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	06/18/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff and resident interviews, the facility failed to keep a urinary catheter collection bag from lying on the floor for 1 of 1 resident reviewed for indwelling urinary catheters (Resident #5). The findings included:Resident #5 was admitted to the facility on [DATE] with diagnoses that included overactive bladder, hydronephrosis (the swelling of one or both kidneys caused by a buildup of urine), and bladder-neck (the base of the bladder) obstruction.Resident #5's physician orders revealed a physician order dated 03/26/26 for a urethral catheter, due to urinary retention related to hydronephrosis, ensure tubing is patent and catheter is in a privacy bag. Resident #5's annual Minimum Data Set assessment dated [DATE] revealed Resident #5 to be cognitively intact. Resident #5 was coded as having an indwelling catheter.Review of Resident #5's care plan last reviewed on 04/21/26 revealed a care plan for an indwelling urinary catheter for hydronephrosis. Interventions included to position catheter bag and tubing below the level of the bladderAn observation of Resident #5 completed on 06/17/26 at 11:24 AM revealed her to be in her room, in bed visiting with two outside visitors. An observation was made at this time of Resident #5's urinary catheter collection bag, the bag was lying flat on the floor beside her bed and approximately 1 1/2 feet from one of the standing visitor's feet. Observation of the catheter bag that was on the floor revealed it did have an undetermined amount of urine in the bag. An interview with Resident #5 on 06/17/26 at 11:25 AM revealed she had gotten up earlier in the day and went to the communal dining room for breakfast but requested to return to her bed after breakfast. She reported a nurse aide (whom she could not recall) assisted her to bed after breakfast. Resident #5 reported she could not transfer without assistance and had not touched her catheter bag while getting back into bed.An interview with Nurse Aide (NA) #1 who was assigned to Resident #5's hall on 06/17/26 at 11:28 AM revealed he was working on Resident #5's hall but that he did not assist Resident #5 back to bed after breakfast and stated it must have been NA #2 who was also working on Resident #5's hall.An interview with NA #2 on 06/17/26 at 11:32 AM revealed she was working on Resident #5's hall and verified that Resident #5 did get up earlier in the day but had requested to return to bed. She also verified that she assisted Resident #5 back to bed. NA #2 stated for residents who have catheters, when they were transferred back to bed, she would hang the catheter bag from the bed frame to ensure that it remained off the floor. An observation of Resident #5's catheter bag with NA #2 on 06/17/26 at 11:34 AM revealed the catheter bag to remain on the floor by Resident #5's bed. A continued interview with NA #2 revealed she must have forgotten to get Resident #5's catheter bag hung on the bed frame when she assisted Resident #5 back to bed after breakfast.An interview with the Director of Nursing on 06/17/26 at 11:47 AM revealed the facility's policy was to ensure that catheter bags and tubing remained off the floor. She also reported that when Resident #5 was assisted back to bed, the catheter bag should have been hung from her bed frame to ensure it did not touch or lie on the floor.An interview with the Administrator on 06/17/26 at 11:53 AM revealed she expected catheter bags to be kept off the floor. She reported that when a resident was in bed, the catheter bag should be hung from the bed frame.

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