STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345088	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRINITY GLEN	**849 WATERWORKS ROAD WINSTON-SALEM, NC 27101**

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 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family interview, and staff interviews, the facility failed to protect 1 of 3 sample residents (Resident #1) from physical abuse inflicted by a staff member that resulted in Resident #1 being struck in the face. The Findings Included: Resident #1 was admitted on [DATE] with a [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was severely cognitively impaired, had behavioral symptoms that significantly interfered with care and social interactions. The MDS also revealed Resident #1 required extensive assistance with 1-person assistance for activities of daily living (ADL's). Review of Resident #1's care plan dated 12/5/2019 revealed focus areas included for resident to be comfortable living in facility, remain safe and avoid injury while moving throughout the facility, and to effectively communicate her needs. Resident #1 was also care planned for confusion, behaviors, and mood disorientation. Review of the 24-hour Report dated 7/31/2020 revealed an allegation of physical abuse of Resident #1 by NA (Nurse Aid) #1 that occurred on 7/31/2020 at 6:30 PM. The 24-hour report was signed by the Staff Development Coordinator on 7/31/2020. Review of the 5-Working Day Report dated 8/4/2020 revealed the allegation of abuse to Resident #1 was investigated and substantiated. The report stated on 7/31/2020 at approximately 6:30 PM NA #2 witnessed NA #1 slap resident on face while resident was sitting in a wheelchair. Resident #1 had gotten out of her wheelchair and was walking alone in the hallway. NA #1 assisted resident back into wheelchair. As NA #2 was walking towards NA #1 and Resident #1, NA #1 slapped resident across right cheek. NA #1 was suspended on 7/31/2020 with a termination on 8/6/2020. Notification was made to law enforcement and the state agency. Review of written statement by NA #1 dated 8/6/2020, revealed on 7/31/2020 she noticed Resident #1 holding onto the side rails in the hallway. NA #1 walked over to Resident # 1 and sat her down into a wheelchair. Resident #1 spoke to NA #1, NA #1 then tapped Resident #1 on the chin. An observation on 8/18/2020 at 12:20 PM of camera footage, recorded by the facility, dated 7/31/2020 at 5:33 PM, revealed Resident # 1 walking in the hallway. NA #1 approached Resident #1 and assisted Resident into her wheelchair. NA # 1 was observed using her left hand to contact Resident #1's face. An interview with Director of Nursing (DON) on 8/18/2020 at 11:52 AM revealed she received a phone call on 7/31/2020, stating NA #1 had hit Resident #1 in the face. The DON was not at the facility at the time of the call about the incident, but stated she called the Staff Development Coordinator, who was present in the facility, and instructed her start the investigation. An interview with Staff Development Coordinator (SDC) on 8/18/2020 at 12:32 PM revealed on 7/31/2020 she received a phone call from the DON. The DON informed SDC of the reported incident and asked her to investigate. The SDC stated upon her immediate arrival to unit, she relieved NA#1 of her duties and asked to leave the building. NA #1 was asked to provide a written statement detailing the incident. NA #1 declined to leave a written statement prior to exiting the facility on 7/31/2020. SDC stated she completed the 24-hour report. An interview with NA #2 (who witnessed the incident) on 8/18/2020 at 12:46 PM, revealed on 7/31/2020, upon exiting another resident's room, NA #2 looked down the hallway and observed NA #1 placing Resident #1 into her wheelchair. He stated that Resident #1 appeared to be agitated and lashed out towards NA#1. He stated he then observed NA #1 slap Resident #1 on the face. NA #2 stated he removed Resident #1 from the situation and reported the incident to Nurse #1. An interview was attempted on 8/18/2020 at 1:03 PM with NA #1 via telephone. There was no answer and no returned call. An interview with Nurse #1 on 8/18/2020 at 1:03 PM revealed during her shift on 7/31/2020, NA # 2 reported to her that NA #1 hit Resident #1 in the face. Nurse # 1 contacted the Director of Nursing and performed a physical assessment of Resident #1. An interview with Resident #1's family member on 8/18/2020 at 2:45 PM, revealed family member received a telephone call from facility staff stating Resident #1 had been struck in the face by a Nurse Aid. Family member stated she was advised the police had been notified and were investigating. She further stated the police contacted her the following day regarding the investigation. An interview was conducted with the Administrator on 8/19/2020 at 4:40 PM. During this interview, she stated NA#1 should have asked for a change in assignment if she was feeling burn out from working with Resident #1. On 8/19/20 at 4:18PM, the facility shared the following plan to address the incident: Plan of Correction for QAPI Incident date 7-31-20 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 was immediately removed from contact with this nursing assistant (C.N.A.#1) and the observing CNA (C.N.A. #2) reported to his nurse (RN) on unit. Staff Development Coordinator was in building on another unit. She immediately told CNA #1 to leave facility and that she could not return until she had been contacted by DON. Resident #1 was immediately assessed by RN on unit. There was no redness nor bruising noted. Physician Services and family have been notified by DON. Completed 7-31-20 2. How will you identify other residents having the potential to be affected? All residents had skin assessments completed as well as individual interviews. There were no issues identified with these audits. Completed 7-31-20 to 8-4-20. 3. What measures will be put into place or systemic changes made to ensure it will not happen again? Staff education completed for all employees on Abuse. Completed all working by 8-3-20 to 8-5-20, then completed mailing to any that were not working 8-5-20. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Quality Improvement Coordinator will monitor four employees 3X weekly for 4 weeks observing interactions with residents and outcomes. These audits will be presented at our Quality Assurance Performance Improvement (QAPI) meeting for review. Began week of 8-3-20, will complete week of [DATE]. Will review results in QAPI meeting on 9-11-20. 5. Completion date 8-5-20 As part of the validation process on 8/18/20 and 8/19/20, the plan of correction was reviewed and included the in-services related to abuse, resident rights, staff burnout and dementia care for all staff members, documentation that revealed 100% of all residents alert and oriented were interviewed regarding concerns about safety/abuse, in- house residents had a skin assessment conducted, employee files were reviewed to verify background checks and abuse training was completed upon hire, the grievance logs were reviewed to verify no complaints related to abuse were reported, and the QAPI plan to include monitoring to be completed. Date of correction action completion. Final Compliance date 8/5/20.

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

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.