resident #82 was readmitted to the facility on 1/9/2023 with obstructive and reflux uropathy and retention of urine. A physician order dated 7/10/2023 specified the suprapubic indwelling urinary catheter was to be changed during the day shift on the 1st of the month starting 8/1/2023. The significant change Minimum Data Set assessment dated 9/6/2023 assessed Resident #82 to have an indwelling urinary catheter. A review of the Treatment Administration Record (TAR) for August 2023 revealed that Resident #82's indwelling suprapubic catheter was changed on 8/1/2023 by evidence of the nurse initials.	F 842	F-tag 842-Resident Records-Identifiable information Facility failed to accurately document changing an indwelling suprapubic urinary catheter for resident #82. Corrective actions accomplished for those residents found to have been affected by deficient practice: On 11/11/2023 the facility nurse #6 entered a late entry to the Electronic Medical Record (EMR) stating that she did change the indwelling urinary catheter for resident #82 on 10/1/2023. Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken: On 11/3/2023 the Director of Nursing (DON) audited all residents with indwelling catheters, 9 in facility, to ensure accurate documentation was made for the changing of indwelling catheters. The audit revealed all 9 residents had appropriate, accurate documentation. Measures/ systemic changes put in place	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 842	Continued From page 33 A review of the TAR for September 2023 revealed on 9/1/2023 the indwelling suprapubic catheter was changed for Resident #82 by evidence of the nurse's initials. A review of the TAR for October 2023 revealed no documentation for the changing of the indwelling suprapubic catheter. No nursing note documented the indwelling suprapubic urinary catheter had been changed. Nurse #6 was interviewed by phone on 10/25/2023 at 12:52 PM. Nurse #6 reported she worked on 10/1/2023 and she did change Resident #82's indwelling urinary catheter. Nurse #6 reported she used the same size catheter that Resident #82 had previously inserted, but she was not able to recall the size of catheter or the balloon size. Nurse #6 reported the suprapubic catheter supplies had been gathered for her and she used the package with Resident #82's name on it. Nurse #6 didn't know who gathered the supplies and was not certain why she had not documented the catheter change and reported, "it's usually busy on the weekend, it might have slipped my mind." The Director of Nursing (DON) was interviewed on 10/26/2023 at 3:20 PM. The DON reported catheter changes should have been documented in the TAR.	F 842	to ensure the deficient practice does not reoccur: Beginning on 11/11/23, the DON in-serviced all nurses on accurately documenting indwelling catheters Care including the changing of the indwelling catheter. All nurses not educated on 11/11/23 were in-serviced before beginning their next Shift. Monitoring of corrected actions to ensure the deficient practice will not reoccur: All catheter documentation will be audited by DON, Unit Manager (UM) and Staff Development Coordinator (SDC) using the Catheter Care and Catheter Bags Audit tool 1x weekly for 2 months, then 1x monthly for 3 months to ensure accurate documentation on changing indwelling urinary catheters. The DON will report findings of audits to the Quality Assurance Performance Improvement (QAPI) committee meeting monthly x 5 months. The QAPI committee can make changes to ensure facility compliance of deficient practice.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format.	F 851		11/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 851	Continued From page 34	F 851		

Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

§483.70(q)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 851	Continued From page 35 agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to submit accurate payroll data on the Payroll Based Journal (PBJ) report to the Centers for Medicare and Medicaid Services (CMS) for the 3rd quarter in fiscal year 2023. The facility did not report accurate weekend staffing and did not accurately report licensed nurse coverage 24 hours a day. Findings included: The CMS submission report, PBJ Final File Validation Report for Fiscal Year Quarter 3,2023 (April 1 - June 30) was reviewed and indicated the facility reported excessively low weekend staffing and failed to have Licensed Nurse Coverage 24 hours per day on Sunday, 04/09/23, Saturday, 05/20/23, Sunday, 05/21/23, Sunday 06/04/23, and Sunday 06/18/23. Nurse staff timecards, daily nurse staff	F 851	F-tag 851 □ Payroll Based Journal Facility failed to submit accurate payroll data on the Payroll Based Journal (PBJ) report to the centers for Medicare and Medicaid Services (CMS) for the 3rd quarter in fiscal year 2023. Corrective actions accomplished for those residents found to have been affected by deficient practice: On 10/26/2023 the Payroll/AP Bookkeeper pulled staffing documents for the 3rd quarter dates and compared to the staffing hours reported on the Payroll Based Journal (PBJ) report for the 3rd quarter fiscal year 2023. The comparison identified multiple Baylor Certified Nursing Assistants (C.N.A) and Registered Nurse (RN) hour codes that did not pull over from the facilities□ current payroll system. Due to system time constraints changes could not be made to the 3rd quarter PBJ report. On	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 851	Continued From page 36 schedules, and posted nurse staff documents dated for 4/9/23, 5/20/23, 5/21/23, 6/4/23 and 6/18/23, were reviewed and revealed multiple licensed and unlicensed nurse staff were not recorded accurately or were omitted on the PBJ report (1705D) for the 3rd quarter of Fiscal year 2023. An interview conducted on 10/26/23 at 8:45 AM with the Payroll Manager revealed she was educated minimally about the automated payroll and timecard system used by the facility. She had not been educated to verify nursing staff timecards with data automatically entered by the electronic timecard system prior to quarterly submission of PBJ data to CMS because the electronic system should have transferred the correct data into the PBJ reports. The Payroll Manager revealed she was not aware that data imported to the PBJ report was incorrect and not reflective of actual nurse staff dates and hours worked as reflected on the electronic timecards. On 10/26/23 at 2:42 PM an interview was conducted with the Administrator. The Administrator revealed the Payroll Manager had met the intent of submission to CMS of PBJ data, but the facility had no feedback or other data to check for report accuracy after quarterly PBJ reports were submitted.	F 851	11/8/2023 the Payroll/AP Bookkeeper began comparing the facilities 4th quarter staffing documents to the staffing hours that transferred over to the PBJ report for the 4th quarter and will manually enter in those staffing hours that did not transfer into the 4th quarter PBJ Report as the quarter had not closed yet for final submission of this information. This will ensure accurate data has been submitted. Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken: On 10/26/2023 the Payroll/AP Bookkeeper pulled staffing documents for the 3rd quarter dates and compared to the staffing hours reported on the Payroll Based Journal (PBJ) report for the 3rd quarter fiscal year 2023. The comparison identified multiple Baylor Certified Nursing Assistants (C.N.A) and Registered Nurse (RN) hour codes that did not pull over from the facilities current payroll system due to system error. Due to system time constraints changes could not be made to the 3rd quarter PBJ report. On 11/8/2023 the Payroll/AP Bookkeeper began comparing the facilities 4th quarter staffing documents to the staffing hours that transferred over to the PBJ report for the 4th quarter and will manually enter in those staffing hours that did not transfer into the 4th quarter PBJ Report as the quarter had not closed yet for final submission of this information. This will ensure accurate data has been submitted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 851	Continued From page 37	F 851	Measures/ systemic changes put in place to ensure the deficient practice does not reoccur: On 11/8/2023 the Payroll/Accounts Receivable (AR) bookkeeper met with the Vice President of Teammate Services and Senior Accountant to correct missing payroll codes that are not currently transferring to the PBJ report. The system corrections are scheduled to be completed on 11-13-2023 and future 4th Quarter PBJ submissions will be uploaded to reflect complete and accurate staffing numbers. This will ensure all hours were accurately be captured going forward. The Payroll/AR Bookkeeper will audit Bi-weekly payroll periods, beginning 11/10/2023 for the next quarter to ensure that all clinical hours worked for that pay period are transferred to the PBJ report and that the reported hours are complete and accurately reported PBJ report. This Plan of Correction (POC) and its audit will be monitored by the Administrator and DON during a weekly QA meeting to ensure that audits are completed timely. Monitoring of corrected actions to ensure the deficient practice will not reoccur: The Payroll/AR Bookkeeper will bring audit sheet before the Quality Assurance and Performance Improvement (QAPI) Committee monthly with the QAPI Committee responsible for ongoing compliance. The QAPI committee can make changes to ensure facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 851	Continued From page 38	F 851	compliance of deficient practice.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to	F 867		11/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 867	Continued From page 39	F 867		

adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 867	Continued From page 40 resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance	F 867	F-tag 867 □ QAPI/QAA Improvement Activities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 867	Continued From page 41 Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the 3/30/2022 recertification and complaint investigation survey. The deficiency was in the area of label and store drugs and biologicals (F761). The continued failure during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: The tag is cross referenced to: F761-Based on record reviews, observations, and staff interviews, the facility failed to discard expired insulin injection pens in 1 of 3 medication rooms (Medication room on A/B Hall) and in 1 of 5 medication carts (the secured unit medication cart) and monitor the temperature daily in 1 of 3 medication refrigerators (the C/D Hall medication refrigerator). During the recertification and complaint investigation survey conducted 3/30/2023 the facility was cited for failing to discard expired medications from three medication carts and one storage room. On 10/26/2023 at 2:49 pm an interview was conducted with the Administrator, and he stated the facility's Quality Assurance and Performance Improvement (QAPI) meeting is held monthly and quarterly. He stated the department managers (Director of Nursing, Unit Manager, Staff Development Coordinator, Infection Control Nurse, Maintenance Director, Environmental Services Manager, and Dietary Manager) are	F 867	Facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the 3/30/2022 recertification and complaint investigation survey. Corrective actions accomplished for those residents found to have been affected by deficient practice: No residents were directly involved with this citation. Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken: No residents were directly involved with this citation. Measures/ systemic changes put in place to ensure the deficient practice does not reoccur: On 11/8/2023, the administrator re-educated the Leadership Team related to the appropriate functioning of the QAPI Committee, and the purpose of the committee is to include, identify issues, and correct repeated deficiencies related to Labeling and storing of drugs and biologicals (F761). On 11/8/23, the facility QAPI Committee held a meeting to review the purpose and function of the weekly Quality Assurance (QA) meeting and the Monthly QAPI meeting and review on -going compliance issues. This meeting included all members of the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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
F 867	Continued From page 42 present at the monthly QAPI meetings and the at the quarterly QAPI meetings, and the physician and pharmacist attends the quarterly meetings. The Administrator stated the facility strived to improve in all areas, but they should have improved in the area of drug labeling and storage which was identified in the previous survey.	F 867	Monitoring of corrected actions to ensure the deficient practice will not reoccur: The facility QA meeting will meet a minimum of weekly and QAPI Committee will meet a minimum of monthly ongoing to identify issues and monitor audits form all POC□s to include the labeling and storing of drugs and biologicals. The Administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions. The QAPI committee can make changes to ensure facility compliance of deficient practice.	