

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 01/23/2024
NAME OF PROVIDER OR SUPPLIER TRINITY ELMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3750 HARPER ROAD CLEMMONS, NC 27012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	Initial Comments Report of a Follow Up Construction Section Biennial Survey by Tod Hancock, conducted on January 23, 2024. Cited deficiencies have not been corrected. A Plan of Correction is required.	{C 000}		2/1/2024
{C 199}	Exhaust Ventilation SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (g) The spaces listed in this Paragraph shall be provided with exhaust ventilation at the rate of two cubic feet per minute per square foot. This requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation in these specified spaces: (1) soiled linen storage; (2) soil utility room; (3) bathrooms and toilet rooms; (4) housekeeping closets; and (5) laundry area. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1. Based on observation and testing with a thin plastic sheet, the facility does not provide working exhaust ventilation in required spaces. Findings on January 23, 2024: a. 400 Hall, Bedroom 405 Bathroom - the exhaust ventilation system was not drawing. b. 300 Hall, Environmental Services - the exhaust ventilation system was not drawing. c. 200 & 300 Halls, Nurse Station Restroom - the exhaust ventilation system was not drawing. d. 500 Hall, Bedroom 501 Bathroom - the	{C 199}	Replaced fan belt on unit on the roof.	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Joe Germano

TITLE

Supervisor

(X6) DATE

2/15/2024

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 01/23/2024
NAME OF PROVIDER OR SUPPLIER TRINITY ELMS			STREET ADDRESS, CITY, STATE, ZIP CODE 3750 HARPER ROAD CLEMMONS, NC 27012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE 2/1/2024	
{C 199}	Continued From page 1 exhaust ventilation system was not drawing.	{C 199}			