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	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Grove	631 Junction Creek Drive Wilmington, NC 28412

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. (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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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and staff and resident interviews, the facility failed to act upon concerns that were reported by the Resident Council and communicate the efforts to address concerns that were reported during Resident Council Meetings for 7 of 9 months reviewed (November 2024, March 2025, April 2025, May 2025, June 2025, July 2025 and August 2025). Findings included: a. The Resident Council Agenda dated 10/28/24 indicated in the notes section of the form that the following concerns were voiced: more sugar-free desserts, updated call bell system, and call bell response time. Staff in attendance at the meeting were Social Worker #1, the Director of Nursing and the Dietary Manager. b. The Resident Council Agenda dated 11/18/24 did not indicate that a response was provided to the council regarding the concerns that were voiced on 10/28/24 or any follow-up that the facility completed. Staff in attendance at the meeting were: Social Worker #1, the Administrator and the Dietary Manager. c. The Resident Council Agenda dated 2/24/25 indicated that the following concern was voiced: the dryer is broken in the laundry room. d. The Resident Council Agenda dated 3/24/25 indicated that the following new concerns were voiced: staffing concerns and staff not available to assist after meals are served. The March meeting minutes did not indicate that a response was provided to the council regarding the concerns that were expressed at the 2/24/25 meeting or any follow-up that the facility completed. Staff in attendance were Social Worker #1, the Administrator, Director of Nursing, and the Dietary Manager. e. The Resident Council Agenda dated 4/28/25 indicated the following new concerns were voiced: air conditioners not working in some resident rooms, staffing concerns, staff not available to assist after meals are served, and residents not offered choices for meals. The April meeting minutes did not indicate that a response was provided to the council regarding the concerns that were expressed at the 3/24/25 meeting or any follow-up that the facility completed. Staff in attendance were the Administrator, Dietary Manager, and Social Worker #1. f. The Resident Council Agenda dated 5/27/25 indicated the following concerns were voiced: air conditioning not working in some resident rooms and Nurse Aides sitting after serving meals and not assisting the residents when asked. The Agenda indicated that these concerns were voiced the previous month and the Administrator was to address. The May meeting minutes did not indicate that a response was provided to the council regarding the concerns that were expressed at the 4/28/25 meeting or any follow-up that the facility completed regarding air conditioning, staff not assisting after meals and not offered choices at meals. Staff in attendance was Social Worker #1. g. The Resident Council Agenda dated 6/30/25 indicated the following concerns were voiced: air conditioning not working in all rooms, Nurse Aides sitting after serving meals and not assisting residents when asked. The June meeting minutes did not indicate that a response was provided to the council regarding the concerns that were expressed at the 5/27/25 meeting or any follow-up that the facility completed regarding air conditioning, Nurse Aides sitting after serving meals and not getting up to help when asked. Staff in attendance were Social Worker #1 and the Administrator. h. The Resident Council Agenda dated 7/28/25 indicated the following concerns were voiced: air conditioning not working in all rooms, Nurse Aides sitting after serving the meals and not assisting residents when asked. The July meeting minutes did not indicate that a response was provided to the council regarding the concerns that were expressed at the 6/30/25 meeting or any follow-up that the facility completed regarding the air conditioning and Nurse Aides sitting after meals were served and not assisting residents when asked. Staff in attendance were Social Worker #1 and the Administrator. i. The Resident Council Agenda dated 8/25/25 indicated the following concerns were voiced: staffing. The August meeting minutes did not indicate that a response was provided to the council regarding the concerns that were expressed at the 7/28/25 meeting or any follow-up that the facility completed regarding the air conditioners and the Nurse Aides sitting after serving the meals and not assisting residents when asked. Staff in attendance were Social Worker #1, Dietary Manager and Administrator. During an interview with the Resident Council on 9/17/25 at 10:30 AM the residents stated that Resident Council meetings were held regularly but their concerns were not addressed. The residents stated they felt that their concerns fell on deaf ears. The residents stated that they were told I'll look into it, when they expressed concerns, but nothing was ever done, and this made them feel like they did not make any difference. An interview was conducted with Resident #16 on 9/17/25 at 11:00 AM. Resident #16 stated that the council met monthly, and Social Worker (SW) #1 recorded the concerns that were expressed. Resident #16 indicated that nothing was done about the concerns that were expressed in the meetings. Resident #16 stated she attended all the Resident Council meetings and was frustrated with the lack of follow-up because

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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 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and Responsible Party (RP) and staff interviews, the facility failed to provide written grievance summaries for 1 of 1 resident (Resident #37). Findings included: Review of facility policy dated 08/01/23 titled Guaranteed Fair Treatment Process read in part: The Administrator, Executive Director or other individual designated to oversee the concern process will receive a copy of all written grievances for tracking purposes and will assist with investigations as necessary. The person filing the concern has the right to receive a written summary of a statement of the concern, the steps taken to investigate the concern, a summary of pertinent findings or conclusions, whether the concern was confirmed or not confirmed, and any corrective actions taken or to be taken by the facility. The Administrator, Executive Director will provide a written response within 3 working days, unless all parties are notified that additional time is needed.Resident #37 was admitted to the facility on [DATE].Resident #37's quarterly Minimum Data Set (MDS) dated [DATE] indicated that the resident was cognitively intact. A review of the facility's grievance log from 10/11/24 through 09/18/25 revealed one grievance from Resident #37's Responsible Party (RP) dated 07/06/25, for an air-conditioning thermostat not working properly in resident's room, with room temperature reading 76.8 F. On the response to concern section of the grievance form dated 07/09/25 read, Removed room system from outdated computer system. Now, resident's room is constantly 70-71 degrees Fahrenheit (F.). The resident and RP expressed gratitude and verbally said room is at the temperature they want. On the bottom page of the grievance form was dated 07/09/25, as resolved; but the grievance page summary and finding section was left blank. The section stating a copy of the grievance decision section was given to the individual was blank, along with the next line of the form stating the written notification was sent by email or postal mail to the individual was also left blank, without a signature or date. An interview was conducted on 09/18/25 at 8:10 AM with the Maintenance Director. He stated he was aware of one written grievance dated 07/06/25 from Resident #37's RP, regarding resident's air conditioning not working properly. The Maintenance Director did know of another grievance regarding laundry dryer #3 breaking down around the end of April/2025, but it was reported through his work order system and not from a resident or their family. The maintenance director stated Resident #37's written air conditioner thermostat grievance dated 07/06/25 was resolved the same day it was reported, which required resident's room thermostat being reprogramed and re-set. He stated he was not sure if a written grievance summary letter about the air conditioner was ever given to the residents or his RP. The Maintenance Director stated he received multiple work orders for the laundry's 3rd dryer breaking down, which were also repaired timely by their outside laundry repair vendor within a couple of days. He stated even with the 3rd dryer down; the facility's remaining 2-dryers were more than able to launder all of residents clothing timely. He stated he never received a written grievance about the down dryer from Resident #37 or his RP. He stated he received notifications of the down dryer always through their electronic work order system. He also stated he never heard of any residents not receiving their laundered clothing due to a dryer being down. An interview was conducted on 09/18/25 at 3:15 PM with Resident #37's RP. She stated she put in 6-grievances verbally or by email to the facility's administrative staff (Administrator, Director of Nursing, and Social Worker). She stated she had never received a written grievance summary from the facility for any of her 6 grievances. An interview was conducted on 09/18/25 at 9:00 AM with the Social Worker (SW). She stated Resident #37's RP never received a completed written grievance summary for any of RP's grievances, because the administrative staff deemed them to be concerns, not official grievances. Therefore, the administrative staff did not need to fill out a formal written grievance for Resident #37's or his RP, or provide a written summary to the complainant for RP's 6-verbal/emailed grievances: protein serving sizes were too small, mouthwash not provided timely, no staff were feeding the resident, facility's broken dryer resulted in the resident having no pants, and resident's room air-conditioning thermostat was not working properly. The Social Worker (SW) revealed that she did not know until today that she needed to provide a written grievance summary to grievance/concern complainants. She said she thought the verbal summary was okay. She said before today, she had only called, emailed, or spoken to complainants in person and verbally summarized the grievances, with nothing given to them in writing. She said she did not know she was required to provide a written grievance summary to every complainant. The SW said the resolution to Resident #37's six concerns/grievances were given to the complainant or his RP verbally, which included:1. Resident #37 gained greater than 5 lbs. in two months and had always received

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff, Power of Attorney, and Nurse Practitioner interview, the facility failed to protect a severely cognitively impaired resident (Resident #65) from the right to be free of physical abuse. On 08/29/25 at approximately 10:30 PM, when Nurse Aide (NA) #1 and NA #2 were providing care for Resident #65 who was agitated and combative, NA #2 struck the resident with an open hand on the left side of her face. This action would have caused a reasonable person psychosocial harm such as feelings of anger, fearfulness, humiliation, and helplessness. The deficient practice occurred for 1 of 3 residents reviewed for abuse (Resident #65).Findings included:Resident #65 was readmitted to the facility on [DATE] with diagnoses that included Alzheimer's disease with late onset, dementia with unspecified severity and behavioral and mood disturbances, anxiety and chronic pain.Review of the care plan for Resident #65 revised on 06/05/2025 revealed the following focus areas:Impaired Functional Performance as evidenced by (AEB) requiring staff assistance to complete activities of daily living (ADL) secondary to impaired cognition, decreased mobility, and unsteady gait and balance. Resident #65 refused assistance and resisted care at times. Anticipate resident requiring increased assistance as her disease process progresses. The goals were that Resident #65 would continue to participate in ADL through the next review. Interventions included to always approach in a friendly, non-threatening manner, try to re-direct with refusals; and allow resident to calm down then have another staff member attempt or re-approach in a timely manner if resident is resisting care. Resident #65 has mood and behavior problems with episodes of pacing, rummaging, screaming, being short tempered, being easily annoyed, being verbally and physically abusive towards staff, setting off door alarms and will frequently remove pants secondary to Alzheimer's/dementia with mood and behavioral disturbance. Resident #65 will refuse taking her scheduled medications at times. She gets angry when there is a facility emergency and she's not allowed to assist, such as when another resident falls. The goal was for Resident #65 to continue to participate in decision making regarding her daily routine and not injure herself or others when being abusive by the review date. Interventions included to anticipate and meet the needs of Resident #65, stop and talk with her as passing by (resident enjoys looking at family photos, clipping coupons, flipping through newspapers and books, drinking coffee), encourage visitation from family for socialization and diversion, encourage out of room for meals and activities, attempt to keep a consistent routine, offer snacks or drinks (resident loves coffee) for diversion, intervene as necessary to protect the rights and safety of others, remove from the situation and take to an alternate location as needed, minimize the potential for the resident's disruptive behaviors by offering tasks which divert attention, monitor behavior episodes and attempt to determine underlying causes considering location, time of day, persons involved, and situations and document behavior and potential causes. Review of a quarterly Minimum Data Set (MDS) dated [DATE] documented that Resident #65 had short and long term memory problems and was rarely or never understood. She was aware of the location of her room, staff faces and names; but did not know the current season or that she was in a nursing home. She continuously presented inattention and disorganized thinking. Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing) occurred on 1 to 3 days. Other behavioral symptoms not directed towards others (such as verbal or vocal symptoms like screaming) occurred on 1 to 3 days. The facility filed an Initial Allegation Report to the State on 08/30/25 at 12:37 AM for an allegation of abuse. The accused employee was NA #2. The facility became aware of the incident on 08/29/2025 at 10:30 PM. The allegation details were that the resident (Resident #65) became combative during care and was hitting and kicking the nurse aides. The resident hit NA #2 in the face and NA #2 swatted back at the resident. NA #2 was suspended pending an investigation, all residents were assessed with no new issues noted. Local law enforcement and DSS were notified on 08/30/25. The facility documented that the resident suffered no physical or mental harm. The facility Investigation Report was filed with the State on 09/08/25. The allegation was not substantiated by the facility because post investigation the Administrator determined that NA #2 did not swat at Resident #65 because there was no injury or mental anguish. The accused individual's employment (NA #2) was terminated related to the allegation on 09/04/25. In a telephone interview with NA #1 on 09/16/25 at 2:27 PM she stated she had asked NA #2 help her with an incontinent round for Resident #65 at approximately 10:30 PM on 08/29/25. She explained that it was the normal baseline behavior for Resident #65 to strike out at staff during incontinence care or showering. She explained that 2 aides were always needed when providing incontinent

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to document accurate information on the daily nurse staffing sheets to include the census for 4 of 4 days of the survey (09/15/25, 09/16/25, 09/17/25, and 09/18/25).The findings include: A review of the daily posted nurse staffing information sheets for the 4-neiborhoods dated 09/15/25, 09/16/25, 09/17/25, and 09/18/25 revealed no entry in the areas of census for the 4- resident neighborhoods and for all shifts. The census number on 1st (7:00 AM - 3:00 PM), 2nd (3:00 PM - 11:00 PM), and 3rd (11:00 PM - 7:00 AM) shifts were left blank for the following days: 09/15/25, 09/16/25, 09/17/25, and 09/18/25. An interview on 09/18/25 at 11:00 AM was conducted with the facility's temporary scheduler. She verified that the census numbers for the facility's 4-neighborhoods on their daily nurse staffing sheets were all left blank. She stated she was not including facility census on daily nurse staffing sheets. Scheduler stated that the Administrator would work with her to ensure all the assignment sheets and daily nurse staffing posting reflects, daily census, and who was working the floor and when. An interview was conducted on 09/18/25 at 03:00 PM with the Administrator. He stated he was unaware the daily posted nurse staffing information sheets were not filled out completely to include census numbers for the 4- neighborhoods. Administrator said the facility's temporary scheduler was new to the position and that as the current Administrator he would take it upon himself to train the new scheduler in how to fill out the daily schedule forms correctly and would review the forms daily to ensure the daily posted nurse staffing information sheets are filled out completely to include census numbers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, record review, and staff interviews the facility failed to 1.) maintain clean technique (a strategy used during wound care to prevent or reduce the risk of transmission of microorganisms from one person to another or from one surface to another. This includes in part; maintaining a clean field (clean workspace) to prevent cross contamination) during wound care to a Stage III left heel pressure wound. Nurse #6 did not clean the work surface area or place a barrier prior to placing the wound care supplies that included a clean dressing onto the resident's dresser and did not place a barrier underneath the resident's (Resident #11) left heel during wound care which allowed the left heel to touch the floor and potentially contaminate the wound. 2.) implement the infection control policy and procedures for Enhanced Barrier Precautions (EBP) when providing direct care activities to residents with a Stage III pressure wound and an indwelling medical device (Resident #11 and Resident #100). This occurred for 3 of 3 staff members who were observed for infection control practices (Nurse #6, Nurse #5, Nurse Aide #6). Findings included: 1.) During an interview on 09/17/25 at 3:30 PM the Infection Control Preventionist Nurse stated there was no facility policy in place regarding the procedures to use when performing dressing changes. A wound care observation was conducted on 9/17/25 at 12:44 PM of Nurse # 6 providing wound care to Resident #11's Stage III left heel pressure wound. Resident #11 was oriented to person only and was observed in her room sitting up in a wheelchair during the wound care. Nurse #6 donned gloves and a gown and placed the wound care supplies on Resident #11's dresser without placing a barrier down or cleaning the work area. Nurse #6 removed Resident #11's shoe revealing no dressing covering the left heel wound. Nurse #11 did not place a barrier between Resident #11's left heel and the floor to prevent potential contamination of the wound. Resident #11's heel was left uncovered and resting on the floor while Nurse #6 retrieved the wound supplies. Nurse #6 returned and lifted the left heel, cleaned the wound with wound cleanser, then left the heel resting on the floor while she retrieved the wound medication. Nurse #6 then lifted the heel, applied the medication to the wound then left the heel resting on the floor again while she retrieved the new dressing. Nurse #6 then lifted the heel from the floor and applied the new dressing. During an interview on 09/17/25 at 1:00 PM Nurse #6 stated she had been a nurse less than one year. Nurse #6 stated the previous dressing must have fallen off and indicated she did not think to place a barrier under Resident #11's right heel prior to letting the heel rest on the floor to prevent possible contamination of the wound. Nurse #6 indicated she should have placed a barrier under Resident #11's heel and cleaned the dresser or placed a barrier down before placing the wound care supplies on it. She stated it was done in error, and she received infection control training upon hire to the facility. During an interview on 09/17/25 at 3:30 PM the Infection Control Preventionist Nurse stated Nurse #6 should have placed a clean barrier under Resident #11's heel for the dressing change to prevent the heel wound from touching the floor and cleaned the area or placed a barrier on the dresser before placing the new dressing supplies on it to reduce the risk of contaminating the wound. She stated Nurse #6 had received infection control training. 2.) The facility's Infection Control Policy revised 4/3/25 revealed in part: Enhanced Barrier Precautions (EBP) were designed to reduce transmission of multidrug resistant organisms (MDRO) and employed targeted gown and glove use during high contact resident care activities. EBP was indicated for residents with wounds and/or indwelling medical devices even if the resident was not known to be infected or colonized with a MDRO. a. During an observation on 09/17/25 at 1:30 PM Nurse #5 was observed performing a peripherally inserted central catheter (PICC) line flush (a PICC line is a type of central venous catheter used to access the veins near the heart to deliver medications and other treatments. A PICC line flush is the process of injecting normal saline or heparin through the PICC line to keep it clear of blockages and to ensure it remains functional for the delivery of medications) for Resident #100. Nurse #5 was wearing gloves but no gown. An enhanced barrier precautions sign was observed on Resident #100's door. Personal Protective Equipment (PPE) supplies were inside of Resident #100's room at the doorway. During an interview on 09/17/25 at 1:35 PM Nurse #5 stated she was aware Resident #100 was on enhanced barrier precautions. Nurse #5 stated she knew she had to wear gloves but was not certain that she needed to wear a gown as well when providing direct care including flushing a PICC line. Nurse #5 stated she had received infection control training including training on enhanced barrier precautions. b. During an observation on 09/17/25 at 12:00 PM Nurse Aide #6 was observed in Resident #11's room in the bathroom preparing to assist Resident #11 to the toilet. Nurse Aide #6 was not wearing a gown or gloves. Resident #11 had a Stage III left heel pressure wound. Nurse Aide #6 picked up Resident #11's left heel