STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345106	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Ridge	2140 Medical Park Drive Hickory, NC 28602

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on record review and staff interviews, the facility failed to accurately code a Medicare 5-day Minimum Data Set assessment for the use of antipsychotics for 1 of 5 residents reviewed for unnecessary medications (Resident #87). The findings included: Resident #87 was initially admitted to the facility on [DATE] with diagnoses that included dementia with behaviors and cognitive communication deficit. Resident #87 subsequently readmitted to the facility on [DATE] after a brief hospitalization . Review of Resident #87's Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE] revealed he was not receiving antipsychotic medications. Review of Resident #87's physician orders revealed an order dated 03/07/25 for Seroquel Oral tablet (antipsychotic medication) 25 milligrams (mg). The order was for Resident #87 to take 1/2 of a tablet, one time a day for mood disorder. Review of Resident #87's medication administration record revealed he received Seroquel 25mg starting on 03/07/25. During an interview with MDS Nurse #1 on 03/27/25 at 11:09 AM, she reported when she completed Minimum Data Set assessments, she reviewed residents' medication administration records and physician orders. She stated she was aware that Resident #87 was taking Seroquel at the time she completed the Minimum Data Set assessment and must have miscoded it in error. An interview with the Director of Nursing, on 03/27/25 at 11:22 AM, revealed Resident #87 had discharged from the facility and when he returned, he came back with a new physician order for Seroquel. She reported MDS nurses typically reviewed all of a resident's medications when they complete the Minimum Data Set assessments. She indicated that Resident #87's Minimum Data Set assessment dated [DATE] should have accurately represented his current use of an antipsychotic medication. During an interview with the Administrator on 03/27/25 at 12:03 PM, she indicated she expected resident Minimum Data Set assessments to accurately reflect the individual resident and their care needs and that included the medications that particular resident was currently taking.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on observations, record reviews, manufacturer's instructions, and staff and Consultant Pharmacist interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 28 opportunities, resulting in a medication error rate of 7.14% for 1 of 5 residents observed during the medication administration (Residents #25). The findings included: The manufacturer's instructions for prefilled Lantus insulin pen indicated that priming the insulin pen each time was an important step to ensure there were no air bubbles in the insulin and the full dose of insulin was given. Priming the insulin pen: 1. Dial up 2 units: turn the dose selector dial to 2 units, 2. Prime the pen: Press the injection button to let out any air bubbles and ensure the insulin is flowing correctly, 3. Check for a drop of insulin: you should see a drop of insulin on the tip of the needle, 4. Repeat if necessary. Resident #28 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus. Review of Resident #28's physician orders revealed an order dated 06/24/25 for Lantus insulin Pen injector, inject 85 units subcutaneously one time a day for diabetes mellitus. On 03/26/25 at 9:08 AM an observation was made of Nurse #1 as she removed a Lantus prefilled insulin pen from the medication cart, placed a needle on the pen and turned the dose selector to 30 units in preparation for the injection. The Nurse removed another needle from the medication cart and explained that she would need to inject Resident #28 twice because her total dose of insulin was 85 units and that was too much to inject all 85 units at one time. The Surveyor accompanied Nurse #1 to Resident #28's room where the Nurse injected the Resident with the Lantus insulin without priming the insulin pen per the manufacturer's instructions. Nurse #1 then removed the needle from the prefilled insulin pen and applied the other needle then turned the dose selector to 55 units and proceeded to inject Resident #28 with the second dose of insulin again without priming the insulin pen. An interview was conducted with the Consultant Pharmacist on 03/27/25 at 12:08 PM. The Pharmacist explained that it was important to prime the insulin pen before every injection so that air bubbles were removed to ensure the total amount of insulin was delivered. The Pharmacist indicated that air bubbles can take up space that could prevent the correct dosage of insulin from being administered. Multiple attempts were made to interview Nurse #1, but the attempts were unsuccessful. Interviews were conducted with the Director of Nursing (DON) and the Administrator on 03/27/25 at 12:50 PM. The DON explained that Nurse #1 had attended the skills training which included how to utilize insulin pens therefore she could not address why Nurse #1 did not prime the insulin pen each time she gave the injection. The DON stated it was important that insulin pens be primed before injecting to remove the air bubbles and ensure all the ordered insulin dose was given to the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37280 Based on observations, record reviews and staff interviews, the facility failed to follow their Hand Hygiene policy and procedure when the Director of Nursing did not perform hand hygiene after removing gloves and donning a clean pair of gloves while providing wound care to Resident #71 and Nurse #2 did not perform hand hygiene after removing gloves and donning a clean pair of gloves while providing wound care to Resident #62 for 2 of 3 staff members observed for infection control practices (Director of Nursing and Nurse #2). The findings included: A review of the facility's Hand Hygiene policy and procedure last revised 10/12/23 revealed in part: Hand Hygiene: Policy: Practicing hand hygiene is a simple yet effective way to prevent infections. Performing hand hygiene can prevent the spread of germs, including those that are resistant to antibiotics. All teammates are trained and regularly inserviced on the importance of hand hygiene in preventing the transmission of infections. Teammates are expected to follow hand hygiene procedures to help prevent the spread of infections to other staff members, residents, and visitors. Note: Hand Hygiene means cleaning hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e., alcohol-based hand sanitizer including foaming or gel), or surgical hand antisepsis. Procedures: 4. Before donning gloves and after removing gloves. 1. On 03/25/25 at 11:25 AM an observation was made of the Director of Nursing (DON) providing wound care to Resident #71 who had a stage 3 pressure ulcer on his coccyx. The Resident was positioned on his right side in preparation for the treatment and the previous wound dressing had been removed. The DON washed her hands and donned clean gloves and gown. The DON cleansed the pressure ulcer with wound cleanser-soaked gauze from the inside of the wound outward, then doffed her gloves and without sanitizing her hands donned a clean pair of gloves. The DON then applied and sealed the ordered dressing with an island dressing and doffed her gloves and gown, washed her hands with soap and water, gathered her supplies and trash and left the room. Interviews were conducted with the Director of Nursing (DON) and the Administrator simultaneously on 03/27/25 at 1:42 PM. The DON explained she did not realize that she did not sanitize her hands between glove changes and stated she should have sanitized her hands after doffing her gloves and prior to donning clean gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 03/26/25 at 11:40 AM an observation was made of Nurse #2 providing wound care to Resident #62 with the Director of Nursing (DON) assisting. Resident #62 had a stage 4 pressure ulcer on her right foot. Nurse #2 sanitized her hands and donned a clean gown and gloves and removed the dressing from the right foot ulcer and threw the old dressing in the trash can. Nurse #2 then proceeded to doff her gloves and without sanitizing her hands donned clean gloves and cleansed the pressure ulcer with wound cleanser-soaked gauze from the inside outward and applied the ordered dressing followed by an island dressing. Nurse #2 then covered the right foot with an ABD pad and wrapped it with gauze. Nurse #2 then doffed her gloves and washed her hands before donning clean gloves. The Director of Nursing removed the dressing from Resident #62's (2) stage 3 sacral pressure ulcers then doffed her gloves and washed her hands with soap and water after the end of the treatment. Nurse #2 cleansed the pressure ulcers with wound cleanser-soaked gauze from the inside outward and then doffed her gloves and without sanitizing her hands, donned clean gloves. Nurse #2 then applied the ordered dressing and an island dressing then doffed her gown and gloves and washed her hands with soap and water, gathered her supplies and trash and left the room. Multiple attempts were made to interview Nurse #2 but the attempts were not successful. Interviews were conducted with the Director of Nursing (DON) and the Administrator simultaneously on 03/27/25 at 1:42 PM. The DON explained she did not realize that Nurse #2 did not sanitize her hands between glove changes and stated she should have sanitized her hands after doffing her gloves and prior to donning clean gloves.