	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION (X3) DATE SURVEY COMPLETED
		345109	B. WING		12/16/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				24724 SOUTH BUSINESS 52	
TRINITY P	LACE			ALBEMARLE, NC 28001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE
E 000	Initial Comments		E 000		
		.73, Emergency			
F 600 SS=D	Free from Abuse and CFR(s): 483.12(a)(1)	0	F 600		1/13/22
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to			
	§483.12(a) The facilit	ty must-			
	physical abuse, corpo involuntary seclusion	-			
	Based on record rev interviews, the facility right to be free from r	nts to 1 of 1 resident		Preparation and/or execution of this pla of correction does not constitute admission or agreement by the provider the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provision of federal and state law. To	of /
	The Findings include Resident #49 was ad 1/3/21with a diagnosi encephalopathy and	mitted to the facility on is of metabolic		remain in compliance with all federal and state regulations, the facility has taken of will take the actions set forth in this plan correction. The plan of correction	d vr

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

01/13/2022

CENTER	S FOR MEDICARE &					O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	· · ·	E SURVEY PLETED
		345109	B. WING		12	2/16/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TRINITY P	LACE			24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 600	Continued From page	e 1	F 600			
		Data Set (MDS) dated ident #49 was cognitively		constitutes the facility allegati compliance such that all alleged deficiencies cited have been or v corrected by the date(s) indicate	will be	
	the facilities investiga AM from the Facility S Development Coordir #49] told [Nurse #1] tr [Nursing Assistant (N [Resident #49]. She a kept complaining that [Resident #49] states legs and when they g be asked to help her told [Nurse #1] that w bed [NA #3] had grab she was yelling to let [Resident #49] then s did not put them bruis is what you white wor women'." An email from the Sta (SDC) on 8/24/21 at Supervisor read; "doe The email response a from the Facility supe "[Nurse #1] says she previously". A review of Resident revealed the following August 20,2021 8:07 fragile. Discoloration	PM - skin is warm, dry, noted to both lower me bruising noted to both		The social worker interviewed R #49 on 8/24/21 to discuss concer- ensure resident felt safe at the fa Measures were taken to remove (nursing assistant) #3 from resid assignment on 8/24/21. An addit alert and oriented residents were interviewed on NA #3 assignmen social worker, on 8/24/21. No oth or concerns were voiced during interviews by other residents on assignment. The staff development RN (regis nurse) met with NA #3 on 8/26/2 next working day for NA #3. The development coordinator review policy on customer service. A wir coaching on 8/26/21 was comple the staff development coordinator address NA #3 approach, profes and customer service with her in with resident #49. NA #3 demon understanding of the policy. In a #3 has received additional educa including, the policy, Abuse Inve- and reporting for senior services December 23, 2021. This educa provided by the staff developmen coordinator. NA #3 demonstrate understanding of the abuse inve- and reporting policy.	rns and acility. NA ents ional 8 ent by the ner issues these NA#3 stered 1, the staff ed the itten eted by or to ssionalism teraction strated ddition NA ation stigation on tion was nt d	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345109 B. WING 12/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 TRINITY PLACE ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 600 Continued From page 2 F 600 matters in place to help prevent skin breakdown. NA#3 no longer provides care for August 27th, 2021- 8:30 PM - Skin is warm, dry, Resident #49. This change occurred on fragile. Discoloration noted to BLE. Skin tear to 8/24/21. back side of right hand. Some bruising noted to To ensure no other residents were BUE. No new areas noted. There was no skin evaluation documented after effected all residents with a BIMS score of the facility became aware of the incident with 13 or higher were interviewed by the Resident #49 and NA #3 on August 24, 2021. activity director and activity director assistant on 1/11/22. 20 residents were A review of the Social Workers (SW) interview interviewed using the LSC Resident with Resident #49 included in the facilities Interview form. This interview form asked investigation dated 8/24/21 read in part; specific questions related to safety, abuse "[Resident #49] felt like [NA #3] was upset about and reporting of abuse. 2 grievances were something because she stated to [Resident #49] completed from the interviews and the 'I don't have time to mess with you,' the NA then facility followed the grievance procedure grabbed Resident #49's calves and squeezed to rectify. them while she was helping her get up. [Resident #49] screamed because it hurt, and she asked The administrator reviewed all concerns the NA to please not do that, it hurt. When and grievances logged by the social [Resident #49] was being put back to bed, the NA worker for the past six months to ensure squeezed her calves again. [Resident #49] stated all reports were fully investigated. Review that NA #3 said 'I know what you white women was completed on 1/11/22. Grievances will say to us black women put bruises on you'. reviewed were from January 11, 2022 [Resident #49] stated she did not know why NA through July 1, 2022. No additional issues #3 said that". were found. An interview and observation were completed Measures put into place or systemic with Resident #49 on 12/14/21 at 9:01 AM. An changes made to ensure the deficient observation of Resident #49's both lower practice will not recur: extremities revealed her legs are very small and skin was red and blotchy. Resident #49 stated a Every employee will be in-service by staff member was very rough with her one night 12/30/21 on the policy titled, Abuse back in the fall when she needed to use the Investigation and Reporting for Senior bathroom. Resident #49 stated that she had Services by the staff development pressed her call light and NA #3 came in and had coordinator, or staff development asked me what I needed, and huffed and said coordinator support LPN. Any employee "lordy, lordy then grabbed my legs and snatched not In-serviced by this date will be them around. Resident #49 mentioned that NA #3 in-service prior to their next working shift. stated to her "I know all about you white people,

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CENTER	5 FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345109	B. WING		12/16/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
	LACE			24724 SOUTH BUSINESS 52	
				ALBEMARLE, NC 28001	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETI THE APPROPRIATE DATE
F 600	Continued From page	23	F 60	0	
		nd say anytime you get a	1.00	Abuse training will be prov	vided upon hire
		k person did it. Resident #49		at least annually and upor	
		d when that happened.		issues related to abuse pr	
	-	hat she told NA #3 that she		practices. Abuse Investiga	
		ist because of what she said		Reporting for Senior Serv	
	-	stated that "her comments		provides description of ab	-
	still bother me and ev	ery time I think about how		prevention interventions a	nd identification,
	uncalled for it was. I g	et along with everyone and		investigation and reporting	g. This policy
	I don't know why she	(NA #3) was so mean, I		includes completing the D	HSR Initial
	guess I am not made	to be in nursing homes."		Allegation Reporting Form	
				health human service reg	
		pleted with the Social		Investigation Report, Inter	
		4/21 at 2:54 PM who stated		reporting the incident, inte	•
		#3 (on 8/24/21) went into		resident (if appropriate), r	-
		and grabbed her legs and		medical record, interviewi	-
		but her back to bed grabbed		members on all shifts, inte	-
		W stated that Resident #49 #3 made a comment to		roommates, family memb	
		u white women get together		interviewing other residen employee provides care a	
		put bruises on her'. The		reviewing all circumstance	
		ou ask Resident #49 how		leading up to the incident.	
		d the SW responded, "well,		will be made in writing, sig	
		ourse". The SW stated		Appropriate authorities no	
		nt 'I don't have time to mess		compliance with state and	
	with you' NA #3 shoul			The administrator will be i	
				progress of investigation.	
	An interview was com	pleted with the SDC and the		administrator or designee	
		12/14/21 at 3:10 PM. The		resident and his/her repre	sentative
		ated that she did go in and		informed of the progress i	
		#49 and did look at her legs		investigation. Any accuse	
		ne Facility Supervisor stated		employed by the facility w	
		ad stated that the NA #3 did		pending the investigation.	
		legs had hurt from what		investigation is taking place	
		ty Supervisor stated she did		employed by the facility w	
		ng but like the Nurse #1		unsupervised access to th	
		as already there" The Facility		situation resident to reside	
	-	t Resident #49 stated her		residents will be supervise	-
	legs hurt from what ha	appenea.		appropriate action can be	
				the safety of other resider	its. Emotional

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						NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	()	TE SURVEY	
		345109	B. WING			12/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE		
TRINITY F	PLACE			24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE	
F 600	Continued From page	e 4	F 60	o			
	An interview was con	npleted on 12/15/21 at 2:53 was asked how she assists		support will be provided	as needed.		
		up out of bed. NA #5 stated er walker and put this by the		Reporting, all alleged vie abuse, neglect , exploita	ation or		
	-	out her one arm under her		mistreatment including i			
		around her shoulder and		unknown origin and mis			
		ted that you do have to be		resident property are rep			
	careiul of her call are	eas as they can be sensitive.		immediately but no later after the allegation is ma			
	An interview was con	npleted on 12/15/21 at 2:53		care personnel registry			
		was asked how she assists		enforcement agency, if			
	Resident #49 to get u	up out of bed. NA #6 stated		cause the allegation inv			
		pes hurt a lot and you have		result in serious bodily in			
	-	h her and one must turn her		than 24 hours if the eve			
		help her sit up. Once she		allegation does not invo			
		not rush her as she needs to en you grab her [Resident		serious body injury, to the accordance with the sta			
		ghtly pull on her legs to the			le law.		
		y her hips, if you pull to hard		The administrator or dea	sianee is		
		r and stated, "Resident #49		responsible for completi			
	will always let you kn	ow."		Allegation Report to the	Health care		
				personnel registry section			
				2 Hours after the allegat			
		npleted on 12/15/21 at 5:13 no was working third shift on		events that caused the a abuse or result in seriou	-		
		M to 7:00 AM who was		The administrator or des			
		rd any yelling from Resident		responsible for completi			
		ing. Nurse #4 stated, "I did		Investigation 5 Day repo			
	not hear her [Resider			written report of the find	ings will be		
				included with the DHSR	-		
				Investigation report to th			
		npleted on 12/15/21 at 8:53 stated that it is very hard to		to any other licensing at	unorities.		
		of bed as you need to hold		All abuse investigations	conducted by the		
	-	her at the same time. NA #3		facility will be reviewed l			
		#49 was concerned about		nurse consultant to ensu			
		gs and NA #3 stated the		was followed and no fur	ther actions need		
		bad and was trying to		to be taken. The nurse of			
	re-direct Resident #4	9 instead of focusing on her		receive all reported alleg	nations within 2		

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345109 B. WING 12/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 TRINITY PLACE ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 600 Continued From page 5 F 600 legs. NA #3 was asked if she had grabbed hours of the allegation being made. Date Resident #49's calves and NA #3 stated that she of completion 1/13/22 did not remember and stated that "you have to put your hands underneath her calves and bring All skilled nursing stations have received her legs around to the side of the bed and an abuse instruction education folder to physically pull her legs and you have to put some follow when an allegation or concern is energy into it and put pressure on her legs." reported by any staff member, resident or NA#3 was asked if she was too rough with any person. This folder includes phone Resident #49, and she stated she did not think numbers of administration, local law she had been too rough with Resident #49 but enforcement and Dept of social service, there was a lot of pushing and pulling and nothing initial Health care personnel registry was intentional. NA #3 stated it had been a rough reporting forms, resident / staff interview niaht. forms and a copy of the LSC Abuse NA #3 stated she did not remember her Investigation and Reporting for Senior screaming in pain and was not rushing her. NA #3 Services Policy. All nurses have been stated she knew Resident #49's legs are made aware to notify administrator or sensitive, and Resident #49 told NA #3 to go director of nursing immediately to any slower. NA #3 stated that she did tell her to "come concerns or allegation of abuse. All on" that her back was about to give out. NA #3 licensed nurses have also been made was read the statement interview from the SW aware to complete the initial reporting and Resident #49 which indicated NA #3 stated to form within two hours of any allegation of Resident #49 'I don't have time to mess with you' abuse or bodily harm and to notify outside law enforcement. All staff have been 'I know all about you white people, you gather together and say anytime you get a bruise you educated to notify their supervisor say a black person did it". NA #3 stated that she immediately on any allegations of abuse. did not say those things to Resident #49 and Intervention put in place 1/11/22. would never put anybody down. NA #3 stated she had not been asked to write any statements A total of 6 residents will be interviewed about what happened but stated; "I wish they every week for four weeks to ensure there would have, as I cannot remember the details of are no concerns that have not been what happened now." investigated regarding residents right to be free from mistreatment. Interviews will be conducted by the activity director or social worker. After four weeks, 6 interviews will occur each month for three months until three months of compliance is sustained. Any concerns found during these interviews will immediately be reported to the administrator and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/26/2022 M APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345109	B. WING			12	/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				24	4724 SOUTH BUSINESS 52		
TRINITY PLACE ALBE			LBEMARLE, NC 28001				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From page			600		s will ment se(s) k for o se r yees ee nce gin ce to ts dents ill be gs by g s to ve ents ctivity eeks,	
					compliance is sustained.)Teammate Audit- (interviews 10 employees each week for four weeks. After four weeks		

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
and plan of	CORRECTION	IDENTIFICATION NUMBER:	,		COMPLETED
		345109	B. WING		12/16/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·
TRINITY P	PLACE			24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTIO
F 600	Continued From pag	e 7	F 600	employees will be interviewed each for three months until three months compliance is sustained). All audits completed by the corporate nursing consultant with allegations of abuse facility will be presented at the mon QAPI meeting over the next 12 mon Completion Date of Plan of Correct 1/13/22	of g e by the thly nths.
F 607 SS=D		Abuse/Neglect Policies)-(3)	F 607		1/13/22
		licies and procedures that:			
	neglect, and exploita misappropriation of r				
	§483.12(b)(2) Establ to investigate any su	ish policies and procedures ch allegations, and			
	paragraph §483.95,	e training as required at T is not met as evidenced			
	interviews facility sta Abuse Investigation a Services Policy when report allegations of Residents #113, and abuse. Resident #17 abuse to a staff mem	view and family and staff ff failed to follow the facility's and Reporting for Senior In they failed to promptly abuse for 2 of 3 residents, Resident #49, reviewed for 13 reported allegations of aber who did not report the nanagement, which resulted		For Resident #49, The social work completed an interview with resider on 8/24/21 to discuss concerns reg NA (nursing assistant)#3. NA (nursi assistant) #3 was removed from res assignment on 8/24/21. 8 additional interviews were completed with ale oriented residents on NA #3 assign by the social worker on 8/24/21, no concerns noted.	nt #49 arding sidents Il rt/ ument,

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ 345109 B. WING 12/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 TRINITY PLACE ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 607 Continued From page 8 F 607 delayed. Resident #49 also reported allegation of Nurse #4 and the Charge Nurse were all abuse to staff, and they failed to report the educated on the policy titled, Abuse allegation to the Division of Health Service Investigation and Reporting for Senior Regulation and failed to assess Resident #49 and Services by the staff development investigated the allegation. coordinator RN on 5/14/21. NA (nursing assistant) #1 was educated on policy The findings included: Investigate and Reporting of Senior Services by the staff development 1. A review of the Abuse Investigation and coordinator RN Written education was Reporting for Senior Services revised on provided to Nurse Aide # 1 on May 3/5/2021 revealed facility staff should report 17,2021. NA #1, Nurse #4, and the observed or suspected incidents of abuse to Charge Nurse all acknowledged his/her department manager as soon as he is understanding and the expectation to aware of an incident or potential incident. The follow the LSC policy. nursing supervisor or department manager must notify the administrator and the director of nursing Resident #113 was interviewed by the immediately. The administrator or designee is social worker on 5/14/21 and resident responsible for ensuring the thorough #113 was made aware that NA #1 was investigation of the allegation. While the removed from assignment on 5/14/21. investigation is pending, the accused individual employed by the facility will be suspended, Nurse aide #1 charge nurse, the director pending the results of the investigation. of nursing and the administrator were all reeducated on the policy titled, Abuse Resident #113 admitted to the facility on 4/9/2019 Investigation and Reporting for Senior with diagnoses of heart disease and dementia. Services by the staff development coordinator on 12/23/21. Nurse #4 was Resident #113's Annual Minimum Data Set educated on the Abuse Investigation and assessment dated 4/14/2021 indicated she was Reporting for Senior Services by the staff moderately cognitively impaired and required development coordinator on 12/22/21. extensive assistance with bed mobility and set up assistance with her meal trays. Steps facility will take to identify other residents having the potential to be A review of an abuse investigation dated affected by the same deficient practice: 5/14/2021 revealed Resident #113's Family Member called the facility to report Resident #113 Every resident with a BIMS score of 13 or had told him, while she was visiting with the higher was interviewed by the activity Family Member in his home, Nurse Aide #1 had director and assistant activity director on slammed her dinner tray down on her over bed 1/11/22. 20 residents were interviewed. table several weeks ago, causing pain in her legs, the LSC Resident Interview Tool was

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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			a			0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SI COMPLE	
		345109	B. WING		12/10	6/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TRINITY P	LACE			24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETIO DATE
F 607	Continued From page	e 9	F 60	7		
		o do it again. The Family		used. 2 grievances were noted fr	om the	
		lent #113 if the incident was		interviews. The grievance policy		
		stated Nurse Aide #1 had		followed to rectify all concerns.		
				Measures put into place or system	nic	
	During an interview w	/ith Nurse Aide #1 on		changes made to ensure the defi		
	12/15/2021 at 3:58 pi	m he stated Resident #113		practice will not recur:		
	told him he had hit he	er with the over the bed		Every employee will be inservice	d by	
	table, but he could no	ot remember the date it		12/30/21 on the policy titled, Abu	se	
	happened. He stated	he told Nurse #4 when the		Investigation and Reporting for S	enior	
	incident occurred that	t Resident #113 had		Services by the staff developmer	t	
	accused him of hitting	g her with the over the bed		coordinator, or staff development		
	table and he was rea	ssigned to another resident		coordinator support LPN. Any em	ployee	
		of Resident #113 again.		not inserviced by this date will be		
		he was not suspended		inserviced prior to their next work	ing shift.	
		incident to Nurse #4, and				
		that night. Nurse Aide #1		Abuse training will be provided u		
		after the incident the Staff		at least annually and upon incide		
	Development Coordin			issues related to abuse prohibition		
		ing an allegation and then		practices. Abuse Investigation an		
		Director of Nursing called him		Reporting for Senior Services Po	-	
		to work early and she		provides description of abuse typ		
	interviewed me befor	e I went back to work.		prevention interventions and ider		
				investigation and reporting. This	-	
	•	vith Nurse #4 on 12/15/2021		includes completing the DHSR In		
		d Nurse Aide #1 did not		Allegation Reporting Form, DHSI		
	•	's allegation to her when it		health human service regulation)		
	occurred on 4/30/202			Investigation Report, Interviewing		
		er Nurse Aide #1 intentionally		reporting the incident, interviewin	•	
		d table on her knees on		resident (if appropriate), reviewin		
		er the incident happened.		medical record, interviewing staff		
		immediately went to Nurse		members on all shifts, interviewir	-	
		rking at the time, and asked		roommates, family members and		
		and he told her it was an tated Nurse Aide #1 stated		interviewing other residents to wh		
				employee provides care and or s		
		e dropped and hit her knees knees but did not see any		reviewing all circumstances and leading up to the incident. Witnes		
		ed she reported the incident		will be made in writing, signed an		
	injury. inurse #4 state	eu ane reporteu the moldent	1		ע עמוכע.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ___ 345109 B. WING 12/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 TRINITY PLACE ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 10 F 607 F 607 #113 reported the allegation to her. compliance with state and federal laws. The administrator will be informed of An interview was conducted with the Charge progress of investigation. The Nurse on 12/15/2021 at 5:38 pm and she stated administrator or designee will keep the she did not remember Nurse #4 reporting an resident and his/her representative allegation of abuse involving Resident #113 and informed of the progress in the was not aware of the incident. investigation. Any accused individuals, employed by the facility will be suspended On 12/16/2021 at 1:05 pm an interview was pending the investigation. While the conducted with the Director of Nursing and she investigation is taking place individuals not stated she was not aware of Resident #113 employed by the facility will be denied reporting the allegation of abuse until the Family unsupervised access to the resident. In Member called the Staff Development situation resident to resident abuse, Coordinator on 5/14/2021 and reported the residents will be supervised by staff until allegation. The Director of Nursing stated she appropriate action can be taken to ensure was not working when the allegation was the safety of other residents. Emotional reported, and the Staff Development Coordinator support will be provided as needed. had suspended Nurse Aide #1 and obtained the statements from the staff. Reporting, all alleged violations involving abuse, neglect, exploitation or The Staff Development Coordinator was mistreatment including injuries' of interviewed on 12/16/2021 at 2:07 pm and stated unknown origin and misappropriation of he was not aware of the abuse allegation resident property are reported regarding Resident #113 until 5/14/2021 when the immediately but no later than two hours Family Member called him to report Resident after the allegation is made to the health #113 told him that Nurse Aide #1 intentionally care personnel registry and to the law slammed the over the bed table on her legs enforcement agency, if the events that several weeks ago. He stated he had cause the allegation involve abuse or immediately made the Administrator aware of the result in serious bodily injury , or no later allegation and suspended Nurse Aide #1 until the than 24 hours if the event that cause the investigation was completed. The Staff allegation does not involve abuse or Development Coordinator stated the staff receive serious body injury, to the state agency in accordance with the state law. abuse education at least annually and any time there is an allegation of abuse. The administrator or designee is During an interview with the Administrator on responsible for completion of the Initial 12/16/2021 at 2:21 pm she stated she was not Allegation Report to the Health care personnel registry section of DHSR within aware Resident #113 had reported the allegation of abuse to Nurse #4 before it was reported by 2 Hours after the allegation is made if the

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345109 B. WING 12/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 TRINITY PLACE ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 607 Continued From page 11 F 607 the Family Member to the Staff Development events that caused the allegation involve Coordinator on 5/14/2021. The Administrator abuse or result in serious bodily injury. stated Nurse #4 should have reported Resident The administrator or designee is also #113's allegation of abuse regarding Nurse Aide responsible for completion of the #1 slamming the over the bed table down on her Investigation 5 Day report to NC DHSR. A leas intentionally to her immediately. The written report of the findings will be Administrator stated Nurse Aide #1 should have included with the DHSR 5 day reported to Nurse #1 and the Charge Nurse when Investigation report to the NC DHSR and the resident told him her hurt her legs with the to any other licensing authorities. over the bed table. The Administrator stated the staff should follow the facility's policy for Abuse All abuse investigations conducted by the Investigation and Reporting for Senior Services facility will be reviewed by a corporate and report any allegations of abuse immediately. nurse consultant to ensure the LSC policy was followed and no further actions need to be taken. The nurse consultant will receive all reported allegations within 2 hours of the allegation being made. Implemented measure on 1/13/22. 2. Resident #49 was admitted to the facility on All skilled nursing stations have received 1/3/21 with a diagnosis of metabolic encephalopathy and Parkinson's disease. an abuse instruction education folder to follow when an allegation or concern is The Annal Minimum Data Set (MDS) dated reported by any staff member, resident or 11/7/21 revealed Resident #49 was cognitively any person. This folder includes phone intact. numbers of administration, local law enforcement and Dept of social service, initial Health care personnel registry A review of a policy titled: Abuse Investigations reporting forms, resident / staff interview and Reporting for Senior Services revision date forms and a copy of the LSC Abuse 3/5/21 read in part: Identification and Investigation and Reporting for Senior Investigation: 2. The administrator or designee is Services Policy. These folders were put in responsible for ensuring the thorough place by 1/13/22. All nurses have been investigation of the allegation. 3. Upon receiving a made aware to notify administrator or report of physical abuse, the nursing supervisor director of nurisng immediately to any (or designee) shall immediately examine the concerns or allegation of abuse. All resident. Finding of the examination must be licensed nurses have also been made recorded in the resident's record. 5. The director aware to complete the initial reporting of nursing or designee will begin the abuse form within two hours of any allegation of investigation which will consist of: abuse or bodily harm. All staff have been

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OLITICI	S FOR MEDICARE &				OMB NO. 0938-0
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED
		345109	B. WING		12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
TRINITY F	PLACE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLET
F 607	Continued From page	e 12	F 607		
	" Completing the E Regulation (DHSR) re (initial allegation repo " Interviewing the incident " Interviewing staff have had contact with period of this alleged " Reviewing all circ leading up to the incid 6. Witness reports wil and dated. Witness re with all written reports or designee will moni concerning the incide reaction to his/her inv investigation. Reporti facilities and skilled n violations involving at	Division of Health Service equired reporting from the ort) person(s) reporting the f members (on all shifts) that in the resident during the incident cumstances and events dent II be made in writing, signed eports will be maintained s. The director of social work tor the resident's feeling ent, as well as the resident's		 educated to notify their supervisor immediately on any allegations of Education was provided to all staff members by 12/30/21. A total of 6 residents will be intervievery week for four weeks to ensurate no concerns that have not begin 1/13/2022. Interviews will be cond the activity director or social worke four weeks, February 17, 2022, 6 interviews will occur each month fmonths until three months of complis sustained. Any concerns found these interviews will immediately breported to the administrator and investigated. These interviews will 1/13/2022 	abuse. f iewed ure there en lucted by er. After or three pliance during be
	later than two hours a A review of the facility revealed no reportabl completed related to resident abuse for Re completed an investig following: Social Worl resident, email corres Facility supervisor an statement from the Ac Coaching/Disciplinary not signed statements A review of the email the facilities investiga AM from the Facility S	after the allegation is made y's reportable incidents le investigations were the allegation of staff to esident #49. The facility gation which included the ker's (SW) interview with the spondence between the d the SDC, a signed dministrator and a Employee y Action Report. There were		The director of nursing, staff deve coordinator, or minimum data set will interview 10 employees each 1/13/2022, for four weeks using th Employee Interview Audit: Abuse to ensure all employees can verba demonstrate understanding of the requirements in the policy titled, A Investigation and Reporting for Se Services. After four weeks (Febru 17,2022), 10 employees will be interviewed each month for three until three months of compliance i sustained. Facility process to monitor perform ensure solutions are sustained:	nurse(s) week, by le Policy, ally buse enior ary months s

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		345109	B. WING	12/16/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				24724 SOUTH BUSINESS 52		
TRINITY F	PLACE			ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLE	
E 607	Continued From page	N 13	F 60	7		
F 607	[Resident #49]. She a kept complaining that [Resident #49] states her legs and then the to be asked to help he #49] told [Nurse #1] th back to bed [NA #3] h that she was yelling to [Resident #49] then s did not put them bruis is what you white wor women'." An email from the Sta (SDC) on 8/24/21 at Supervisor read; "doe The email response a from the Facility supe "[Nurse #1] says she previously". A review of Resident revealed the following August 20,2021 8:07 fragile. Discoloration extremities (BLE). So upper extremities (BL August 25th, 2021- 8 matters in place to he August 27th, 2021- 8 fragile. Discoloration back side of right han BUE. No new areas r There was no skin ev the facility became aw	A) #3] was rough with also explains that [NA #3] ther back was hurting. that [NA #3] had grabbed y got into the bathroom had er on the toilet. [Resident hat when she was getting had grabbed her legs so hard o let go because of the pain. tated that [NA #3] told her 'I ses on your legs, I know that men try to say about us black aff Development Coordinator 11:20 AM to the Facility es she have any bruises". at 8/24/21 at 12:07 PM back ervisor to the SDC read: does but they were there #49's skin evaluations g skin assessments: PM - skin is warm, dry, noted to both lower me bruising noted to both JE). No new areas noted. :06 AM pressure reducing elp prevent skin breakdown. :30 PM - Skin is warm, dry, noted to BLE. Skin tear to id. Some bruising noted to	F 60'	 7 interviews will be reported at th QAPI meetings, by the social w director of nursing until the aud is completed. The following QA is scheduled for January 18,20 residents audit scheduled is as Residents will be interviewed ef for four weeks to ensure there concerns that have not been in These interviews will begin 1/1 Then beginning the week of Fe 2022, 6 interviews will be cond monthly by the activity director worker. Monthly audits will con three months until three month compliance is sustained. Team audits will be conducted by the nursing, staff development coo minimum data set nurse(s). 10 each week for four weeks will b interviewed begin by Jan 13, 2 four weeks, beginning Februar 10 employees will be interview month for three months. Team will continue until three months compliance is sustained. All au completed for abuse reporting nurse consultant will be reporte QAPI monthly meeting for the to months. Completion Date of Plan of Co 1/13/22 	vorker or lit schedule API meeting 22. The follows: 6 every week are no avestigated. 3/2022. beruary 17, ucted or social tinue for s of imate of irector of rdinator, or employees be 002. After y 17, 2022 ed each mate audits foldits by the ed in the hext 12	

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/26/2022 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345109	B. WING				12/	16/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	, CODE		
TRINITY P	LACE				4724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
F 607	something because s 'I don't have time to m grabbed Resident #49 them while she was h #49] screamed becau the NA to please not of [Resident #49] was be squeezed her calves that NA #3 said 'I kno will say to us black wo [Resident #49] stated #3 said that". A signed statement fm 8/24/21 read in part; " conducted by the soc [Resident #49] and ot assignment and revie assessments of [Resi abuse did not take pla third shift [NA #3] and inappropriate but the definition of abuse de Medicaid Services (C willful infliction of injur confinement, intimida resulting physical har anguish.'(42 CFR 488 encounter did not me with the standard set- service and professio clearly stated in the L Carolina) WAY policy.	luded in the facilities 24/21 read in part; the [NA #3] was upset about the stated to [Resident #49] the stated to [Resident #49] the stated to [Resident #49] the stated to get up. [Resident se it hurt, and she asked do that, it hurt. When eing put back to bed, the NA again. [Resident #49] stated w what you white women omen put bruises on you'. she did not know why NA om the Administrator dated After reviewing interviews ial worker on 8/24/21, with her residents on that wing recent body dent #49], I concluded that ace. The encounter with the [Resident #49] was behavior did not meet the fined by the Centers for MS). "Abuse", means the y, unreasonable tion, or punishment with m, pain or mental 8.301). However, this et the facility's expectation	F	607				

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T		NSTRUCTION		NO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	, í				MPLETED	
		345109	B. WING		12/16/2021			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			E		
	PLACE				SOUTH BUSINESS 52			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 607	with Resident #49 on stated that a staff men her one night back in use the bathroom. Re "had pressed her call and had asked me wh said 'lordy, lordy' ther snatched them aroun below the knee and w squeezed them, she f #49 stated she had us bathroom and when N back to bed she "thre was very rough. Resident right calf was the wor Resident #49 stated t know all about you wh together and say any say a black person di really felt mad when t that she was nothing she said to me". Resi bleeding it just really that NA #3 is no longer room. An observation revealed her legs are and blotchy. A follow with Resident #49 on stated that "her comm every time I think abo get along with everyo (NA #3) was so mean be in nursing homes"	ervation were completed 12/14/21 at 9:01 AM who mber was very rough with the fall when she needed to esident #49 stated that she light and NA #3 came in nat I needed, and huffed and a grabbed my legs and d. She grabbed my legs vas very rough and eft fingerprints". Resident sed the walker to walk to the NA #3 had put Resident #49 w" her back into bed and dent #49 described that her st because of the pain. hat NA #3 said to her "I hite people, you gather time you get a bruise you d it". Resident #49 stated "I hat happened. I told NA #3 but a racist because of what dent #49 stated I was not hurt. Resident #49 stated er able to come into my of Resident #49's BLE very small and skin was red up interview was completed 12/15/21 at 5:30 PM who nents still bother me and ut how uncalled for it was. I ne and I don't know why she a, I guess I am not made to 	F	307				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/26/2022 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMPI	SURVEY
		345109	B. WING			12/ [,]	16/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
TRINITY P	LACE			24724 SOUTH BUSINESS ALBEMARLE, NC 2800			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE INCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	did not like it of course SW stated I do not km An interview was com Facility Supervisor on Facility Supervisor sta Administrator, and sh report to be complete stated that she did go #49 and did look at he The Facility Supervisor had stated that the N/ she did have scattere #1 stated the bruising Facility Supervisor sta stated her legs hurt fr SDC and the Facility #3 was suspended. T not work the next nigh by then the investigat did not need to susper from performing care An interview was com Administrator on 12/1 that the facility becam staff to resident abuse AM on 8/24/21 and st Administrator was asl about, and the Admin allegation of an unple Resident #49 was up the facility wanted to stated the facility did the state as it did not per the regulation. Th Resident's #49 does I	e, but was not asked". The ow why it was not reported. appleted with the SDC and the 12/14/21 at 3:10 PM The ated the SDC notified the e did not direct a 24-hour d. The Facility Supervisor in and speak with Resident er legs but did not chart it. or stated that "Resident #49 A #3 did grab her legs and d bruising but like the Nurse was already there". The ated that Resident #49 om what happened. The Supervisor was asked if NA he SDC stated that she did ht as she had called out, and ion was completed and we and her. She was removed to Resident #49. appleted with the 5/21 at 9:16 AM who stated he aware of the allegation of e for Resident #49 at 10:45 arted the investigation. The ked what the allegation was istrator stated it was an asant encounter and follow up. The Administrator not report this allegation to meet the definition of abuse e Administrator stated that have frequent pain and moving her legs, she would	F 607				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/26/2022 APPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	
		345109	B. WING			_	12/	16/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST			
TRINITY P	LACE				24724 SOUTH BUSINESS 5 ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	complained of pain. T I think the encounters absolutely, but I don't was met". The Admin did an investigation at that "we do an investi does not meet our cur An telephone intervier Resident #49's respon 12/15/21 at 10:45 AM Resident #49 that mo stated they did remen that were made. The remember any way R physically and the RP [Resident #49] saying legs" but did not recal RP stated that "my m but would get mad if s wrong". The RP state on-going skin issues a accidentally bump it o something it causes h An interview was com PM with Nurse #4 wh 8/23/21 from 11:00 PI asked if she was intervincident. An interview was com PM with NA #3 who s had been too rough w was a lot of pushing a guide her legs and pu	The Administrator stated, "Do should have gone differently is think the criteria of abuse istrator was asked why they nd the Administrator stated igation with any conduct that stomers expectations". w was competed with nsible party (RP) on who stated they had visited orning on 8/24/21. The RP nber some racial comments RP was asked if they tesident #49 was treated P responded, "I do remember g that [NA #3] squeezed her II if she had any marks. The om is not one to get upset she thought something was and "if the aides would on a wheelchair or her discomfort". appleted on 12/15/21 at 5:13 o was working third shift on M to 7:00 AM and was rviewed about the incident d NA #3. Nurse #4 stated	F	607				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/26/2022 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE	
		345109	B. WING				12/	16/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CC	DDE		
TRINITY P	PLACE				24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 607	pain and was not rush knew Resident #49's Resident #49 told NA stated that she did tel back was about to giv did not recall Resider NA #3 was read the s SW and Resident #49 stated to Resident #49 stated she had not statements about what wish they would have details of what happe An interview was com 12/16/21 at 10:11 AM process was for repor DON stated that if the purpose, they would r intent, we would do a stated that any allega reported to the state. did remember that the #3 and Resident #49 that she felt that the N the resident and did r anything intentional. T Resident #49 likes to will tense up and com stated that she thoug during the incident an remember. A follow up interview w	hing her. NA #3 stated she legs are sensitive, and #3 to go slower. NA #3 I her to "come on" that her ve out. NA #3 stated that she at #49 screaming out in pain. tatement interview from the 9 which indicated NA #3 9 'I don't have time to mess bout you white people, you ay anytime you get a bruise on did it". NA #3 stated that things to Resident #49. NA t been asked to write any at happened but stated; "I a, as I cannot remember the ned now." hybe was asked what the tring abuse allegations. The e resident said it was on report it and if there was full n investigation. The DON tion of abuse should be The DON stated that she are was an incident with NA during a transfer and stated NA had moved too quickly for not think that NA #3 would do The DON stated that be moved slowly and she uplain of pain. The DON ht she had been on vacation	F	607	7			

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	OMB NO. 0938-03		
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED		
		345109	B. WING		12/16/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
TRINITY F	PLACE			24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
F 607	Resident #49 and NA	e 19 ews were completed with #3 it seemed to be more of tuation, and it was not	F 607	,			
	reported". The Admin an investigation the fa and written statemen sure if they had gotte Administrator stated t	istrator stated that "during acility would get interviews ts from staff but was not n one from NA #3". The the night nurse should have I a skin assessment should					
F 637 SS=D	Comprehensive Asse	ssment After Signifcant Chg	F 637	,	1/13/22		
	determines, or should there has been a sigr resident's physical or purpose of this sectio means a major declin resident's status that itself without further in implementing standar interventions, that has one area of the reside requires interdisciplin care plan, or both.)	hin 14 days after the facility d have determined, that inficant change in the mental condition. (For in, a "significant change" are or improvement in the will not normally resolve intervention by staff or by rd disease-related clinical is an impact on more than ent's health status, and ary review or revision of the					
	Based on staff and re record reviews the fa- significant change Mi for 2 of 2 residents re status (Resident # 39	esident interviews and cility failed to complete nimum Data Sets (MDSs) viewed for a change in and resident # 42).		Resident #39 had a significant change review with ARD on 1/13/2022 by the interdisciplinary team . Resident #42 h a significant change review with ARD of 1/13/2022 by the interdisciplinary team conducted.	ad on		
		readmitted to the facility on noses of spinal stenosis,		The facility addressed other residents having the potential to be affected by reviewing all residents MDS			

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Facility ID: 923316

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345109 B. WING 12/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 TRINITY PLACE ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 637 Continued From page 20 F 637 peripheral vascular disease (PVD) and transient assessments for any areas of decline or ischemic attack (TIA). improvement that indicate a significant change assessment is required. Review Review of an annual MDS dated 07/07/2021 was conducted by 1/13/2022 by MDS revealed that Resident # 39 had moderate RN(minimum data set), and staff cognitive impairment and required extensive development support LPN. 61 residents assist of at least 2 staff for bed mobility ,transfers MDS reviewed. 0 number of residents and toileting. Resident # 39 required supervision required a significant change assessment. to limited assist of 1 staff to eat, was always incontinent of bladder and bowel and had no pain. Measures put into place or systemic changes made to ensure the deficient A guarterly MDS dated 10/06/2021 for Resident # practice will not recur: 39 included that Resident # 39 had significant The interdisciplinary care plan team, cognitive impairment, felt down, depressed, or including MDS (minimum data set) hopeless on at least 1day of the review period nurses, dining services director, social and 12 to 14 days of feeling bad about herself. worker, and activity director, director of Resident # 39 required extensive assist of 1 staff nursing, administrator and staff to eat and was frequently incontinent of bladder development RN was inserviced by the and bowel. Resident # 39 had no pain. **Director of Clinical Compliance Services** on 1/12/22 regarding conducting A review of a quarterly MDS dated 11/10/2021 significant changes assessments when a included that Resident # 39 required supervision resident experiences a decline or improvement in two or more areas. and set up to eat and she had frequent pain that limited her day-to-day activities. Nurses were inserviced by the MDS Coordinator and Staff Development An interview conducted with MDS nurse # 1 on Coordinator on 1/13/22 on recognizing 12/16/2021 at 11:00 AM. MDS nurse #1 stated and reporting possible significant changes that a significant change MDS was required if a to the MDS coordinator or the nursing resident had 2 areas of decline or improvement in supervisor. New nursing team members resident status as determined by the will be educated on importance of interdisciplinary team that consisted of MDS reporting changes in condition to the nurse #1 and MDS nurse #2. MDS nurse #1 supervisor or MDS (minimum data set) stated that there had been a difference in MDS coordinator during orientation. Residents coding for Resident # 39 but that she was not with potential declines or improvement in certain the MDS was coded correctly. condition are reviewed at the weekly risk meeting to determine if a significant The administrator was interviewed on 12/16/2021 change assessment is indicated. at 1:22 PM. The administrator stated that she expected that significant change MDSs be Facility process to monitor performance

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	יסוד וו א (22)	E CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		345109	B. WING		12/16/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
TRINITY F	PLACE			24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC
F 637	completed as stated i Resident Assessmen 2. Resident #42 was 05/05/21 with diagnor weakness and gait at A review of Resident Data Set (MDS) asse conducted. The func MDS reported the reso only for transfer, dress hygiene and the assis eating she required s up assistance. She r from staff for bed mol person. Locomotion 1 person assist on the A review of Resident Data Set (MDS) asse conducted. The func MDS reported the reso only with eating and of She required extension mobility, extensive as transfer, dressing, toi hygiene	in the regulation and the t Manual (RAI). admitted to the facility on ses that included muscle onormalities. #42's quarterly Minimum assment dated 08/04/21 was tional status section of the sident required supervision using, toilet use and personal stance of 1 person. For upervision only with meal set needed limited assistance bility with the assistance of 1 occurred only 1-2 times with e unit. #42's quarterly Minimum assment dated 10/27/21 was tional status section of the sident required supervision one person physical assist. ve assist of 2 staff with bed assist with 1 person assist for	F 63	to ensure solutions are sustained: To monitor performance, the Direct Nursing or Staff Development Ass LPN will review 3 residents MDS assessments weekly for four week then review 6 MDS assessments in to determine if a significant change warranted. If a significant change needed the Director of Nursing or Development Assistant LPN will are see if a comprehensive care plant completed to address the changes findings will be reported to the QA committee by the Director of Nursi Staff Development Nursing month months of compliance is sustained Completion Date of Plan of Correct 1/13/2022	istant as and monthly e was was Staff udit to was s. Audits PI ng or ly until 3 1.
	the functional status of assessments from 08 MDS nurse stated the much and did not ind change assessment to they looked at the Act (ADL's), but they can	M regarding the decline in on Resident #42's Quarterly 0/04/21 to 10/27/21. The e resident had not changed icate a need for a significant to be completed. She stated tivities of Daily Living fluctuate and if they need a in care and had 2 or more			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/26/2022 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345109	B. WING			12	/16/2021
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRINITY P	LACE				4724 SOUTH BUSINESS 52 ILBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 637	Continued From page	22	F	637			
	with Nurse #5 regardi the resident used to b	e on 12/15/21 at 10:33 AM ng Resident #42. He stated be very independent and she now required a lot more					
	with PT #1 that comp rehabilitation evaluati stated he evaluated h and she had she abso He noted she would r actively participate an	on after some falls. He er post falls on 09/15/21 olutely refused to participate. not stand when asked or					
	since admission inclu	ed Resident #42 had 7 falls ding 08/31/21 and 11/14/21. ays from 9/17 indicated a					
	12:03 PM with MDS N why a significant char done with 2 or more of functional area declin decision if a significar	was done on 12/16/21 at Nurse #1 and she was asked nge assessment was not changes, and with several es. She stated the final nt change needed to be e Interdisciplinary Team, e 2 MDS nurses.					
F 656 SS=D	with the Administrator changes on the MDS areas and the change a significant change s	e on 12/16/21 at 1:05 PM . She stated if there were assessment in 2 or more es were for a prolonged time, should be done. comprehensive Care Plan	F	656			1/13/22

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/26/2022 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY
		345109	B. WING		_	12/ [,]	16/2021
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
TRINITY P			2	4724 SOUTH BUSINESS	52		
			A	LBEMARLE, NC 2800	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that ind objectives and timefra medical, nursing, and needs that are identifi assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that y under §483.24, §483. provided due to the re under §483.10, includ treatment under §483 (iii) Any specialized se rehabilitative services provide as a result of	e 23 ensive Care Plans illity must develop and ensive person-centered ident, consistent with the h at §483.10(c)(2) and cludes measurable mes to meet a resident's mental and psychosocial ed in the comprehensive oprehensive care plan must - re to be furnished to attain nt's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ing the right to refuse .10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its nt's medical record. n the resident and the ive(s)-	F 656				
	(B) The resident's pre future discharge. Faci whether the resident's community was asses	s desire to return to the ssed and any referrals to s and/or other appropriate					

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		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION G	· · · ·	E SURVEY IPLETED
		345109	B. WING		1:	2/16/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
FRINITY F	PLACE			24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 24	F 65	56		
		in the comprehensive care				
		in accordance with the				
		h in paragraph (c) of this				
	section.	······				
	This REQUIREMENT	Γ is not met as evidenced				
	by:					
		iew and staff interviews, the		Corrective action for resi		
	facility failed to devel			be affected by deficient p		
		plans for 2 of 2 residents		Resident #42⊡s care pla		
		lent #59) reviewed for care		1/12/2022 by the MDS (n		
	plans.			set)nurse(s) to reflect res		
	The first in the local sector	1.		status and assistance ne		
	The findings included	1.		Resident #59⊡s care pla 12/16/21 by the MDS Rn		
	1 Resident #42 was	admitted to the facility on		data set) to address nutri		
		ses that included cognitive		weight loss. Interventions		
		it, muscle weakness and gait		on the care plan to monit		
	abnormalities.	.,		supplements as ordered,		
				needed, and monitor labs		
	A review of Resident	#42's quarterly Minimum		made to the electronic me	•	
	Data Set (MDS) asse	essment dated 08/04/21 was		system to ensure nurses	could see the full	
		tional status section of the		care plan on 1/7/22 by th	e Director of	
		sident required supervision		Quality and Life and Care	Э.	
		ssing, toilet use and personal				
		stance of 1 person. For		Steps facility will take to	•	
		supervision only with meal set		residents having the pote		
		needed limited assistance		affected by the same defi	-	
		bility with the assistance of 1 occurred only 1-2 times with		The facility addressed oth having the potential to be		
	1 person assist on th	-		reviewing all residents	•	
		·		ensure assistance with A		
	A review of Resident	#42's quarterly Minimum		accurate and that nutritio		
		essment dated 10/27/21 was		weight loss were address		
	. ,	ated several areas of decline.		conducted by MDS RN(s		
	The functional status	section of the MDS reported		on 1/12/22. 61 reviews w	-	
		supervision only with eating		Revisions were made to		
		sical assist. She required		plans. All care plans were		
		staff with bed mobility,		ensure they were visible		
	extensive assist with	1 person assist for transfer,		1/7/22 by the corporate n	urse consultant.	

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	S FOR MEDICARE &					NO. 0938-03
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		TE SURVEY MPLETED
		345109	B. WING		1	2/16/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
FRINITY F	PLACE			24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 656	Continued From page	e 25	F 65	6		
	dressing, toilet use a			-		
		#42's care plan initiated on		Measures put into place or s	ystemic	
		cently revised on 10/29/21		changes made to ensure the		
		for "Help with my ADL's."		practice will not recur:		
		ddressed oral hygiene and		Measures were put into place		
	refusal of care for her	ADL'S.		the practice does not recur. T interdisciplinary care plan tea		
	An interview was con	ducted with MDS Nurse #1		inserviced on 1/12/22 by the		
		M regarding the care plan		Clinical Compliance Services		
		decline in the functional		ensuring care plans are deve		
	areas. She stated sh	e did not know what the		implemented that accurately	reflect the	
		esident #42's care plan as		care of the residents. The MI	· · /	
		ew. She stated the ADL		(minimum data set) was inse	-	
	information displayed	In her view.		dietary consultant by 1/11/22 addressing nutritional status		
	A follow-up interview	was done with MDS Nurse		loss as part of the care plan.	-	
		03 PM. She stated the		with changes in condition or		
		to view the ADL functional		are reviewed in the weekly a		
		Resident #42's care plan and		meeting. Licensed nursing st		
		/. The MDS nurse noted that		certified nursing staff were ed		
		had more information than transfers, bathing and		how to view care plans, care changes and update notificat	•	
	mobility in the care pl			reporting of changes in cond		
				Minimum Data Set RN - MDS		
	An interview was don	e on 12/16/21 at 1:05 PM		Staff Development Coordinat	or. This	
		regarding Resident #42's		education was provided on 1	/13/22.	
		care plan. She stated the				
	care plan should be a should be a	all inclusive and everyone		Facility process to monitor p to ensure solutions are susta		
	interventions.			To monitor performance, the		
				Nursing, Staff Development (
				or MDS RN(s) will audit 6 car		
		admitted to the facility on		month to determine if the res	ident⊡s care	
	08/27/2021 with diag			plan is appropriate and viewa		
	dementia, insomnia, a	and a history of falls.		nursing staff. Findings will be the QAPI committee monthly		
	A significant change I	Minimum Data Set (MDS)		months of compliance is sust		
	dated 11/17/2021 inc	luded that Resident # 59 had				
	severe cognitive impa	airment and required		Completion of Plan of Correc	tion Date	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ 345109 B. WING 12/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 TRINITY PLACE ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 26 F 656 supervision of 1 staff with meals. Resident # 59 1/13/2022 weighed 109 pounds and was not on a physician prescribed weight loss regimen. Review of a nutritional progress note dated 11/17/2021 at 12:07 PM included that Resident # 59 had a significant weight loss. She received a regular diet and a nutritional supplement two times a day. Resident # 59 was recorded to consume an average of 49% of meals. On 12/16/2021 the care plans for resident # 59 were reviewed and had been updated on 09/16/2021 and on 11/23/2021. The nutritional status and weight loss of resident # 59 was not included in the comprehensive care plans. MDS # 1 was interviewed on 12/16/2021 at 11:00 AM. MDS nurse #1 reviewed the current care plans for Resident # 59 and stated that she did not see nutritional or weight loss care plans for Resident # 59 and that there should be care plans to address those areas. The facility administrator was interviewed on 12/16/2021 at 1:22 PM and she stated that she expected care plans to be implemented and revised to reflect the status of the resident. F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer F 686 1/13/22 SS=E CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		MEDICAID SERVICES				<u>IO. 0938-03</u>	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			()	TE SURVEY MPLETED	
		345109	B. WING		1	2/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
FRINITY P	LACE			24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE	
F 686	Continued From page	e 27	F 68	6			
	demonstrates that the	ey were unavoidable; and					
	(ii) A resident with pre	essure ulcers receives					
		and services, consistent					
	with professional star						
	new ulcers from deve	vent infection and prevent					
		is not met as evidenced					
		iew and staff and physician		Corrective actions were	taken for resident		
		failed to provide pressure		#61. Resident #61 was s			
	-	of 1 resident (Resident #61)		wound doctor on 12/21/2	-		
	reviewed for pressure	e ulcers.		1/11/22 . New treatment			
				coccyx normal saline, ap			
	The findings included	1:		wound bed, pack with Ac			
	Resident #61 was ad	mitted to the facility on		cover with dry dressing o	Jany.		
		ed to the facility on 11/5/21					
		es that included Dementia,		The facility addressed o	ther residents		
	muscle weakness an			having the potential to be			
				reviewing all medical rec			
		significant change Minimum		having wounds to ensure			
		d 11/12/21 which revealed		orders and care plans fo			
		cognitively impaired with a red pressure ulcer. She		place, and that treatmen completed as ordered. F	-		
		ssistance with bed mobility,		on 1/10/2022 by MDS R	-		
	toileting and eating.			data set RN). 8 treatmer			
	incontinent of bowel a			missing in last 30 days.			
				missing treatments were			
		ed on 11/24/21 indicated		wound care physician or			
		Stage 4 wound to the coccyx		wound physician reasse			
	and the goal was to h	eal without signs or ations or infection in three		healing. No residents su consequences as a resu			
		nterventions was to provide		treatment.	III OI A IIII33EU		
	treatment as ordered	-					
	Resident #61 had a p			Measures were put into			
		nthol zinc oxide to buttocks		the practice does not rec	-		
		ted areas. Review of the ation Records revealed there		inserviced by Staff Deve MDS (minimum data Set			

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		ND HUMAN SERVICES				FO	ED: 01/26/2022 RM APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345109	B. WING			1	2/16/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
	PLACE				1724 SOUTH BUSINESS 52 LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	menthol zinc oxide to " 11/17/21 " 11/20/21 " 11/21/21 " 11/24/21 " 11/27/21 " 11/30/21 " 12/11/21 " 12/12/21 Resident #61 had a p 11/30/21 to clean coor with silver alginate dr secure. Change daily Review of the Noverr Administration Record documentation of treat " 11/13/21 " 11/13/21 " 11/14/21 " 11/20/21 " 11/21/21 " 11/21/21 " 11/21/21 " 11/27/21 Review of the medicat Care Physician meass were as follows: 11/9/21 0.6x0.5x0.6 of width x depth) 11/30/21 0.9x0.9x0.5 Resident #61 had a p to clean right buttock silver alginate dressing change daily to aread damage. Review of the Decem	on of the application of o the buttocks on: obysician order dated ccyx pressure ulcer, pack ressing then cover and y every morning until healed. The Treatment d revealed no atment to the coccyx on: al record revealed Wound surements of coccyx wound centimeters (cm.) (length x cm. (length x width x depth) obysician order dated 12/7/21 with normal saline, apply ng, gauze and secure and of moisture associated skin	F	686	regarding importance of carrying out treatments as ordered. If designated wound nurse or treatment aide is una to complete treatments for any reaso the nursing supervisor will ensure that treatments are completed for that shi The weekend supervisor will ensure to treatments are completed on weeker Daily treatment reports will be review ensure treatments are completed by facility supervisor RN. Residents with wounds will be reviewed in the weekl risk meeting, including confirming that treatments are being done as ordered 4. Facility process to monitor perform to ensure solutions are sustained: To monitor performance, the Director Nursing or Staff Development Coordi will audit treatment records for 5 reside monthly to ensure treatments are bei completed as ordered. Findings will to reported to the QAPI committee mon until 3 months of compliance is sustained	able n, at ft. that ids. ed to y at it d. ance of nator dents ng be thly	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 01/26/2022 DRM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED
		345109	B. WING			12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		SI	REET ADDRESS, CITY, STATE, ZIP CO	DE	
	PLACE			.724 SOUTH BUSINESS 52 LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 686	right buttock areas or " 12/8/21 " 12/11/21 " 12/12/21 Review of the medical Care Physician meas were as follows 12/7/21 1.1 cm x 1.1 or x depth) 12/14/21 0.9 cm x 0.9 x depth) During an interview or Treatment Aide II state through Friday and w treatments. She state the floor to provide pathe the floor nurses were wound care. During an interview or Wound Care Nurse sist through Friday. She provided wound care the weekends and in treatment nurse, the mathematical she with the Wound Care stated she did not rew Administration Record were completed. Record review of the	treatment to the coccyx and a lifecord revealed Wound urements of coccyx wound cm x 0.8 cm (length x width e cm x 0.5 cm (length x width a cm x 0.5 cm (length x width com x 0.5 cm (length x width a cm x 0.5 cm (length x width com x 0.5 cm (lengt	F 686			

Facility ID: 923316

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/26/2022 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	
		345109	B. WING			_	12/	16/2021
NAME OF PI	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
TRINITY P	LACE				24724 SOUTH BUSINESS 5 ALBEMARLE, NC 2800 ⁴			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	11/24/21: no assigned 11/27/21: no assigned 12/8/21: floor nurses' 12/11/21: no assigned 12/12/21: no assigned treatments to her assi Resident #61 in the a or designated treatme completed the assign #61 on dates listed be verbalize why: " 11/13/21 " 11/20/21 " 11/20/21 " 11/21/21 " 11/21/21 " 11/27/21 " 11/27/21 " 11/27/21 " 12/8/21 " 12/8/21 " 12/12/21 During an interview of Nurse #2 indicated in assigned to do all treat nurses went home eat changed. She was re cart and resident assis she had not complete #61 prior to the assign informed the nurses of schedule and that the assigned residents' treat During an interview view	d nurse complete own treatments d nurse d nurse d nurse d nurse ia phone on 12/15/21 at dicated she was aware of dminister the wound igned residents including bsence of Treatment Aide II ent nurse. She had not ed wound care for Resident elow and was unable to n 12/16/21 at 10:33 AM, itially on 11/20/21 she was atments but one of the rly, and the schedule was eassigned to a medication gnment. Nurse #2 indicated of the treatment for Resident ment change and that she of the change in the ry were to complete their	F	686				

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORI	D: 01/26/2022 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345109	B. WING		12	/16/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
TRINITY P	LACE			4724 SOUTH BUSINESS 52 LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 686 F 835 SS=D	should be followed as visits the facility briefly wound healing could it changing the dressing During an interview of Director of Nursing ind aware to complete wo a wound care aide or not aware of any prob wound treatments and Treatment Administra	y for Resident #61 and written. She indicated she y each week. She indicated be impacted by not g daily as ordered. In 12/16/21 at 1:00 PM, the dicated that the nurses were bund care in the absence of nurse. She stated she was lems with completing daily d she does not review	F 686 F 835			1/13/22
22-D	§483.70 Administration A facility must be administration enables it to use its re- efficiently to attain or of practicable physical, re- minis REQUIREMENT by: Based on record revi- interviews the facility oversight to ensure al- of 3 residents, Reside were assessed, invest according to the faciliti Reporting for Senior S Findings included: This tag is cross refer F607- Based on record	aninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. is not met as evidenced ew and staff and family failed to provide effective buse allegations made by 2 ent #113 and Resident #49, tigated, and reported sy's Abuse Investigation and Services Policy.		For Resident #49 The social work completed an interview with reside on 8/24/21 to discuss concerns rea NA (nursing assistant)#3. NA (nursi assistant) #3 was removed from re assignment on 8/24/21. 8 addition interviews were completed with all oriented residents on NA #3 assig by the social worker on 8/24/21, no concerns noted. Nurse #4 and the Charge Nurse we educated on the policy titled, Abus Investigation and Reporting for Se	ent #49 garding sing esidents al ert/ nment, o new ere all se	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345109 B. WING 12/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 TRINITY PLACE ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 835 Continued From page 32 F 835 facility's Abuse Investigation and Reporting for Services by the staff development Senior Services Policy when they failed to coordinator RN on 5/14/21. NA (nursing promptly report allegations of abuse for 2 of 3 assistant) #1 was educated on policy residents, Residents #113, and Resident #49, Investigate and Reporting of Senior reviewed for abuse. Resident #113 reported Services by the staff development allegations of abuse to a staff member who did coordinator RN Written education was not report the allegation to facility management, provided to Nurse Aide # 1 on May which resulted in the accused staff member not 17,2021. NA #1, Nurse #4, and the being removed from the facility and an Charge Nurse all acknowledged investigation being delayed. Resident #49 also understanding and the expectation to reported allegation of abuse to staff, and they follow the LSC policy. failed to report the allegation to the Division of Health Service Regulation and failed to assess Resident #113 was interviewed by the Resident #49 and investigated the allegation. social worker on 5/14/21 and resident #113 was made aware that NA #1 was The Administrator was interviewed on 12/16/2021 removed from assignment on 5/14/21. at 2:21 pm and stated the staff should report any allegation of abuse to their supervisor Nurse aide #1 charge nurse, the director of nursing and the administrator were all immediately and then the supervisor should report the allegation to the Director of Nursing reeducated on the policy titled, Abuse and Administrator. The Administrator stated the Investigation and Reporting for Senior staff are educated on abuse at least once a year Services by the staff development and whenever an incident occurs. coordinator on 12/23/21. Nurse #4 was educated on the Abuse Investigation and Reporting for Senior Services by the staff development coordinator on 12/22/21. Steps facility will take to identify other residents having the potential to be affected by the same deficient practice: Every resident with a BIMS score of 13 or higher was interviewed by the activity director and assistant activity director on 1/11/22, 20 residents were interviewed. the LSC Resident Interview Tool was used. 2 grievances were noted from the interviews. The grievance policy was followed to rectify all concerns.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 01/26/2022 FORM APPROVED OMB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345109	B. WING			12/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY,	STATE, ZIP CODE		
				24724 SOUTH BUSINES	S 52		
				ALBEMARLE, NC 280	001		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)		
F 835	Continued From page	e 33	F 8	35			
				changes made to practice will not re Every employee of 12/30/21 on the p Investigation and Services by the s coordinator, or st coordinator support not In-service prior to Abuse training wi at least annually issues related to practices. Abuse Reporting for Ser provides descript prevention interve investigation and includes complet Allegation Report health human ser Investigation Rep reporting the incide resident (if appro medical record, if members on all s roommates, famili interviewing all circu- leading up to the will be made in w Appropriate autho-	will be in-service by policy titled, Abuse Reporting for Senior staff development ort LPN. Any employee y this date will be their next working shift ill be provided upon hire and upon incidents as abuse prohibition Investigation and hior Services Policy ion of abuse types, entions and identification reporting. This policy ing the DHSR Initial ting Form, DHSR (dept rvice regulation) 5 Day port, Interviewing person dent, interviewing the priate), reviewing the netrviewing staff shifts, interviewing ly members and visitors r residents to who the es care and or services umstances and events incident. Witness report riting, signed and dated orities notified in state and federal laws. r will be informed of	rt. e, on, n s, s, rts	
L				1 0	~		

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/26/2022 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345109	B. WING			12	/16/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				24	724 SOUTH BUSINESS 52		
			1	AI	LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 835	Continued From page	e 34	F	835	administrator or designee will keep the resident and his/her representative informed of the progress in the investigation. Any accused individual employed by the facility will be suspe- pending the investigation. While the investigation is taking place individual employed by the facility will be denied unsupervised access to the resident. situation resident to resident abuse, residents will be supervised by staff u appropriate action can be taken to en- the safety of other residents. Emotion support will be provided as needed. Reporting, all alleged violations invol- abuse, neglect , exploitation or mistreatment including injuries' of unknown origin and misappropriation resident property are reported immediately but no later than two hou after the allegation is made to the hea- care personnel registry and to the law enforcement agency, if the events that cause the allegation involve abuse or result in serious bodily injury , or no la than 24 hours if the event that cause allegation does not involve abuse or serious body injury, to the state agen accordance with the state law. The administrator or designee is responsible for completion of the Initi Allegation Report to the Health care personnel registry section of DHSR w 2 Hours after the allegation is made i events that caused the allegation invol- abuse or result in serious bodily injury.	s, nded ls not ls not ln until sure al ving of urs alth v at eter the cy in al vithin f the plve v.	

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STATEMENT OF DEFICIENCIES AND PLANE OF CORRECTION (N) PROVIDENSIGNATION DESTINCTION NUMBER: (P2) NULTIFIE CONSTRUCTION A BULDING (P2) DATE SUPPLY COMPLETED 345109 34100 12/16/2021 NAME OF PROVIDER OR SUPPLIER TRINITY PLACE STREET ADDRESS, CITY, STATE 2/P CODE 34724 SOUTH BUSINESS 52 ALZEMARLE, KC 20001 12/16/2021 MARE OF PROVIDER OR SUPPLIER CADIO EFORGATION WIGHT OF ERCICIDANCE REGULATORY OR SIZE DENTERVISION OF DETICIDANCE REGULATORY OR SIZE DENTERVISION FOR THE OFFICATION SINGUA BE CADIO EFORGATION WIGHT OF RECORDED BY FULL REGULATORY OR SIZE DENTERVISION FORMATION) 0 PROVIDER OWN OF THE APPROPRIATE CADIO EFORGATION WIGHT OF RECORDED BY CADIO EFORGATION WIGHT OF RECORDED BY TAG PROVIDER TRUM OF DETICIDANCE REGULATORY OR SIZE DENTERVISION FORMATION) 0 PROVIDER OWN OF THE APPROPRIATE CADIO EFORGATION WIGHT OF RECORDED BY CADIO EFORGATION WIGHT OF RECORDED BY TAG PROVIDER OWN OF THE APPROPRIATE CADIO EFORGATION WIGHT OF RECORDED BY TAG PROVIDER OWN OF THE APPROPRIATE CADIO EFORGATION OF THE APPROPRIATE DEPUTIENCY OVER THE PROVIDER OWN OF THE APPROPRIATE CADIO EFORGATION OF THE APPROPRIATE CADIO EFORGATION OF THE APPROPRIATE CADIO EFORGATION OF THE APPROPRIATE THE TAGE THE APPROPRIATE CADIO EFORGATION OF THE APPROPRIATE CADIO E			ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/26/2022 MAPPROVED D: 0938-0391	
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MALE OF PROVIDER OR SUPPLIER Interce Address Sa TRINITY PLACE 2172 SOUTH BUSINESS Sa (A) ID PRETIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUATION OR LSC DENTIFYING INFORMATION) ID PRETIX REQUATION OR LSC DENTIFYING INFORMATION) IP PRETIX TAG PROVIDENTS ANO CORRECTION (EACH DEFICIENCY ADDRESS CALL 0.09 (EACH DEFICIENCY ADDRESS CALL			345109	B. WING _			12/	16/2021	
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CALEBRARIE, NC 28001 Construction Construction <thconstructin< th=""> Construction Constru</thconstructin<>					24	724 SOUTH BUSINESS 52			
Prefix TAG IEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PRECENT TAG IEACH CORRECTIVE ACTION SHOULD BE CONSIMILATION (INFORMATION) CONSIMILATION (INFORMATION) PRECENT TAG CONSIMILATION (INFORMATION)					AL	BEMARLE, NC 28001			
responsible for completion of the Investigation 5 Day report to NC DHSR. A written report of the findings will be included with the DHSR 5 day Investigation report to the NC DHSR and to any other licensing authorities. All abuse investigations conducted by the facility will be reviewed by the corporate nurse consultant to ensure the LSC policy was followed and no further actions need to be taken. The nurse consultant will receive all reported allegations within 2 hours of the allegations within 2 hours of the allegation being made. Date of completion rolder to follow when an allegation or concern is reported by any staff member, resident or any person. This folder includes phone numbers of administration, local law enforcement and Dept of social service, initial Health care personell registry reporting forms, resident / staff interview forms and a copy of the LSC Abuse Investigation of and Reporting of Senior Services Policy. All nurses have been made aware to contify administrator or director of nursing immediately to any concerns or allegation of abuse. All licensed nurses have also been made aware to complete the initial reporting form within two hours of any allegation of abuse or bodily harm and to notify outside law enforcement. All staff have been educated to notify and insignation abuse.	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR					(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	ЗE	COMPLETION	
······································	F 835	Continued From page	≥ 35	F 8	335	Investigation 5 Day report to NC DHS written report of the findings will be included with the DHSR 5 day Investigation report to the NC DHSR a to any other licensing authorities. All abuse investigations conducted by facility will be reviewed by the corpora nurse consultant to ensure the LSC p was followed and no further actions n to be taken. The nurse consultant will receive all reported allegations within hours of the allegation being made. D of completion 1/13/22 All skilled nursing stations have receive an abuse instruction education folder follow when an allegation or concern reported by any staff member, resider any person. This folder includes phon numbers of administration, local law enforcement and Dept of social servic initial Health care personnel registry reporting forms, resident / staff intervi forms and a copy of the LSC Abuse Investigation and Reporting for Senior Services Policy. All nurses have been made aware to notify administrator or director of nurisng immediately to any concerns or allegation of abuse. All licensed nurses have also been made aware to complete the initial reporting form within two hours of any allegation abuse or bodily harm and to notify out law enforcement. All staff have been educated to notify their supervisor	and the te blicy eed 2 ate red to s ate e, e, e, ew		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/26/2022 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345109	B. WING _			12/1	6/2021
NAME OF PI	ROVIDER OR SUPPLIER	1		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				24724	4 SOUTH BUSINESS 52		
				ALB	EMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 835	Continued From page	9 36	F8	335			
				e aairi bb A e n c wa T c wft E e d rr II S wn is F e T ii C d is s ru	A total of 6 residents will be interviewe every week for four weeks to ensure the re no concerns that have not been investigated. Interviews will be conduct by the activity director or social worker After four weeks, 6 interviews will occu- each month for three months until three nonths of compliance is sustained. An concerns found during these interview will immediately be reported to the administrator and investigated. The director of nursing, staff developm coordinator, or minimum data set nurse will interview 10 employees each wee our weeks using the form titled, Employee Interviews: Abuse Policy, to ensure all employees can verbally demonstrate understanding of the equirements in the policy titled, Abus investigation and Reporting for Senior Services. After four weeks, 10 employ will be interviewed each month for three nonths until three months of compliant is sustained. Facility process to monitor performance ensure solutions are sustained: The results of the resident / staff audit interviews will be reported at the mont QAPI meetings by the social worker o lirector of nursing until the audit schere is completed and compliance as is sustained for three months for both esident and staff interviews regarding abuse notification. All audits complete	here ted r. ur ee iv iv s hent ee(s) k for o e ee ee ce be ce to s hly r dule	
	7(02.00) Providuo Versione Obe			tł	he corporate nursing consultant with		

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILE				COMPLETED	
345109			B. WING	12	12/16/2021		
NAME OF P	ROVIDER OR SUPPLIER		5				
	PLACE						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
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