STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 recertification survey was conducted from 10/07/24 through 10/10/24 The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 9RE911.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 10/07/24 through 10/10/24. Event ID# 9RE911.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and staff and the Medical Director's interviews, the facility failed to protect a resident's right to be free from physical abuse. On 5/18/24 a severely cognitively impaired resident (Resident #34) was grabbed around the neck using both hands and "choked" by another cognitively impaired resident (Resident #61) in the dining area of the locked dementia unit. Staff	F 600	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 5/18/24, residents #34 and #61 were immediately separated by Nurse and other staff. Resident #34 was then assessed by Nurse and found no red	10/31/24

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

Electronically Signed | 10/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 1 reported Resident #34 was crying and seemed distraught immediately following the incident. A second resident to resident altercation occurred on 5/25/24, 7 days later, when Resident #61 grabbed another cognitively impaired resident (Resident #17) by her neck with one hand and pushed her to the floor. Staff reported Resident #17 yelled out as she was falling down, she seemed scared and frightened during the incident, and after the incident she was upset and distraught and stated that Resident #61 "was trying to hurt me". There were no physical injuries during either incident. This occurred with 3 of 3 Residents (Resident #34, #61, #17) reviewed for resident-to-resident abuse. The action inflicted by Resident #61 would have caused a reasonable person psychosocial harm such as feelings of fearfulness and agitation. Findings included. Resident #61 was admitted to the facility 09/19/23 with diagnoses including dementia with anxiety, agitation, mood with behavioral disturbance, and bipolar disorder. A care plan dated 09/28/23 revealed Resident #61 was at risk for injury to self and others due to a neurologic imbalance that could contribute to the development of manic episodes to include impulsivity, reckless behaviors, and aggression, secondary to bipolar disorder. Resident #61 was very possessive of her personal space and could become aggressive towards others. She experienced episodes of paranoia, anxiety, aggression, pacing, exit seeking and sexual behaviors (flirting/kissing). The goal of care was to not injure herself or others when aggressive,	F 600	marks or signs of injury on residents neck and states that no injury ever developed. Nurse Aide accompanied Resident #34 to residents room and stayed with her to continue to assess resident, no concerns noted. The nurse accompanied Resident #61 to the residents room to continue to assess resident, no concerns noted.. Physician visit completed for Resident #61 on 5/20/24 resulting in adjustment to antianxiety medication and restart of antidepressant medication. The physician and responsible party for each resident was notified on 5/18/24. On 5/25/24, Resident #61 was redirected by Nurse away from Resident #17. Resident #61 went to her room and remained in the room as is typical for this resident. The nurse immediately assessed Resident #17 for injury and found none. Resident #17 did not recall the incident immediately after Nurse assessment and returned to her usual activities. The physician and responsible party for each resident were contacted on 5/25/24. Resident #61 was evaluated by Nurse Practioner on 5/28/24 resulting in adjustment to antipsychotic medication. Resident #61 was evaluated by Physician on 5/30/24 and no further changes occurred. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/24/24, the director of nursing and administrator completed a care plan review for all residents on memory care neighborhood to ensure resident risks for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 2 she will be redirected by staff with inappropriate behaviors and will participate in unit activities without demonstrating inappropriate behaviors through the review date. Interventions included in part: to administer medications as ordered. Update the physician with escalation in mood and behaviors. Assess and anticipate resident's needs. Attempt to keep resident away from other residents when agitated and aggressive. Provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of the source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of a staff member when agitated. If the resident becomes agitated: attempt to intervene before agitation escalates; guide away from the source of distress; Engage calmly in conversation; If response is aggressive, staff will walk calmly away, and approach later. Provide a safe environment. Gently redirect other residents out of her personal space as needed. Guide toward socially appropriate behavior. Encourage medication adherence. Provide structured safe activities. Provide Psychiatric consult as indicated. A physicians order dated 10/27/23 for Resident #61 revealed Escitalopram Oxalate (Lexapro) 20 milligrams (mg) daily for generalized anxiety disorder. Resident #61's Medication Administration Record (MAR) revealed a physicians order dated 04/02/24 for Quetiapine Fumarate (Seroquel- an antipsychotic medication) 50 milligrams (mg). Give in the afternoon along with Quetiapine 12.5 mg for dementia with mood disturbance. A physicians order dated 04/12/24 for Resident	F 600	behaviors were appropriately identified. All risks for behaviors were appropriately identified and all interventions were included in care plans. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 8/1/24, all staff were educated by the staff development coordinator on the Abuse Investigation and Reporting for Senior Services policy. All new staff will be educated during orientation by the staff development coordinator. Ongoing education to be completed annually and as needed. Social Worker will also facilitate effective collaboration of interdisciplinary care team during the weekly meetings encouraging identification of additional risks for behaviors and successful interventions. Beginning 10/30/2024 the Social Worker will meet with staff on memory care neighborhood to ensure knowledge about individual care plans and interventions for residents with dementia and/or negative behaviors. This will occur once per week for three months, then once per month for 6 months. Social Worker will audit 5 individual care plans per week for three months, then 5 per month for 6 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The administrator will receive a summary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 3 #61 revealed Escitalopram Oxalate (Lexapro) 10 milligrams (mg) daily for generalized anxiety disorder. The MDS quarterly assessment dated 04/24/24 revealed Resident #61 was rarely or never understood, with memory problems. She exhibited disorganized thinking and had physical and verbal behaviors directed toward others. She received psychotropic medications. She was independent with ambulation. A physicians order dated 04/26/24 for Resident #61 revealed to increase Escitalopram Oxalate (Lexapro) to 20 milligrams (mg) daily for generalized anxiety disorder. a.) Resident #34 was admitted to the facility on 03/24/22 with diagnoses including Alzheimer's, and dementia. A care plan dated 02/28/23 revealed Resident #34 had the potential for adverse consequences related to psychotropic medications prescribed for treatment of depression, anxiety, and agitation. Interventions included in part; to administer medications as ordered and monitor for escalating mood and behaviors; and to notify the physician of new or changed symptoms and report unusual behaviors to the nurse, such as agitation, drowsiness, hallucinations, and anxiety. The Minimum Data Set (MDS) quarterly assessment dated 05/16/24 revealed Resident #34 was severely cognitively impaired. She exhibited verbal behaviors directed toward others. She received psychotropic medications. A behavior note dated 05/18/24 at 7:26 PM	F 600	of weekly meetings once per week for three months, then once per month for 6 months. The administrator will report on summaries to the QA committee during each QAPI meeting for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 4	F 600		

documented by Nurse #1 revealed resident (Resident #34) was hit and called names by another resident (Resident #61) . Resident #61 then proceeded to choke the other resident. This nurse intervened and the residents were separated. The Director of Nursing (DON) and family members were notified.

During a phone interview on 10/09/24 at 12:44 PM Nurse #1 stated she witnessed the altercation between Resident #61 and Resident #34 on 05/18/24. She was sitting at the nurses station and Resident #34, who had a history of saying things that didn't make sense, she raised her voice and the nurse immediately looked up and saw Resident #34 hit Resident #61 with her arm on her upper leg as she was walking by. She reported that Resident #61 was walking by Resident #34 from the side and grabbed Resident #34 from the side by her neck with both hands wrapped around her neck. This occurred in the dining room in the locked dementia care unit. She stated it happened so fast and she immediately jumped up and ran to where the residents were, and she and another Nurse Aide intervened at the same time and separated the residents. Nurse #1 reported that she saw Resident #61 put both hands around Resident #34's neck but she could not tell the force used by Resident #61 once she grabbed her by the neck. She stated there were no marks or redness on Resident #34's neck at that time and no injury to her neck ever developed. She reported that Resident #34 did not have any shortness of breath or respiratory distress from being grabbed by the neck at that time or at any time following the altercation. She stated Resident #34 started crying and seemed distraught and the Nurse Aide immediately took Resident #34 in her wheelchair to her room. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 5	F 600		

was still crying but shortly after the incident Resident #34 seemed okay and did not remember what had happened. Nurse #1 stated she immediately redirected Resident #61 who was independent with ambulation and walked her to her private room where she stayed. She stated Resident #61 told her that Resident #34 was picking on her in school and while riding the bus and she had enough of it and stated, "I bet she [Resident #34] wouldn't do that again." She stated the altercation occurred in the dining area where the 300 hall and the 400-hall joined. She stated Resident #61 resided on the 300 hall and Resident #34 resided on the 400 hall. She reported that she stayed with Resident #61, and the Nurse Aide stayed with Resident #34 in their rooms until they had both calmed down. She stated she could not recall who the Nurse Aide was that day. She stated as soon as the situation was under control and residents were safe and the situation was deescalated, she then reached out to the Director of Nursing, the Physician, notified the resident's Responsible Party, and notified Psychiatry Services to let them know Resident #61 needed to be seen as soon as possible. She reported both residents rooms were on opposite sides of the unit, and the incident occurred during the afternoon, but she couldn't remember the exact time. She stated Resident #61's room was in direct sight of the nurses station, and she initially stayed in Resident #61's room approximately 30 minutes following the incident. She stated Resident #61 spent a lot of time in her room and stayed in her room for the remainder of her shift. Later in the shift neither resident seemed to remember what happened. She reported signs of agitation had decreased with both residents after the incident. She reported that she was instructed by the Physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 6	F 600		

to give Resident #34 an as needed medication but could not recall what medication. Nurse #1 stated she had worked in the facility since December 2022, and primarily worked on the locked unit and there had been no previous altercations reported to her regarding the residents.

Review of the Medication Administration Record (MAR) dated May 2024 revealed Resident #34 was administered Ativan (anti-anxiety medication) 0.5 milligrams as needed for agitation by Nurse #1 on 05/18/24 at 2:11 PM.

During an interview on 10/09/24 at 3:20 PM Nurse Aide #1 stated she worked on 05/18/24 from 3:00 PM until 11:00 PM but she did not witness the incident because she came in later on 2nd shift. She stated she was told Resident #61, who had dementia, had choked Resident #34, who also had dementia. She stated Resident #34 talked a lot and would carry on and could have said something that provoked Resident #61, but she was uncertain if that's what happened since she did not witness the altercation. She stated both residents were acting as usual during the shift, and she did not recall seeing any marks or redness on either resident. She reported she had worked in the facility for 7 months on the locked unit and she had never witnessed Resident #61 or Resident #34 lash out physically to other residents.

Attempts were made during the investigation to contact the Nurse Aide #2, #3, and #4 who worked on 05/18/24 from 7:00 AM until 3:00 PM. They were no longer employed and there was no response. Attempts were made to contact Nurse Aide #5 and #6 who worked on 05/18/24 from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 7	F 600		

3:00 PM until 11:00 PM and there was no response.

A physicians note dated 05/20/24 at 10:36 AM documented by the Medical Director revealed Resident #61 was a 78-year-old with osteoarthritis (OA) and dementia. She continued to have episodes of agitation. She had an altercation with another resident (Resident #34) over the weekend. Resident #61 was alert and oriented to person only. The assessment included the diagnoses of OA and dementia with agitation. The plan of care for Resident #61 included changing the time of Resident #61's Buspar (antianxiety medication) dosing to noon instead of later in the evening.

An interview was conducted on 10/09/24 at 3:30 PM with the Director of Nursing (DON) along with the Administrator. The DON stated she was notified by Nurse #1 on 05/18/24 following the incident between Resident #61 and Resident #34. She stated Nurse #1 told her what happened, and the situation had deescalated, the residents were immediately separated, and there were no injuries. She stated both residents went back to their rooms, and that all residents were safe. She stated Resident #61 had remained in her room following the incident and there was no further contact between the two residents. She stated the residents resided on the locked dementia unit and all residents on the locked unit had constant supervision. She stated both residents had severe dementia, and they had not had any altercations with each other prior to that time. Following the incident, they did a medication review regarding the residents and concluded that Resident #61 had a recent dose reduction of her antidepressant medication. They ended up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 8	F 600		

increasing her back to the initial dose. She stated she instructed Nurse #1 to closely monitor both residents, and to notify the Physician and the Responsible Party. She stated both residents appeared to be at their baseline following the incident.

During an interview on 10/10/24 at 12:06 PM the Medical Director stated she was made aware of the incident on 05/18/24 between Resident #61 and Resident #34. She reported that Resident #61 was adjusting to medication changes during that time period. They increased the medication back to the initial dose and she was currently stable on her medications. Resident #34 had no injury from the incident. There had been no further altercations between the residents since that time. She stated both residents had severe dementia and Resident #61 was not considered a threat to other residents.

b.) Resident #17 was admitted to the facility on 12/19/17 with diagnoses including Alzheimer's, dementia with behavioral disturbances, and psychosis.

The Minimum Data Set (MDS) quarterly assessment dated 03/13/24 revealed Resident #17 was severely cognitively impaired. She had no physical behaviors directed toward others but did have verbal behaviors directed toward others. She received psychotropic medications. She used a walker for mobility.

A care plan dated 03/15/24 revealed Resident #17 had impaired cognitive function and thought processes secondary to Alzheimer's, Dementia and psychosis. She could be irritable, suspicious of taking medications, short tempered, easily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 9	F 600		

annoyed and physically aggressive. She had episodes of wandering into other residents rooms and taking their personal belongings. Interventions included in part; to administer medications as ordered. Provide consistent care and routines to decrease confusion. Redirect when needed. Cue, reorient and supervise as needed. Evaluate for situational stressors. Review medications and record possible causes of cognitive deficit such as new medications or dosage increases; recent discontinuation, omission or decrease in dose, drug interactions, adverse drug reactions, or drug toxicity.

An incident note dated 05/25/24 at 7:52 PM documented by Nurse #2 revealed she heard a crashing noise while she was at the nurses station. She witnessed Resident #17 falling down onto her left side next to another residents chair. A witness stated another resident (Resident #61) grabbed Resident #17 by her neck and pushed her down. Resident #61 stated Resident #17 pushed into her with her walker and hit her in the left eye, so she grabbed her and pushed her down. Resident #17 was unable to state what occurred. The residents were separated for safety with no injuries noted. Neurologic checks were initiated for Resident #17 without abnormal findings. The Physician, the Director of Nursing and the residents' Responsible Party were made aware of the incident.

During an interview on 10/09/24 at 2:18 PM Nurse #2 stated she worked fulltime in the locked unit and had worked in the facility since 2022. She stated Resident #17 ambulated with supervision with her rollator and tended to run into things. She didn't witness the incident between Resident #61 and Resident #17 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 10	F 600		

05/25/24 but heard the commotion from the nurses station and looked up as Resident #17 was falling down and landed on the floor. Resident #61 said Resident #17 ran into her with her walker. She stated Resident #17 bumped Resident #61 with her rollator and Resident #61 got upset. She reported that she didn't witness Resident #61 putting her hands on Resident #17's neck but a nurse aide (she could not recall which nurse aide) reported that Resident #61 grabbed Resident #17 by the neck and pushed her down. The residents were immediately separated, and she checked on Resident #17. She did a neurologic check, and physical assessment and Resident #17 appeared to be okay and had no marks or redness on her neck, and there was no respiratory distress. Resident #61 was redirected and was walked down to her room. She stated once the situation had deescalated, the residents were redirected, and all residents were safe, she called the Director of Nursing. She also notified the resident's Responsible Party, and Physician and no new physician orders were received. She stated immediately following the altercation Resident #17 was upset and distraught, she yelled out as she was falling down then once they got her up and sitting in a nearby chair, she seemed okay. Resident #17 carried on as usual with no signs of distress. She stated Resident #17 was her usual self and did not remember the incident. She had no indicators of pain that she recalled and her physical assessment including a skin assessment was normal. Nurse #2 stated it happened out of the blue and there had been no arguing or no interaction between the two residents that day and no altercations between them since then.

During an interview on 10/09/24 at 3:55 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 11	F 600		

Nurse Aide #7 stated she witnessed the altercation on 05/25/24 between Resident #61 and Resident #17. She stated it occurred in the locked unit in the dining area. Resident #17, who had severe dementia, was walking through with her rollator and bumped into Resident #61, who also had dementia. Resident #61 grabbed Resident #17 by the neck with one hand and pushed her to the ground. Resident #17 fell, landed on the floor but she did not hit her head. Resident #17 yelled out as she fell. She stated she immediately went to Resident #17 to make sure she was okay, and at that time Nurse #2 came up and assessed Resident #17. She stated Resident #61 was easily redirected following the incident and went down to her room. She stated she could not tell how strong of a hold Resident #61 had on Resident #17's neck. There was no redness on Resident #17's neck that she saw, and Resident #17 had no difficulty breathing or shortness of breath. She stated the incident happened really fast and the residents were separated. She stated they sat Resident #17 down in a chair close by and she was up moving around as usual soon after. She reported that she routinely worked on the locked unit, and she had not witnessed any change in Resident #17 following the incident and there had been no altercations between the two residents since then.

During an interview on 10/10/24 at 11:05 AM Nurse Aide #8 stated she witnessed the altercation between Resident #61 and Resident #17 on 05/25/24. She reported that she was standing in the dining room and Resident #17 was sitting in a chair with her walker in front of her. Resident #61, who ambulated independently, tried to squeeze by her and hit Resident #17's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 12	F 600		

walker. Resident #17 stood up and started yelling at her. Resident #61 grabbed her and caused Resident #17 to fall. She stated she could not say for sure exactly where Resident #61 grabbed Resident #17, but it was somewhere above her shoulder area. The residents were immediately separated. Nurse #2 assessed Resident #17, and they did vital signs on Resident #17 every 15 minutes. She reported there were no injuries that she saw and there was no sign of shortness of breath or difficulty breathing. She indicated that she did not see redness on Resident #17's neck. She stated Resident #61's family came in after the incident and calmed her down. She stated Resident #61 got upset easily but was never aggressive or attacking anyone. She stated Resident #17 had no change in behavior, but she typically got aggressive and resistive to care because she did not understand things but that was her normal behavior. She stated in the moment of the altercation, Resident #17 seemed scared and frightened and Resident #17 stated "she was trying to hurt me", but later she did not remember the incident. She stated she routinely worked on the locked unit and there had been no altercations between the two residents since that time.

A progress note dated 05/28/24 at 10:22 AM documented by Nurse Practitioner #1 indicated Resident #17 was a 95-year-old with dementia with behaviors. She was seen today for follow up from "attack" by another resident (Resident #61). The nurse this weekend reported she (Resident #17) was choked and pushed to the ground. She denied any pain on assessment and she did not want to be examined fully today and was getting agitated. There was no bruising to her neck. The physical assessment revealed she was in no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 13	F 600		

distress. There were no new skin lesions, or rashes. There was no change in vision, no complaints of headache, and no neurologic changes. She had no anxiety or depressive symptoms. The conjunctiva (thin, clear membrane that covers the inner surface of the eyelid and the white part of the eyeball) was clear with no drainage or erythema (redness). She had no changes from baseline and was up ambulating. The assessment and plan of care revealed weakness, dementia with behaviors, and agitation. There were no medication changes. Resident #17 continued with agitation at times and as needed medications would continue. There was no physical trauma found or reported from assault.

A progress note dated 05/29/24 documented by the Psychiatrist revealed a psychiatric evaluation for mood for Resident #61, a 78-year-old. The Psychiatrist indicated they were asked to see Resident #61 urgently after an altercation with another resident (Resident #17). When asked about the incident, Resident #61 stated that "a little boy hit me, so I sort of swatted back at him, and he told everyone I hit him in the stomach. Sometimes in life you just have to deal with people like that". She denied suicidal ideation or hallucinations and was pleasantly confused. Staff reported that Resident #61 hit another resident (Resident #34) last week, but the other resident provoked and struck her first. This incident occurred as "another resident bumped into her with her walker and [Resident #61] reported she hit her [Resident #34]. She [Resident #61] then grabbed her [Resident #34] by the throat and dropped [Resident #34] to the ground." The Primary Care Provider saw Resident #61 since and increased her Seroquel (antipsychotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 14	F 600		

medication). She has a history of dementia, and bipolar disorder. Her signs and symptoms are moderate, occurring intermittently throughout the week and month. She denied paranoia or delusions, and she was compliant with medications. There were no reported side effects or concerns. The associating and modifying factors include chronic health conditions, loss of mobility and independence, and living in a long-term care/rehabilitation facility.

A Physicians note dated 05/30/24 at 12:49 PM documented by the Medical Director indicated Resident #61 had genetic testing and was taken off Lexapro (antidepressant) based on this report. Her behaviors seemed to increase, and she was placed back on Lexapro. She had an incident right before restarting the Lexapro with one resident (Resident #34) and a similar episode with a second resident (Resident #17) on 05/25/24. Resident #61 was on Seroquel (antipsychotic medication) three times a day. Psychiatry Services was asking to change to extended-release dosing. The Medication Administration Record (MAR) was reviewed at length. The Medical Director indicated they would not make any changes at this time and discussed this with her Responsible Party. Resident #61 was noted to only be back on Lexapro for five days and may have needed more time for it to be effective. Resident #61's Buspar (anti-anxiety medication) was continued.

A progress note dated 5/30/24 at 3:36 PM documented by Nurse #2 revealed a new order was received for (Resident #61) to change Seroquel (antipsychotic medication) to 150 milligrams extended release daily. The Responsible Party was notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 15	F 600		

During an interview on 10/10/24 at 12:06 PM the Medical Director stated she was made aware of both incidents (05/18/24 and 05/25/24) regarding Resident #61. She reported that Resident #61 was adjusting to medication changes during that time period. They made necessary dose adjustments during that time which she tolerated. She was stable on her medications and there had been no further altercations between the residents since that time. She stated both residents had severe dementia and Resident #61 was not considered a threat to other residents.

An interview was conducted on 10/09/24 at 3:30 PM with the Director of Nursing (DON) along with the Administrator. The DON stated she was made aware of the altercation between Resident #61 and Resident #17 on 05/25/24. She stated with any resident-to-resident altercation they reviewed the incident, they made sure all residents were safe and then made determinations on the root cause of the altercation. She stated both residents had severe dementia, and, in this case, she felt like the altercation was a reflexive response by Resident #61 versus a willful action regarding both incidents. She stated they determined that Resident #61 had recent psychotropic medication changes during the time of the altercations. Her Lexapro was decreased, and her behavior increased in that short period of time. She stated they notified the Physician and the Psychiatrist, and both evaluated Resident #61 and agreed to increase her Lexapro to the initial dose. She stated her medications were resumed at the original dose and she has had no altercations with any residents since then. She stated that all residents on the locked unit were closely supervised by staff. She indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 600	Continued From page 16 Resident #61 was stable on her current medications and was not a threat to other residents. Attempts were made to interview the Psychiatrist who evaluated Resident #61. She was on sick leave and there was no further response.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and	F 607		10/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 607	Continued From page 17 (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their abuse policy for reporting an alleged violation of abuse when the facility failed to report two resident to resident altercations to the State Agency, Adult Protective Services, and to Law Enforcement following the altercations. There was no documentation that a written investigation was conducted. This occurred with 3 of 3 residents (Resident #34, Resident #61, and Resident #17) who were investigated for abuse. Findings included. The facility policy titled, "Abuse Investigation and Reporting", revised 01/26/23 revealed in part; all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2 hours if the events that cause the allegation involve abuse or result in serious injury, or no later than 24 hours if the events that cause the allegations do not involve abuse or result in serious injury to the Administrator, NC Department of Health Service Regulation (DHSR), and to Adult Protective Services. This included an allegation regarding any individual against whom an allegation was made. Reports of any reasonable suspicion of crime against a resident of the facility must be submitted to at least one law enforcement agency. The Administrator will ensure that a completed Initial Allegation Report is submitted to DHSR in the required timeframe. Adult Protective Services must also be notified within the same time frames. The Administrator will ensure that a report of the investigation is submitted within 5	F 607	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10/9/24, the Administrator completed initial allegation reports on two resident-to-resident altercations and submitted them to DHSR. The investigation report was completed and submitted to DHSR on 10/17/24. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: By 10/25/24, the Administrator will review all incidents for the past 6 months to ensure no other resident-resident situations were reportable. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 10/23/24, the Administrator and Director of Nursing completed education with the Executive Director on the Abuse Investigation and Reporting for Senior Services policy. Ongoing education to be completed annually and as needed. On 10/24/24, the Administrator and Director of Nursing developed a quick-reference tool to assist in evaluating resident to resident reportable incidents at the time of occurrence. The tool reviews what type of incidents constitute potential abuse and what types of outcomes would	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 607	Continued From page 18 working days of the allegation using the DHSR Investigation Report. a.) Resident #34 was admitted to the facility on 03/24/22 with diagnoses including Alzheimer's, and dementia. Resident #61 was admitted to the facility 09/19/23 with diagnoses including dementia with anxiety, agitation, mood and behavioral disturbance, and Bipolar Disorder. A behavior note dated 05/18/24 at 7:26 PM documented by Nurse #1 revealed resident (Resident #34) was hit and called names by another resident (Resident #61) . Resident #61 then proceeded to choke the other resident. This nurse intervened and the residents were separated. The Director of Nursing (DON) and family members were notified. During a phone interview on 10/09/24 at 12:44 PM Nurse #1 stated she witnessed the altercation between Resident #61 and Resident #34. She was sitting at the nurses station and Resident #34 who had a history of saying things that didn't make sense, she raised her voice and the nurse immediately looked up and saw Resident #34 hit Resident #61 with her arm on her upper leg as she was walking by. She reported that Resident #61 was walking by Resident #34 from the side and grabbed Resident #34 from the side by her neck with both hands wrapped around her neck. This occurred in the dining room in the locked dementia care unit. She stated it happened so fast and she immediately jumped up and ran to where the residents were, and she and another Nurse Aide intervened at the same time and separated the residents.	F 607	be considered abuse, e.g. crying, becoming fearful, etc. The tool also directs the reader to consider how a reasonable person would react in a situation. Beginning 10/25/24 the director of nursing or designee will audit every resident incident report the next business day to ensure all incidents that are required to be reported have been reported. The director of nursing or designee will do this every business day for a month and then weekly for a quarter. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Executive Director will review all audits completed by the director of nursing. A summary of the audits will be included in the Administrator QAPI report.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 607	Continued From page 19	F 607		

Nurse #1 reported that she saw Resident #64 put both hands around Resident #34's neck but she could not tell the force used by Resident #61 once she grabbed her by the neck but stated there were no marks or redness on her neck at that time and no injury to her neck ever developed. She reported that Resident #34 did not have any shortness of breath or respiratory distress from being grabbed by the neck at that time or at any time following the altercation. She stated Resident #34 started crying and seemed distraught and the Nurse Aide immediately took Resident #34 in her wheelchair to her room she and she was still crying but shortly after the incident Resident #34 seemed okay and did not remember what had happened. She stated as soon as the situation was under control and residents were safe and the situation was deescalated, she then reached out to the Director of Nursing.

b.) Resident #17 was admitted to the facility on 12/19/17 with diagnoses including Alzheimer's, dementia with behavioral disturbances, and psychosis.

An incident note dated 05/25/24 at 7:52 PM documented by Nurse #2 revealed she heard a crashing noise while she was at the nurses station. She witnessed Resident #17 falling down onto her left side next to another residents chair. A witness stated another resident (Resident #61) grabbed Resident #17 by her neck and pushed her down. Resident #61 stated Resident #17 pushed into her with her walker and hit her in the left eye, so she grabbed her and pushed her down. Resident #17 was unable to state what occurred. The residents were separated for safety with no injuries noted. Neurologic checks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 607	Continued From page 20	F 607		

were initiated for Resident #17 without abnormal findings. The Physician, the Director of Nursing and the residents' Responsible Party were made aware of the incident.

During an interview on 10/09/24 at 2:18 PM Nurse #2 stated she worked fulltime in the locked unit and had worked in the facility since 2022. She stated Resident #17 ambulated with supervision with her rollator and tended to run into things. She didn't witness the incident between Resident #61 and Resident #17 on 05/25/24 but heard the commotion from the nurses station and looked up as Resident #17 was falling down and landed on the floor. Resident #61 said Resident #17 ran into her with her walker. She stated Resident #17 bumped Resident #61 with her rollator and Resident #61 got upset. She reported that she didn't witness Resident #61 putting her hands on Resident #17's neck but a nurse aide (she could not recall which nurse aide) reported that Resident #61 grabbed Resident #17 by the neck and pushed her down. She stated once the situation had deescalated and the residents were redirected, and all residents were safe, she called the Director of Nursing.

An interview was conducted on 10/09/24 at 3:30 PM with the Director of Nursing (DON) along with the Administrator. The DON stated she was notified by Nurse #1 on 05/18/24 following the incident between Resident #61 and Resident #34. She stated Nurse #1 told her what happened, and the situation had deescalated, the residents were immediately separated, and there were no injuries. She stated both residents went back to their rooms, and that all residents were safe. She stated Resident #61 had remained in her room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 607	Continued From page 21	F 607		

following the incident and there was no further contact between the two residents. She stated both residents had severe dementia, and they had not had any altercations with each other prior to that time. She was also made aware of the altercation between Resident #61 and Resident #17 on 05/25/24. She stated with any resident-to-resident altercation they reviewed the incident, they made sure all residents were safe and then made determinations on the root cause of the altercation. She stated both residents had severe dementia, and, in this case, she felt like the altercation was a reflexive response by Resident #61 versus a willful action regarding both incidents. She stated they determined that Resident #61 had recent psychotropic medication changes during the time of the altercations. Her Lexapro was decreased, and her behavior increased in that short period of time. She stated they notified the Physician and the Psychiatrist, and both evaluated Resident #61. She stated her medications were resumed at the original dose and she has had no altercations with any residents since then. She stated that all residents on the locked unit were closely supervised by staff. She indicated Resident #61 was stable on her current medications and was not a threat to other residents. She stated they did not consider either altercation to be resident abuse. She reported she did a verbal investigation to include talking with all staff involved during both altercations, ensuring a physical examination was completed by the nurse to assess for injury, as well as ensuring the safety of all residents on the unit with close monitoring of the residents by the staff. Also, notifying the Physician and Psychiatrist who both completed evaluations of the residents. She stated she did not complete a written report of the investigation to include the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 607	Continued From page 22 staff interviews or obtain written witness statements. The Administrator stated since the altercations were not considered abuse, they did not report the allegations to DHSR, Adult Protective Services, or to law enforcement.	F 607		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide adaptive equipment for eating for 1 of 1 resident (Resident #62) reviewed for adaptive devices for eating. Findings included: Resident #62 was admitted on 8/27/24 with diagnosis which included adult failure to thrive, diabetes, dementia, and protein calorie malnutrition. Resident #62's admission Minimum Data Set (MDS) assessment dated 9/2/24 revealed the resident had severe cognitive impairment. Review of Resident #62's care plan revealed a focus dated 9/17/24 for self-care performance deficit as evidenced by requiring staff assistance to complete activities of daily living secondary to impaired cognition and impaired mobility. Interventions included set-up assistance with	F 810	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10/10/24, Resident #62 was given all ordered special adaptive devices and meal was served. Resident did not demonstrate any negative outcome due to the adaptive device being given after the meal service began. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/24/24, the director of nursing and administrator completed a chart review for all residents to identify those with orders for adaptive equipment to ensure all orders were on the meal tickets. On 10/24/24 Administrator rounded during mealtime to ensure everyone with an adaptive device ordered received their	10/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 810	Continued From page 23 eating; be sure to cut food up and offer finger foods as needed. The resident may need cueing to stay on task and may need physical assistance with certain foods. Dycem (a non-skid rubbery mat) under the plate, Right-handed large handle curved spoon (left bent), lightweight non spill handled cup with a lid and a straw and raised edge partitioned plate. A physician order dated 9/18/24 for Resident # 62 specified to place blue Dycem piece under red raised divider plate; right-handed built-up spoon (left bent); lightweight non-spill handled cup with a lid and a straw; pillow placed behind patient's back for positioning during self-feeding. Assistance needed during feeding: needs assistance to place spoon in right hand, scoop food onto spoon, does best with finger foods, needs to be told what food is on the plate and redirected to eat more when distracted with meals. Review of an occupational therapy evaluation and plan of treatment dated 9/18/24 revealed Resident #62 was evaluated for self-feeding needs. The focus of Resident #62's treatment plan indicated the resident required assistance with self-feeding to maintain her skill level and adjust to the use of the bent spoon due to impaired range of motion due to arthritis. The evaluation noted Resident #62 had low vision and was provided with a blue Dycem under the plate to avoid slipping on the tabletop, left bent right-handed large handled curved spoon, lightweight non-spill cup with a lid and a straw and red raised edge partitioned plate. The evaluation indicated that Resident #62 required assistance with meals to encourage intake. Resident #62 consumed 90 percent of her meal	F 810	device for mealtime. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: By 10/24/24, all nursing and dietary staff were educated by the staff development coordinator on the protocol related to adaptive equipment and dining procedures including reviewing the meal ticket to ensure the needed adaptive equipment is on the tray at the time of service. All new nursing and dietary staff will be educated during orientation by the staff development coordinator. Ongoing education to be completed annually and as needed. Director of Food Services will provide list of all residents who have orders for adaptive devices to Nurse on each neighborhood. Nurse will verify that all residents receive ordered adaptive devices at each meal. The Neighborhood Coordinator will audit 10 residents for compliance 5 times per week for 4 weeks, once per week for 1 month, then monthly for 4 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The administrator will receive audits 5 times per week for 4 weeks, once per week for 1 month, then monthly for 4 months. Summary of audit reviews will be included in Administrative QAPI report for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 810	Continued From page 24	F 810		

with assistance and adaptive equipment. Instructions were provided to staff regarding the adaptive equipment and assistance needed at mealtimes.

An observation was conducted of the lunch meal on 10/07/24 at 12:45 PM. Resident #62 was sitting in the dining room with a white sectional plate in front of her with a serving of chicken and dumplings and French fries in front of her. Resident #62 did not have the ordered built-up silverware or the non-spill handled cup. Resident #62 was not eating and was not assisted by staff with her meal. At 12:55 PM Resident # 62 was not eating and was not assisted by the staff. At 1:45 PM Resident #62 picked up a French fry and attempted to eat it. Resident #62 did not consume anything at the meal and was not assisted by staff with her meal.

An observation was conducted on 10/9/24 at 12:40 PM. Resident #62 had a red high walled sectional plate for her meal with no Dycem under the plate and did not have the ordered built up/bent silverware or the Kennedy cup. Resident #62 was attempting to scoop food with the standard fork. Resident #62 was unable to get the food to her mouth.

An interview was conducted with Nursing Assistant (NA) # 1 on 10/9/24 at 1:50 PM. NA # 1 indicated she did not think there were any residents that required special silverware or cups for meals. NA # 1 stated the adaptive equipment was listed on the meal ticket for each resident. NA # 1 indicated Resident #62 used a sectional plate, but she did not know of any other special devices that she required for eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 810	Continued From page 25	F 810		

An interview was conducted with Unit Coordinator # 1 on 10/9/24 at 3:34 PM. Unit Coordinator # 1 stated the nursing staff were responsible for getting the special adaptive devices such as built-up silverware and special cups for residents for the meals. Unit Coordinator # 1 indicated the meal ticket listed the adaptive devices that were ordered, and the nursing staff were to ensure those items were provided when serving resident meals.

An interview was conducted on 10/10/24 at 11:15 AM with Nursing Assistant (NA) # 2. NA # 2 stated the meal ticket listed the residents' diet and any special items or devices for meals. NA # 2 stated the dietary staff plated the meal and handed it to the NAs. The NAs then obtained the silverware, cups and any additional items for the meals. Once all items were assembled, the meal was served to the residents. NA # 2 stated she did not know what the non-spill handled cup was and did not know of any resident that required a special cup or special silverware.

An interview was conducted with the Dietary Manager on 10/10/24 at 11:45 AM. The Dietary Manager stated there were residents that required adaptive equipment including built up silverware, non-spill handled adaptive cups, and high walled sectional plates for eating. The Dietary Manager stated she kept a list in the kitchen of residents with orders for adaptive equipment. The Dietary Manager stated she instructed the dietary staff to check the list of adaptive equipment and then bring the items to the unit for the meal service. The Dietary Manager indicated there was a meal ticket for each resident and each meal which listed the ordered diet and adaptive equipment. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 810	Continued From page 26	F 810		

nursing staff were responsible for reading the meal tickets for each resident and ensuring the adaptive equipment was provided when they served the meal. The Dietary Manager indicated she expected the residents would receive the ordered adaptive equipment for each meal. The Dietary Manager indicated the therapy staff communicated with her frequently regarding adaptive equipment for the residents.

Review of the Dietary Manager's adaptive equipment tally report kept in the kitchen for the dietary staff revealed Resident #62 was listed as the following equipment was ordered: non-spill handled cup with a lid and a straw, red 3 compartment plate, Dycem rubber placemat, right angled bent fork, and right-angled bent spoon.

An interview was conducted with the Administrator on 10/10/24 at 4:00 PM. The Administrator stated he expected that the residents would be provided with assistive devices for eating and drinking.