STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	C 07/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/10/23 through 07/13/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # BQ8K11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/10/23 through 07/13/23. Event ID# BQ8K11. The following intakes were investigated: NC00203564, NC00196321, and NC00196320. 9 of the 9 complaint allegations did not result in deficiency. 8/1/23 After IDR request and administrative review, example 1 for f812 is deleted	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		8/15/23

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

Electronically Signed | 08/01/2023

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to maintain dignity for a resident (Resident #76) with an uncovered urinary drainage bag, with urine visible for public view from the hallway. The reasonable person concept was applied as individuals have the expectation of being treated with dignity and would not want their urine visible to visitors, staff, and other residents, for 1 of 1 resident reviewed for dignity. The findings included: Resident #76 was admitted to the facility on	F 550	F550 Resident Rights/Exercise of Rights 7/12/23 Urinary drainage bag for resident #76 was placed in a drainage bag cover. 7/12/23 Neighborhood Coordinators audited all residents with urinary drainage bags to assure compliance. 7/12/23 Staff Development Coordinator began re-education for all nursing staff regarding Residents Rights for covering urinary drainage bags to ensure the liquid contained in the bag is hidden, and the	

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F 550	Continued From page 2 08/17/2022. Diagnoses included urinary tract infection (UTI), dementia, and urinary retention. The quarterly Minimum Data Set assessment for Resident #76 revealed he was severely cognitively impaired. He was coded as having an indwelling urinary catheter. Resident #76's Care Plan last reviewed on 05/01/2023 revealed a plan of care for indwelling catheter with an intervention to position the catheter bag and tubing below the level of the bladder and away from entrance room door. An observation of Resident #76 occurred on 07/10/2023 at 11:48 A.M. Resident #76 was lying in bed and his urinary drainage bag was visible from the hallway with dark amber urine noted. Another observation of Resident #76 occurred on 07/12/2023 at 10:38 A.M. Resident #76 was lying in bed and his urinary drainage bag was visible from the hallway with dark amber urine noted. An interview with Nurse Aide (NA) #3, who was assigned to Resident #76's hall, was completed on 07/12/2023 at 10:41 A.M. NA #3 stated that Resident #76 should have a cover on his urinary drainage bag. She further stated that she would get a cover for the urinary drainage bag. An interview with Nurse #3 was completed on 07/12/2023. Nurse #3 stated that urinary drainage bags should have a privacy cover on them. She further stated that she did not know why Resident #76's urinary drainage bag did not have a cover. An interview was completed with the Director of Nursing (DON) on 07/13/2023 at 10:16 A.M. The	F 550	rationale for such. This includes education that the privacy covers must be used without regard to whether or not the resident exits the room. No nursing staff will work beyond 8/15/23 until re-educated on these policies. The Neighborhood Coordinators will maintain a current list of all residents with urinary drainage devices. Facility will send a drop-in privacy cover with residents leaving facility to attend urology appointments, where the device would possibly be replaced. For new admissions arriving with an indwelling urinary catheter, the drainage bag will be replaced with a bag with a privacy screen upon arrival. Any new urinary collection devices placed will be inspected within 24 hours to ensure the privacy bag is intact. Director of Nursing, Neighborhood Coordinator, or designee will audit all urinary drainage bags for a covering once weekly until QAPI meeting on 10/19/23. Any non-compliance will be corrected immediately, and appropriate education/disciplinary action provided. Director of Nursing will report audit findings to 10/19/23 QAPI.	

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F 550	Continued From page 3 DON stated that she thought the breakdown in the process was a lack of education. She further stated that staff didn't know a resident that doesn't leave their room should have a privacy cover on their urinary drainage bag if it can be seen from the hallway.	F 550		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff and Director of Nursing interviews, and record review, the facility	F 761	F761 Label/Store Drugs and Biologicals	8/15/23

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F 761	Continued From page 4 failed to: store an opened bottle of lorazepam in the locked drawer of the medication cart, label a bottle of ophthalmic solution and a bottle of eye drops with an opened date and discard 2 bottles of eye drops that had exceeded the manufacturer's recommendation for usage for 1 of 2 medication carts observed for medication storage. Findings included: Observation of the Airlie by the Sea medication cart on 7/11/23 at 4:10 PM with Nurse #2 in attendance revealed: An opened bottle of lorazepam 2 milligrams per milliliter with liquid observed in the vial in the top unlocked drawer of the medication cart. Resident #34's bottle of Ketorolac 0.5% ophthalmic solution with no opened date observed on the bottle. Medication was delivered on 4/24/23. Resident #39's bottle of Brimonidine eye drops with an opened date of 5/10/23. The manufacturer recommendation for Brimonidine eye drops indicated discard 4 weeks after opening. Resident #47's bottle of Brimonidine eye drops with an opened date of 3/24/23. Resident #47's bottle of Lumigan 0.01% eye drops with no opened date. An interview was conducted on 7/11/23 at 4:15 PM with Nurse #2 who was assigned to the Airlie by the Sea medication cart. Nurse # 2 revealed she administered a dose of lorazepam out of the bottle from the emergency kit earlier that day but there was not another nurse available to witness wasting the remainder of the medication in the	F 761	7/11/23 Lorazepam was properly wasted by Neighborhood Coordinator and another licensed nurse according to facility policy. 7/11/23 Audit performed by Neighborhood Coordinator to ensure all narcotic medications were being stored according to facility policy, Controlled Medication Storage and Disposal. This was accomplished by auditing Emergency Kit (E-Kit) sign out sheet. All narcotics in E-Kit were accounted for and secured by two locking devices. 7/11/23 Staff Development Coordinator began education for all nurses regarding the facility policy Controlled Medication Administration and Controlled Medication Storage and Disposal. No nurse will work beyond 8/15/23 until re-educated on this policy. Director of Nursing, Assistant Director of Nursing, Neighborhood Coordinator, or designee will audit E-Kit disposal of narcotic medications to verify proper wasting procedures are being followed. Audits will be conducted 1 time per week for 4 weeks, then every 2 weeks for 4 weeks, then 1 time per month until 10/19/23 QAPI meeting. Any issues noted will be corrected immediately with appropriate re-education/disciplinary action provided. Director of Nursing will report audit findings at 10/19/23 QAPI meeting. 7/11/23 Opened eye drops with open date	

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F 761	Continued From page 5 vial. Nurse #2 did not know why she had not placed the opened bottle of lorazepam in the locked drawer in the medication cart. Nurse #2 further revealed the eye drops should have been labeled with the date they were first used. Interview on 7/13/23 at 10:58 AM with the Director of Nursing (DON) indicated that there was a breakdown in the process for labeling medications with opened dates. The DON indicated the breakdown occurred due to further education required. DON indicated she expected that medications would be discarded if past the recommended usage date and that medications would be labeled when opened.	F 761	of greater than 4 weeks prior and undated eye drops were discarded by the Neighborhood Coordinator. 7/11/23 All medication carts were audited by Neighborhood Coordinators for undated or opened eye drops with open date of greater than 4 weeks prior. Any found was discarded. 7/11/23 Staff Development Coordinator began education for all nurses on Eye Medication Administration policy and procedure. No nurse will work beyond 8/15/23 until re-educated regarding this policy. Neighborhood Coordinator or designee will audit medication carts 1 times per week until 10/19/23 QAPI meeting. Any non-compliance will be corrected immediately, and appropriate education/disciplinary action provided. Neighborhood Coordinators will report their findings on 10/19/23 at QAPI meeting.	
F 811 SS=D	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent	F 811		8/15/23

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F 811	Continued From page 6 with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to adhere to the list of residents who met the criteria to have paid feeding assistants assist them with eating. Paid Feeding Assistant #1 was observed feeding Resident #68. Resident #68 was assessed to have difficulty swallowing and on a pureed diet and was not to be fed by a paid feeding assistant. The deficient practice occurred for 1 of 1 paid feeding assistant. Findings included: Resident #68 was admitted to the facility on 11-27-2020. Diagnoses included dementia and dysphagia (difficulty swallowing).	F 811	F811 Feeding Assistant/Training/Supervision/Resident 7/10/23 Paid feeding assistant was immediately instructed to stop feeding resident #68 7/10/23 Paid feeding assistant was re-educated on who she was able to assist with feeding according to updated list of residents she had been provided. 7/10/23 Education began for paid feeding assistant and nurses on Bluewater Neighborhood regarding list of approved residents the paid feeding assistant could	

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F 811	Continued From page 7 The physician's orders for Resident #68 revealed an order for a regular diet, pureed texture, regular/thin consistency dated 12/28/2022. The quarterly Minimum Data Set assessment dated 04/18/2023 revealed Resident #68 was severely cognitively impaired and required extensive assistance of one staff member for eating. Resident #68's plan of care to maintain adequate nutritional status listed the following interventions: monitor/document/report any signs and symptoms of difficulty swallowing such as pocketing, choking, coughing, drooling, and holding food in her mouth. Review of the Diet Order Tally Report list of residents on a regular textured diet provided by the facility dated 5/30/2023 revealed Resident #68 was not listed as a resident paid feeding assistants could assist with eating. An observation of Paid Feeding Assistant #1 feeding Resident #68 a pureed diet occurred on 07/10/2023 at 12:15 P.M. An interview with the Paid Feeding Assistant was completed on 07/10/2023 at 12:18 P.M. The Paid Feeding Assistant stated that she always fed Resident #68 lunch because it took her so long to eat. An interview with Assistant Director of Nursing (ADON) was completed on 07/10/2023 at 3:39 P.M, The ADON stated that paid feeding assistants were allowed to feed residents that are on a regular textured diet. She further stated that	F 811	assist with feeding. Neighborhood Coordinator or designee will audit 1 times per week for 3 weeks to assure paid feeding assistant is feeding residents on her list. 7/28/23 the paid feeding assistant position has been eliminated with no plans to reinstate position.Neighborhood Coordinator will report audit findings at 10/19/23 QAPI.	

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F 811	Continued From page 8 Resident #68 was not on the list of residents the paid feeding assistants could assist with eating, because she was on a pureed textured diet. An interview was completed with Speech Language Pathologist (SLP) #1 on 07/12/2023 at 10:19 A.M. SLP #1 stated that Resident #68 was receiving SLP services for difficulty with eating and swallowing. She stated that Resident #68 had difficulty with the oral phase, and that she would pocket her food, cough, and take a very long time to eat. SLP #1 stated that because it took her so long to eat, she would become fatigued before she finished her meals. She further stated that Resident #68 required physical assistance and cueing while eating. An interview with SLP #2 was completed on 07/12/2023 at 10:53 A.M. SLP #2 stated that the final recommendation from her for Resident #68's diet was a pureed diet with thin liquids. She further stated that Resident #68 should be watched closely while eating for pocketing and to make sure she swallows the food. An interview was conducted with the Director of Nursing (DON) on 07/13/2023 at 09:42 A.M. The DON stated that the breakdown in the process was that the list of residents on a regular textured diet was not posted in a visible place in the nurses' station and the nurses did not know who the paid feeding assistant was allowed to feed and not allowed to feed. She further stated that the paid feeding assistants had been given the list of residents they could feed after they finished the training.	F 811		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		8/15/23

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F 812	Continued From page 9 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to: keep an oscillating fan clean which was blowing onto the food preparation area of the kitchen. The findings included: During a follow-up observation of the main kitchen area on 07/11/23 at 4:12 PM an oscillating fan was blowing into the kitchen. The fan was located about six feet in front of the kitchen's main food preparation table unit. The face, blades, and back of the oscillating fan was coated with a thick layer of dirt and long strands of dust. At this time the kitchen aide #1 stated she knew she should not have aimed the fan toward the preparation table where she was working, but she	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 7/11/23 Fans immediately removed from the food prep/cook area by the Food Service Director 7/11/23 No other food prep/cook area to audit. 7/14/23 Food Service Director began education for all dietary staff regarding fan cleanliness in the kitchen. No staff will work beyond 7/17/23 until they are re-educated regarding this policy. Food Service Director, Assistant Food	

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F 812	Continued From page 10 was hot. The DM reported it was important to keep all kitchen fans clean so they would not blow dust and dirt into food and onto food preparation surfaces, causing cross-contamination. DM stated she thought the oscillating fan was used mainly in the dish machine area because during the summer it got so hot in that area of the kitchen. During an interview with the Administrator and DM on 07/13/23 at 4:30 PM, they both reported it was their expectation the facility's kitchens follow all regulatory guidelines for food and kitchen sanitation safety.	F 812	Service Director, or designee will audit the cleanliness of fans in the kitchen 5 times per week for 1 week, then 2 times per week for 1 week, then weekly until 10/19/23 QAPI. Any issues noted will be corrected immediately with appropriate re-education/disciplinary action provided. Food Service Director will report the findings of audit at the 10/19/23 QAPI meeting.	