STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345152	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Village	1265 21 Street NE Hickory, NC 28601

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to update and revise an individualized person-centered comprehensive care plan for 1 of 5 residents whose comprehensive care plans were reviewed (Resident #72).The findings included:Resident #72 was admitted to the facility on [DATE] with diagnoses which included non-traumatic brain dysfunction, Alzheimer's disease, non-Alzheimer's dementia, and seizure disorder.A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 had severe cognitive impairment and required substantial/maximal assistance (helper does more than half the effort) with the ability to roll left and right while in bed. A Physical Therapy Discharge summary dated [DATE] through 01/19/26 revealed Resident #72's discharge recommendations was a two person assistance for transfers and gait. A Physical Therapy note dated 01/12/26 written by Physical Therapist #1 revealed Resident #72 required partial/moderate assistance (helper does less than half the effort) for rolling left and right in the bed.On 03/11/26 at 9:03 AM, an interview was conducted with Physical Therapist #1. During the interview, she stated Resident #72 required moderate to maximum assistance of two staff members with everything. She stated Resident #72 required direction and verbal cues. Physical Therapist #1 stated when the resident was discharged from therapy services she required one-person assistance with bed mobility.Review of Resident #72's care plan dated 01/16/26 revealed a focus area related to functional performance. Interventions included that Resident #72 was independent with bed mobility (rolling left and right), requiring only verbal cues and occasional hands-on prompting due to cognition.Review of Resident #72's care guide (a guide that explains to staff members what assistance each resident requires) on 03/10/26 revealed the following documentation: Roll left and right independent. On 03/10/26 at 11:15 AM, an interview was conducted with Nurse Aide (NA) #1. During the interview she confirmed she was caring for Resident #72. She explained Resident #72 required assistance of one to two staff members with bed mobility depending on the day and how the resident was. NA #1 explained the first thing staff members were supposed to do was check the care guide in the morning, which came from the resident's care plan, to see how each resident transferred. NA #1 stated she knew Resident #72's care guide said she was independent; however, staff working with the resident on the floor knew that the information was incorrect but had not mentioned it to anyone. On 03/11/26 at 10:16 AM, an interview was conducted with Nurse #1. During the interview, she stated Resident #72 required assistance of one staff member for bed mobility. She explained it was the MDS Nurse who would alter the care plans and update the care guide.On 03/10/26 at 11:56 AM, an interview was conducted with MDS Nurse #1. During the interview, she stated she was responsible for the care plans for the facility. She explained that the Director of Nursing (DON) could also update the care plans and care guide. She stated the former DON had updated the care plan on 01/16/26 to show Resident #72 was independent for bed mobility. MDS Nurse #1 reviewed the Physical Therapy discharge summary then explained she had discussed Resident #72 with Physical Therapist #1 and the Nurse Aides who stated Resident #72 required at least one-person assistance for bed mobility. MDS Nurse #1 stated the care plan should not have indicated that Resident #72 was (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	independent for bed mobility and it should have been correctly reflected in the care plan and care guide. She explained the typical process was for Therapy services to call her with any updates or changes with mobility status. She did not recall being informed of a status change but stated she should have seen the therapy note. On 03/11/26 at 1:10 PM, an interview was conducted with the Administrator, who stated that she expected all residents to have an accurate comprehensive care plan, and the care plan should reflect the resident's clinical condition and care needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide care in a safe manner when a resident was rolled out of bed hitting the floor face first during incontinence care. This deficient practice affected 1 of 3 residents reviewed for accidents (Resident #72).The findings included:Resident #72 was admitted to the facility on [DATE] with diagnoses that included non-traumatic brain dysfunction, Alzheimer's disease, non-Alzheimer's dementia, and seizure disorder.A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 had severe cognitive impairment and required substantial to maximal assistance (helper does more than half the effort) with the ability to roll left and right while in bed.Review of Resident #72's Medication Administration Record (MAR) dated January 2026 revealed she had no orders for a anticoagulant medication.A Physical Therapy note dated 01/12/26, written by Physical Therapist #1, revealed Resident #72 required partial to moderate assistance (helper does less than half the effort) for rolling left and right in bed.On 03/11/26 at 9:03 AM, an interview was conducted with Physical Therapist #1. During the interview, she stated Resident #72 required moderate to maximum assistance of two staff members with everything. She stated Resident #72 required direction and verbal cues. Physical Therapist #1 further stated that when the resident was discharged from therapy services, she required one-person assistance with bed mobility.A review of Resident #72's care plan dated 01/16/26 revealed a focus area related to functional performance. Interventions included that Resident #72 was independent with bed mobility (rolling left and right), requiring only verbal cues and occasional hands-on prompting due to cognition.A review of Resident #72's care guide (a guide that explains to staff members what assistance each resident requires) on 03/10/26 revealed the following documentation: Roll left and right independent.An observation conducted on 03/10/26 at 11:09 AM of Resident #72 revealed she was sitting in her wheelchair in the main common area of the locked unit. Resident #72 was observed smiling at the surveyor however was unable to communicate verbally.An incident report dated 01/14/26 at 7:15 AM, written by Nurse #1, revealed she was notified by a staff member (Nurse Aide #2) that Resident #72 was on the floor. Upon entering the room, the resident was observed lying face down on the floor next to her bed. Resident #72 had rolled off the bed while care was being provided. No injuries were initially observed. The detailed report revealed Resident #72 was a two-person assistance with transfers. On 01/14/26 at 7:15 AM, NA #2 was providing care for the resident when he attempted to roll her to change her brief. She continued to roll off the side of the bed and onto the floor. Resident #72 sustained an abrasion to her face, with no other injuries noted. Interventions following the fall included placing a side rail on the left side of the resident's bed to aid in mobility while turning.A nursing progress note written by Nurse #1 dated 01/14/26 at 4:50 PM, recorded as a post-fall evaluation, revealed that at 7:15 AM Resident #72 had a witnessed fall. While staff were changing her brief, the resident rolled out of bed. As a result, she sustained an abrasion to the right side of her forehead. On 03/10/26 at 11:29 AM, an interview was conducted with Nurse Aide (NA) #2. During the interview, he stated that on 01/14/26 around 7:10 AM, he entered Resident #72's room to provide incontinence care and assist her with dressing for the day. He explained that she was awake, and he informed her he was going to change her and roll her onto her side. NA #2 stated he picked up the bed pad underneath the resident and pulled it upward, placing the resident onto her left side. He further stated that as he lifted and her weight shifted toward the other side, she continued rolling and went off the bed onto the floor face first. NA #2 stated he attempted to catch her; however, he was unable to reach her because he was positioned across the bed. He stated he ran to the other side and observed the resident face down on the carpeted floor and called out for Nurse #1. He explained Resident #72 was non-verbal and was pointing to her forehead, where there was an abrasion. NA #2 stated Nurse #1 entered the room and assessed Resident #72, and the staff then used a gait belt to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assist the resident back into her wheelchair. NA #2 stated the bed was in a low position at the time of the fall. NA #2 further stated that earlier that morning he had been informed during rounds that Resident #72 had changed to requiring a two-person assist with transfers, but not with bed mobility. He explained he had not worked with the resident since that update but acknowledged he should have rolled her toward him instead of away from him during care.On 03/11/26 at 10:16 AM, an interview was conducted with Nurse #1. During the interview, she stated that on 01/14/26 she remembered NA #2 calling out for assistance from the Resident's room. She stated that upon entering the room, she observed Resident #72 face down on the carpeted floor. Nurse #1 immediately assessed the resident and obtained vital signs. No major injuries were noted; however, an abrasion was present on her forehead. Resident #72 was placed on neurological checks due to hitting her head and was assisted back into her wheelchair using a gait belt with assistance from another staff member. Nurse #1 stated that NA #2 reported that while he was rolling Resident #72 in bed to provide incontinence care, he rolled her away from him using the bed pad, which resulted in her rolling off the bed onto the floor. The interview further revealed that staff were required to provide verbal cues to Resident #72, as she would not understand what to do without guidance due to cognitive impairment. Nurse #1 stated that NA #2 should have rolled the resident toward him during care rather than away from him.On 03/11/26 at 9:05 AM, an interview was conducted with the Director of Nursing (DON). During the interview, she stated she was the interim DON and was not in that role at the time of the incident. She explained that Resident #72 required verbal cues and assistance from at least one staff member with bed mobility. The DON stated that after reviewing the incident on 01/14/26, NA #2 should have rolled the resident toward him during incontinence care rather than away from him. She also stated she would have expected him to provide appropriate verbal cues prior to rolling the resident.On 03/11/26 at 1:06 PM, an interview was conducted with the Administrator. During the interview, she stated that appropriate positioning of Resident #72 would have included rolling her toward NA #2 during care rather than away from him.

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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. Based on observations, record review, and staff interviews, the facility failed to follow their Hand Hygiene Policy when the Wound Care Nurse failed to doff her gloves, sanitize her hands, and don clean gloves after cleaning Resident #57's sacral wound and surrounding area and prior to cutting and placing the alginate with silver (highly absorbent wound dressing) on his wound bed during wound care. The deficient practice occurred for 1 of 8 staff observed for infection control practices (Wound Care Nurse).The findings included:Review of the facility's policy entitled Hand Hygiene which is part of the Infection Control Policies and Procedures, last revised on 10/12/23 read in part, 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 in-serviced 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.Procedures:4. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations:Before donning gloves and after removing glovesBefore and after handling clean or soiled dressings, gauze pads, contaminated equipment, etc.Before moving from a contaminated body site to a clean body site during resident care.6. The use of gloves does not replace handwashing/hand hygiene.Review of Resident #57's electronic medical record (EMR) revealed wound care orders for an unstageable pressure ulcer to his sacrum. The wound orders dated 03/01/26 read, cleanse with normal saline (NS), pat dry, apply alginate with silver and cover with dry dressing daily every day shift and as needed for protection.An observation was conducted on 03/11/26 at 10:12 AM of wound care being provided to Resident #57 for his sacral wound. The Wound Care Nurse with mask, gown, goggles, and gloves on cleansed the overbed table with a wipe and placed a barrier on the table and then her wound supplies. She doffed her gloves sanitized her hands and donned clean gloves and cleaned the wound bed of Resident #57's sacral wound. The Wound Care Nurse doffed her gloves, sanitized her hands, donned clean gloves and cleaned the outer wound area with NS-soaked gauze and patted the wound dry. She then, without doffing her gloves, sanitizing her hands and donning clean gloves, proceeded to cut the alginate with silver dressing and placed it on the wound bed to make sure it was covered. The Wound Care Nurse then doffed her gloves, sanitized her hands and donned clean gloves and placed a clean dressing on the wound over the alginate with silver. She doffed her gloves, washed her hands with soap and water, donned clean gloves and proceeded to Resident #57's heel wounds. After completing care to the heel wounds she gathered her trash, doffed her gloves, eye protection, gown and mask, washed her hands with soap and water, gathered her trash and left the room.An interview on 03/11/26 at 10:40 AM with the Infection Preventionist (IP) revealed the Wound Care Nurse should have doffed her gloves after cleaning the wound, sanitized her hands, donned clean gloves and then proceeded with cutting the alginate with silver dressing and applying it to the wound bed. An interview on 03/11/26 at 12:20 PM with the Wound Care Nurse and the Director of Nursing (DON) revealed that the Wound Care Nurse stated she was not aware that she had not doffed her gloves, sanitized her hands and donned clean gloves after cleansing the area around the wound bed and before cutting and applying the alginate with silver dressing to the wound bed. The Wound Care Nurse stated she should have cleansed the wound and surrounding area and then doffed her gloves, sanitized her hands, and donned new gloves prior to cutting and applying the alginate with silver dressing to the wound bed. The DON stated that she agreed that when moving from a dirty procedure (cleansing the wound and surrounding area) to a clean procedure (applying wound treatment) you should doff your gloves, sanitize your hands, and don clean gloves prior to the clean procedure.An interview on 03/11/26 at 2:15 PM with the Administrator revealed she would have expected the Wound Care Nurse to follow their Hand Hygiene policy and procedure while providing wound care.