PRINTED: 06/08/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
345		345554	B. WING			C 05/09/2023	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COL	<u>I</u> DE	03/	09/2023
TRINITY G	ROVE			631 JUNCTION CREEK DRIVE			
IRINIT GROVE				WILMINGTON, NC 28412			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	FC	000			
	from 05/08/23 throug IKCH11. Intake # NC	ation survey was conducted h 05/09/23. Event ID# 00201714 was investigated.					
	deficiency.	allegation did not result in					
F 607 SS=E	Develop/Implement A CFR(s): 483.12(b)(1)	Abuse/Neglect Policies -(5)(ii)(iii)	F 6	007			5/15/23
	§483.12(b) The facilit implement written po	ty must develop and licies and procedures that:					
	§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,						
	§483.12(b)(4) Establi QAPI program require	sh coordination with the ed under §483.75.					
	facilities in accordance Act. The policies and	e reporting of crimes -funded long-term care be with section 1150B of the d procedures must include the following elements.					
		sting a conspicuous notice of defined at section 1150B(d)					
		phibiting and preventing I at section 1150B(d)(1) and					
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	 RE	TITLE			(X6) DATE

Electronically Signed 05/19/2023

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.

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		345554	B. WING		C <b>05/09/2023</b>		
NAME OF PROVIDER OR SUPPLIER  TRINITY GROVE				STREET ADDRESS, CITY, STATE, ZIP CODE 631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412	<b>.</b>	00/03/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 607	Continued From page 1 (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their abuse policy for reporting and investigating abuse when Nurse Aide #1 failed to report allegations of staff (Nurse Aide #2) to resident abuse to facility management as soon as she observed or suspected incidents of resident abuse so that an investigation could have been conducted. This failure had the potential to affect residents in the facility.  Findings included.  The facility's policy titled "Abuse Investigation and Reporting for Senior Services" revised 09/19/22 revealed in part, it was the responsibility of all facility personnel to promptly report any incident or suspected incident of resident abuse or neglect to facility management. These reports may be made without fear of retaliation from this facility or staff. The person observing or suspecting incidents of resident abuse, neglect, or exploitation must report such knowledge or suspicion to the nursing supervisor or the department manager as soon as he or she is aware of an incident or potential incident. The Administrator or designee is responsible for ensuring a thorough investigation of the allegations is conducted.  During a phone interview on 05/08/23 at 6:00 PM		F 60	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	with Nurse Aide #1 s nurse aide and start approximately 2 mo stated during the 2 r facility she primarily	rview on 05/08/23 at 6:00 PM she stated she was a new ed working at this facility on this ago in March 2023. She months she worked at the worked the 3:00 PM to 11:00 ed memory care unit along					

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TRINITY GROVE    DAY   TO   PREFIX   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   PREFX   PREF	345554		345554	B. WING			05/	09/2023
TRINITY GROVE    MAINTY STATEMENT OF DEFICIENCIES   PROVIDER'S PROVIDER'S LANGE CORRECTION   CROSS-REFERENCED TO THE APPROPRIATE	NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
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PRINTED: 06/08/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345554		B. WING			C <b>05/09/2023</b>		
NAME OF PROVIDER OR SUPPLIER  TRINITY GROVE				STREET ADDRESS, CITY, STATE, ZIP CODE 631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412		03/09/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 607	anything about it. She made that assumption received abuse training recognizing signs of a reporting the suspicion supervisor. She state the nurse on the unit, the Administrator of the solution that an investigation have been done but as that an investigation have been done but as During an interview of Administrator along with (DON) each stated Normal reported any suspicion by Nurse Aide #2 or at them. The DON state training upon hire and identifying, and report abuse and indicated a that reports of abuse of retaliation. The DO confirmed that Nurse reported for allegation they were not made as abuse by Nurse Aide Aide #1 should have the suspected abuse	management just didn't do e stated she should not have in. She stated she had ing upon hire that included abuse, types of abuse, and in of abuse immediately to a dishe should have notified the Director of Nursing, or nese allegations right away on by management could stated she did not do that.  In 05/09/23 at 9:00 AM the with the Director of Nursing urse Aide #1 had not in of staff to resident abuse any staff member to either of diall staff received abuse if at least annually regarding ting actual or suspected staff were also made aware may be made without fear in and Administrator both Aide #2 had never been in so fresident abuse and aware of any suspected #2. They each stated Nurse reported to either of them allegations involving Nurse so that an investigation	F6				