STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345109	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Place	24724 South Business 52 Albemarle, NC 28001

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews with staff and a resident, the facility failed to provide a safe transfer. The resident was transferred manually by stand pivot (A technique for moving where a resident stands with assistance and pivots on their feet then sits. This technique requires the ability to bear most of their body weight.) and supported under her arm pits by Nursing Assistant (NA) #1. During transfer the resident's right knee had a popping sound and the resident reported immediate pain. The resident was transferred to the hospital for an evaluation and x-ray determined the resident had a non-displaced fracture (the bone fractured but did not move out of place) of the proximal tibia-fibula (fracture of the shin and calf bone just below the knee). The resident had a knee immobilizer placed. This deficient practice affected 1 of 4 residents reviewed for accidents (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] with the diagnosis of stroke.The care plan dated 7/24/25 for Resident #1 documented she had an activity of daily living deficit. Transfers were total lift (mechanical lift). The quarterly Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a severely impaired cognition. Her functional limitations were impaired upper body on one side and lower body no impairment. The resident required maximal assistance to roll and up to sit in her bed and lying to sitting and sitting to stand was not applicable. The resident was dependent during transfer. The resident had no pain and was not receiving therapy. On 9/10/25 at 1:40 pm NA #1 was interviewed. NA #1 stated she was assigned to Resident #1 on 9/2/15 evening shift. The resident required mechanical lift for transfer. NA# 1 requested NA #2 assist with the transfer of the resident using mechanical lift. The resident was sitting in a reclining wheelchair, and the sling was out of place. The NA moved the sling underneath the resident. When the resident was lifted, she was slipping out of the sling. The resident was then manually transferred, both NAs lifted and transferred the resident from her chair. NA #1 felt it was safer to manually transfer the resident to prevent a fall out of the sling. NA #1 went on to further state she placed the resident's arms over her shoulders for the transfer. The nurse was not informed the sling was in the wrong position and the resident was manually transferred. The resident complained her right leg was hurting after the transfer and the nurse was informed immediately. This type of transfer had not happened before the incident. On 9/10/25 at 1:20 pm an interview was conducted with NA #2. NA #2 stated she walked into Resident #1's room to assist NA #1 as the second person for the mechanical lift. The lift pad was up the resident's back and not underneath her. NA #1 stated to NA #2 how she was unable to reposition the sling. NA #1 had thought it would not be safe to use the lift pad/sling in its position; the resident could fall. NA #1 decided to transfer the resident without the lift. NA #1 used the stand pivot method with the resident's arms over the NAs shoulders and was holding her by her pants for support. NA #2 stated she observed the transfer and could not see the resident's legs. NA #2 stated we heard a pop as the transfer was done. NA #2 stated she would move the sling if not in the proper place before attempting to use the mechanical lift. NA #2 further stated she would never transfer a resident by standing when they needed a lift. The resident had not said anything about the type of transfer. The resident stated my knee, my knee it hurt during the stand pivot transfer. The resident was successfully transferred without falling. NA #2 indicated she made a concerned facial expression to NA #1 during transfer and NA #1 stated she had done this before transfer successfully but had not mentioned which resident. NA #2 stated she had not observed NA #1 manually transfer a resident that required a mechanical lift before. Nurses' note dated 9/3/25 written by Nurse #1 documented on 9/2/2025 at 10:25 pm NA #1 reported that while putting Resident #1 to bed with the lift, they heard a popping sound from her right knee. The knee appeared to be rotated to the right, and the resident complained of pain. On 9/10/25 at 1:32 pm an interview was conducted with Nurse #1. Nurse #1 stated she was at the nurses' station evening shift 9/2/25 when NA #1 and NA #2 informed Nurse #1 they had to rearrange the sling for the mechanical lift to transfer Resident #1 into her bed. The NAs thought the resident's bottom was going to come through the sling and rushed to put her in bed and heard something pop. Nurse #1 indicated she was informed by both NAs that the resident was on the sling for transfer. The sling was under the resident when her leg was assessed in her bed. The resident stated she heard a pop in her right leg, and it hurt. Nurse #1 further stated the resident had not mentioned anything about the transfer, and she was not asked. Tylenol was administered for pain, and the NP was notified. Nurses' note dated 9/2/25 at 9:15 pm written by Nurse #2 documented a discharge summary note that Resident #1 was sent to the hospital for evaluation of her right knee pain after transfer via Emergency Medical Services. The resident rated her pain at 10 out of 10 (10