

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER TRINITY ELMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3750 HARPER ROAD CLEMMONS, NC 27012		
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey on 08/28/24 and 08/29/24.	D 000	Plan Of Correction: Measures to correct deficient area: Plan of Protection put in place at time of survey exit.	9/23/2024
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 7 sampled residents (Resident #5) related to a resident who had falls resulting in injuries. The findings are: Review of the facility's policy on fall risk reduction and management dated May 2023 revealed: -If a resident fell, interventions were put in place to reduce the risk of falling and the potential for serious injury. -If a resident was determined to be at risk for falls, staff should immediately implement interventions to reduce the risk of falls or serious consequences from falls. -If a resident continued to fall, staff were to re-evaluate the situation to determine whether it was appropriate to continue or change interventions.	D 270	1. Assign a staff member to provide 1:1 supervision/assistance until family can make arrangements with a sitter service. 2. Call daughter to discuss family's provision of sitter service until deemed medically stable. 3. Ensure gripper socks on at all times. 4. Complete 3050R on resident for significant change. 5. Consult with PT to evaluate resident's room for any safety factors. 6. Educate all nursing staff on increased needs of this resident.	

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

Diana Bernhe-Albert

TITLE

Administrator

(X6) DATE

10/03/2024

STATE FORM

6899

KHSO11

If continuation sheet 1 of 49

Reviewed and Acknowledged K.M. 10/08/24

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D 270	Continued From page 1 -If a resident fell, a post-fall assessment was completed including observation of possible injury, vital signs, level of consciousness, presence of pain, and any other sign of symptom of injury. -The resident's care plan should be reviewed after a fall and any changes or additional interventions documented. Review of Resident #5's current FL2 dated 02/06/24 revealed: -Diagnoses included hypertension, insomnia, and atrial fibrillation. -Resident #5 was intermittently disoriented. -She was ambulatory with a walker as an assistive device. Review of Resident #5's care plan dated 07/25/24 revealed: -She was ambulatory with a walker and wheelchair as assistive devices. -She had limited strength. -She was oriented. -She required limited assistance with toileting and bathing. -She was independent with ambulation/locomotion, dressing, grooming/personal hygiene, and transferring. -She was a high risk for falls. Review of Resident #5's Licensed Health Professional Support (LHPS) evaluation dated 04/25/24 revealed: -Resident #5 performed most of her activities of daily living (ADLs) and ambulated with a rolling walker. -Ambulation with devices was marked as a LHPS task. Review of Resident #5's LHPS evaluation dated	D 270	Measures to prevent problem from occurring again: • Review all residents with falls in past 30 days for supervision needs. • Educate all staff on implementation and documentation of interventions with each fall to prevent further falls/injuries. Post Fall Checklist and Post Fall Intervention Forms initiated with each fall. • Falls will be reviewed weekly by interdisciplinary team to ensure appropriate supervision/intervention in place.	9/26/2024

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D 270	Continued From page 2 07/24/24 revealed: -Resident #5 was working with physical therapy (PT) and occupational therapy (OT) to improve weakness and safety. -Resident #5 refused staff assistance with some ADLs. -Ambulation with devices was marked as a LHPS task. Observation of Resident #5's room on 08/29/24 at 12:34pm revealed: -Resident #5 was sitting on the edge of her bed. -Resident #5's entire left arm had purple bruising and was in a sling. -There were several pieces of furniture in the room but no obvious tripping hazards. -There was no fall mat on the floor next to the bed. -There was a call light system on the wall next to the bed, and it was within reach of Resident #5. Observation of Resident #5 on 08/29/24 at 3:20pm revealed she had abrasions on her face and nose. a. Review of an Incident/Accident report dated 06/29/24 revealed: -Resident #5 had an unwitnessed fall in her room at 3:00am. -She was found by a medication aide (MA). -She was observed in her room with a gash and blood on top of her head. -She reported to staff that she did not know what happened and she thought something hit her on the head. -She went to the emergency room (ER). Interview with the MA who completed the 06/29/24 Incident/Accident report on 08/29/24 at 3:46pm revealed:	D 270	Who will monitor the situation: • HCC and MCC will ensure Post Fall Checklist and Post Fall Interventions are completed with each fall. • IDT will review falls weekly in team meeting. How often monitoring will take place: • Audits will be completed weekly x 4 weeks then monthly x 6 months, then quarterly until compliance sustained. Findings will be reviewed in quarterly QAPI meetings. Completion dates: • Plan of Protection was implemented on 8/29/2024. All steps were completed on 9/6/2024. • Staff education was completed on 9/6/2024. • Audits have been initiated and will continue until compliance is sustained.	9/26/2024

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D 270	Continued From page 3 -She completed the 06/29/24 Incident/Accident report for Resident #5's fall. -Another staff told her Resident #5 fell on 06/29/24. Review of Resident #5's progress note dated 06/29/24 revealed: -Resident #5 was found in her room by a MA and Resident #5 was sitting in her chair with an open head laceration. -Resident #5 told the MA she fell but did not remember how or where. -The MA notified Resident #5's primary care provider (PCP). Review of Resident #5's hospital visit notes dated 07/01/24 revealed: -Resident #5 was seen in the ER for a laceration on top of her head on 06/29/24. -Resident #5 thought something fell on top of her head. -Resident #5's laceration was 5 centimeters (cm) long, and the bleeding was controlled with pressure. -Staples were used to close the laceration. -Resident #5 was discharged back to the facility on 06/29/24. Review of Resident #5's signed physician's orders dated 07/02/24 revealed: -There was an order for OT evaluate and treat due to poor safety awareness and decreased upper body strength. -There was an order for PT evaluate and treat due to frequent falls and transfer assistance. b. Review of an Incident/Accident report dated 06/30/24 revealed: -Another residents' family members heard a big bang from Resident #5's room and informed a	D 270		

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D 270	Continued From page 4 MA. -Resident #5 had an unwitnessed fall in her room at 5:05pm. -She was found by the MA and was sitting in the corner of her room on top of her shredder. -She had a skin tear on her left elbow. -Resident #5 did not remember what she was doing when she fell. Interview with the MA who completed the 06/30/24 Incident/Accident report on 08/29/24 at 3:40pm revealed: -She found Resident #5 sitting in the corner of her room on top of her paper shredder on 06/30/24. -Resident #5 had a skin tear on her elbow which she treated. -She notified Resident #5's primary care provider (PCP) and family. Review of staff resident monitoring documentation sheet dated 06/30/24 revealed: -Staff checked on Resident #5 at 4:00pm, 6:00pm, 8:00pm, and 10:00pm. -There was no additional documentation of staff monitoring for Resident #5 after her fall on 06/29/24. Review of Resident #5's signed physician's orders dated 07/02/24 revealed: -There was an order for OT evaluate and treat due to poor safety awareness and decreased upper body strength. -There was an order for PT evaluate and treat due to frequent falls and transfer assistance. c. Review of an Incident/Accident report dated 08/24/24 revealed: -Resident #5 had an unwitnessed fall in her room. -She was found by a personal care aide (PCA). -She was observed on the floor by her bathroom	D 270		

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D 270	Continued From page 5 door by a MA. -Resident #5's left shoulder was swollen and the MA called emergency medical services (EMS). -Resident #5 told the MA she tripped over her walker and fell. -Resident #5 complained of severe pain and she thought her left shoulder was fractured. -A representative from the hospital called the MA and told the MA that Resident #5's left shoulder was fractured. -She left for the ER on 08/24/24 at 4:30pm and returned to the facility at 7:20pm. Review of Resident #5's hospital discharge summary dated 08/24/24 revealed: -Resident #5 presented to the ER following a fall. -An x-ray of the left shoulder revealed a humeral fracture of the left arm. -Her left arm was placed in a sling, and she was discharged back to the facility on 08/24/24. Interview with a MA on 08/29/24 at 3:10pm revealed: -She completed the Incident/Accident report after Resident #5's fall on 08/24/24. -Resident #5 had fallen and fractured her arm. -EMS transported Resident #5 to the hospital. -MAs were expected to check Resident #5's blood pressure once a shift for 72 hours after a fall. -Resident #5's entire left arm was swollen and purple since she fractured her arm on 08/24/24. d. Review of an Incident/Accident report dated 08/25/24 revealed: -Resident #5 had an unwitnessed fall in her room at 7:07pm. -She was observed on the floor and was crying, and her wheelchair was behind her. -The resident told the MA she was trying to get to	D 270		

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D 270	Continued From page 6 her bed and her wheelchair rolled away from her. -Resident #5 had no apparent injuries. -There was no documentation of interventions put in place after the fall on 08/25/24 to prevent falls. Interview with a MA on 08/29/24 at 5:25pm revealed: -She completed the Incident/Accident report for Resident #5's fall on 08/25/24. -Resident #5 did not call for staff assistance when she needed help and wanted to be independent. -Resident #5 had multiple falls during the week of 08/29/24. -Staff routinely checked on all the residents every two hours. Review of staff resident monitoring documentation sheet dated 08/26/24 revealed staff checked on and offered toileting assistance to Resident #5 at every two hours from 8:00am to 11:30pm. Review of staff resident monitoring documentation sheet dated 08/27/24 revealed staff checked on and offered toileting assistance to Resident #5 at 1:30am, 3:30am, and every two hours from 8:00am to 10:00pm. e. Review of an Incident/Accident report dated 08/28/24 revealed: -Resident #5 had an unwitnessed fall in her room at 9:05pm. -The medication aide (MA) was assisting another resident and heard a loud noise coming from Resident #5's room. -Resident #5 was lying on the floor between her refrigerator and bathroom door. -The MA asked Resident #5 what happened, and the resident did not respond for 3 minutes. -Resident #5 was very confused.	D 270		

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D 270	Continued From page 7 -Resident #5 had no apparent injuries. Interview with a MA on 08/29/24 at 3:10pm revealed: -She completed the Incident/Accident report for Resident #5's fall on 08/28/24. -Staff heard a noise from Resident #5's room. -Resident #5 fell on 08/28/24 during second shift. -Resident #5 was breathing, but was very confused and not responding to staff questions. Review of staff resident monitoring documentation sheet dated 08/28/24 revealed staff checked on and offered toileting assistance to Resident #5 every two hours from 8:00am to 10:00pm. f. Review of an Incident/Accident report dated 08/29/24 revealed: -Resident #5 had an unwitnessed fall in her room at 5:56am. -She was found by a MA. -She was observed on the floor in her room. -She was wearing a sling on her left arm and regular socks. -She told the MA she "did not know how she ended up on the floor." -There was red bruising on Resident #5's forehead. Review of Resident #5's PT notes revealed: -Resident #5 received PT services beginning on 07/11/24 to 08/30/24. -There was documentation on 08/30/24 Resident #5 was non-weight bearing in her left upper extremity. -Severe pain from her left arm fracture was preventing ambulation at the time of PT service. -PT recommended Resident #5 only use her wheelchair for mobility with staff assistance and	D 270		

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D 270	Continued From page 8 to have staff assistance with all transfers. Review of Resident #5's OT notes revealed: -Resident #5 received OT services beginning on 07/12/24 to 08/28/24. -There was documentation on 08/23/24 Resident #5 attempted to complete mobility around her room without using a front wheeled walker placing the resident at high fall risk. -Resident #5 required constant verbal, visual, and tactile instruction cues to use a front wheeled walker at all times. Interview with a personal care aide (PCA) on 08/29/24 at 5:33pm revealed: -She checked on the residents every two hours. -She was told to check on Resident #5 more frequently after Resident #5 fell and fractured her arm on 08/24/24. -If a resident fell, she let the MA know and tried to comfort the resident. -If a resident was on the toileting list, she walked around to all of the residents on her hallway and asked if they needed assistance with toileting every two hours. -Resident #5 was currently using a wheelchair for an assistive device, and thought Resident #5 was using a walker for an assistive device before her fall on 08/24/24. -Resident #5 needed assistance with toileting, dressing, and transfers since her fall on 08/24/24. -She was not told to do anything differently as far as implementing interventions to reduce the risk of falls for Resident #5. Interview with a second PCA on 08/29/24 at 5:39pm revealed: -She checked on the residents every two hours. -She documented her resident checks.	D 270		

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D 270	Continued From page 9 -She was told to check on Resident #5 more frequently after Resident #5 fell and fractured her arm on 08/24/24. -Resident #5 was mostly independent before the week of 08/24/24. -If a resident fell, she checked on the resident and then informed the MAs that a resident had fallen. Interview with a MA on 08/29/24 at 5:17pm revealed: -Resident #5 was independent for the most part. -Resident #5 was sometimes confused about the time of day. -She did not think Resident #5 had a history of falls prior to June 2024. -She thought Resident #5 was aware of what was happening and when Resident #5 was in pain. -She was not sure if Resident #5 was a high fall risk. -She did not know if there were any interventions put in place for Resident #5 following her falls. -She tried to ensure Resident #5 had shoes or gripper socks on and Resident #5's call bell was in reach. -She thought Resident #5 was on the toileting list and was offered toileting assistance very two hours. -She thought Resident #5 had fallen more frequently the week of 08/24/24 because she wanted to be independent and was not asking for help from staff. -All residents were checked on every two hours. -She knew to check on Resident #5 more frequently following her falls. -No one had told her to check on Resident #5 more frequently before the fall on 08/24/24, because Resident #5 was mostly independent prior to 08/24/24. -Whenever a resident fell, she found out if	D 270		

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D 270	Continued From page 10 anyone witnessed the fall. -She checked range of motion and vital signs after a resident fell. -She checked for injuries after a resident fell. -She notified the PCP and emergency contact after a resident fell. -She completed an Incident/Accident report after a resident fell. Interview with a second MA on 08/29/24 at 5:25pm revealed: -The PCAs checked on all the residents every two hours. -Staff had told her to check on Resident #5 more frequently after Resident #5 fell on 08/24/24. -Prior to 08/24/24, she was not told to check on Resident #5 more frequently. -When a resident fell, she checked for injuries and checked vital signs. -She checked range of motion. -If a resident had no apparent injury, she helped them to stand up. -She notified the PCP and the residents' family members after a fall. -She notified the Director of Nursing (DON) of resident falls and completed an Incident/Accident report. Interview with the Resident #5's PCP on 08/29/24 at 4:20pm revealed: -She was aware of all six of Resident #5's falls since 06/29/24 and had seen Resident #5 after every fall. -She thought the cause of most of Resident #5 falls was Resident #5 trying to be independent and not asking for staff assistance. -She thought the staff had done "a lot of interventions" after Resident #5's falls. -The facility "could not do fall mats or bed alarms" and could only monitor residents more frequently	D 270		

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D 270	Continued From page 11 and offer toileting assistance. -The facility would not use fall mats because when they were used previously, residents with fall mats were at increased risk for falls because the fall mats created a tripping hazard. -She would not have expected staff to do additional interventions to decrease the risk of Resident #5 falling after her previous falls. Interview with the DON on 08/29/24 at 6:30pm revealed: -Staff were told to watch for signs of Resident #5 being in pain after she had falls. -Resident #5 insisted on dressing and toileting herself independently. -She expected all residents to be checked on at least every two hours in general. -There were no additional interventions implemented following Resident #5's falls that were documented. Interview with the Administrator on 08/29/24 at 6:12pm revealed: -She was aware of all six of Resident #5's falls. -After a resident fell, she expected staff to document, complete an Incident/Accident report, and notify the DON. -She expected staff to check on Resident #5 every hour after her falls instead of every two hours. -She verbally told PCAs and MAs to check on Resident #5 every hour, but the staff documentation sheets for resident monitoring checks did not change and were only documented every two hours. -There was no written documentation of hourly checks for Resident #5, only every two hours. -She expected staff to ensure there were no trip hazards in Resident #5's room.	D 270		

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D 270	Continued From page 12 The facility failed to provide supervision for a resident (#5) who had 6 unwitnessed falls resulting in hospital visits for a fractured arm, a laceration to her head, and sustained bruising to her forehead. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on August 29, 2024. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 13, 2024.	D 270		9/23/2024
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure referral and follow-up for 2 of 7 sampled residents (#4 and #5) related to a resident who did not have a nutritional supplement available for administration and the provider was not notified the supplement was not available; the resident refused medication and the provider was not notified (#4) and there was a physician's order for resident weights that was not completed as ordered (#4 and #5). The findings are: Based on observations, interviews, and record reviews, the facility failed to provide a therapeutic	D 273	PLAN OF CORRECTION Measures to correct deficient area: • Past 30 days of MARs reviewed. Nurse Practitioner notified of any medications, treatments or physician orders not followed.	

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NAME OF PROVIDER OR SUPPLIER TRINITY ELMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3750 HARPER ROAD CLEMMONS, NC 27012		
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D 273	Continued From page 13 diet as ordered for 1 of 3 sampled residents (#4) who had an order for a nutritional supplement. The findings are: 1. Review of Resident #4's current FL2 dated 05/29/24 revealed diagnoses included chronic atrial fibrillation, depression, anxiety disorder, dry eye syndrome, and constipation. a. Review of Resident #4's primary care provider's (PCP's) progress note dated 06/04/24 revealed: -Resident #4's biggest issue was her weight and nutrition. -She was very thin and frail as well as having kyphosis. -She requested a vegetarian diet. -She would likely need some type of supplement, but uncertain which one due to her allergy to milk and lactose. Review of Resident #4's PCP's progress note dated 06/18/24 revealed: -Resident #4 had a diagnosis of protein-calorie malnutrition which was chronic and ongoing. -She had a restricted diet as a vegan and did not use sugar. -She would likely need some type of supplement, but uncertain which one due to her allergy to milk and lactose. -Resident #4's family member showed the PCP a protein supplement that contained 30gm of protein. -The PCP was going to order one serving nightly once Resident #4's family member obtained the supplement. Review of Resident #4's June 2024 electronic medication administration record (eMAR) for	D 273	3. Medication/treatments/physician orders will be monitored for any consecutive period of 3 days or more by the HCC, MCC using the attached audit. Audits will be completed weekly x 4 weeks then monthly x 6 months, then quarterly until compliance sustained. Findings will be reviewed in quarterly QAPI meeting.	9/23/2024

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D 273	Continued From page 14 06/19/24 through 06/30/24 revealed: -There was an entry for protein oral powder 1 dose once a day for protein supplement; family to provide the protein powder- medication aide (MA) was to contact Resident #4's family member when running low. -There was documentation protein powder was administered 5 of 12 opportunities between 06/19/24 and 06/30/24. -There was no documentation protein powder was administered on 06/19/24, 06/20/24, 06/23/24, 06/24/24, and 06/26/24 - 06/28/24 due to "waiting on family" and "not here". Review of Resident #4's eMAR for July 2024 revealed: -There was an entry for protein oral powder 1 dose once a day for protein supplement; family to provide the protein powder- medication aide (MA) was to contact Resident #4's family member when running low. -There was documentation protein powder was administered 12 of 31 opportunities. -There was no documentation protein powder was administered on 07/01/24 - 07/05/24, 07/06/24, 07/07/24, 07/15/24 - 07/18/24, 07/20/24 - 07/22/24, 07/24/24 - 07/26/24 and 07/29/24 - 07/31/21 due to "waiting on family". Review of Resident #4's August 2024 eMAR for 08/01/24 through 08/27/24 revealed: -There was an entry for protein oral powder 1 dose once a day for protein supplement; family to provide the protein powder- medication aide (MA) was to contact resident #4's family member when running low. -There was documentation protein powder was administered 11 of 27 opportunities. -There was no documentation protein powder was administered on 08/01/24, 08/03/24,	D 273		

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D 273	Continued From page 15 08/04/24, 08/07/24 - 08/09/24, 08/13/24 - 08/15/24, 08/17/24 - 08/19/24, 08/21/24, and 08/27/24 - 08/31/24 due to "waiting on family" and "waiting on pharmacy". Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/29/24 at 11:50am revealed: -The pharmacy did not have an order for protein powder. -The facility entered all their orders on the eMAR. Observation of nutritional supplements available for Resident #4 revealed there was no protein powder available. Interview with Resident #4 on 08/29/24 at 10:03am revealed: -The facility's primary care provider (PCP) wanted her to have a protein supplement, but she did not need it. -Her family member had not brought any protein powder to the facility that she knew of and she had not been administered any protein powder as a supplement. Interview with a medication aide (MA) on 08/29/24 at 2:42pm revealed: -Protein powder supplement was not available for Resident #4 because the family member never brought it to the facility. -She called Resident #4's family member during the second week of July 2024 and the family member stated she was going to talk to Resident #4 before bringing in the protein powder supplement. -She did not call Resident #4's family member back after the supplement was not brought in. -She did not follow up with Resident #4's PCP to let her know the Resident #4's family member	D 273		

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D 273	Continued From page 16 had not brought in the protein powder supplement that was ordered. Interview with Resident #4's family member on 08/29/24 revealed: -Resident #4 was vegan and did not eat anything with a face. -She found a protein powder supplement for Resident #4 and discussed it with her PCP, but she was afraid that if she purchased the supplement, Resident #4 would not drink it. -She talked to the Director of Nursing (DON) about Resident #4 not wanting to take the protein powder supplement. -She never purchased or brought in the protein powder supplement to the facility. -The DON called her on 08/29/24 about the protein powder supplement and she told the DON to discontinue it. Interview with Resident #4's PCP on 08/29/24 at 8:16am revealed: -She ordered Resident #4 a protein powder supplement that was recommended by Resident #4's family member. -Resident #4's family member was to provide the protein powder supplement for Resident #4. -Staff told her at the beginning of July 2024 that Resident #4's family member had not brought in the protein powder supplement. -She did not know Resident #4 continued to not have the protein powder supplement available. -She expected facility staff to let her know Resident #4 did not have the protein powder supplement available. Interview with the DON on 08/29/24 at 6:30pm revealed: -She noticed the protein powder supplement was not on the medication cart in July 2024, so she	D 273			

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D 273	Continued From page 17 called Resident #4's family member. -She did not think anymore about getting the protein powder supplement discontinued. -She did not remember if the MAs told her in passing that the protein powder supplement was still not available in the facility for Resident #4. -Resident #4's protein levels were normal. Interview with the Administrator on 08/29/24 at 5:41pm revealed: -She called Resident #4's family member in July 2024 to let her know that Resident #4 did not want and did not like the protein powder supplement. -She contacted Resident #4's PCP and requested that the protein powder supplement be discontinued. -MAs were responsible to review the eMARs every 2 weeks looking for medications that had been discontinued or expired and medications that had not been administered. -MAs should have let the DON know if a medication or supplement had not been administered as ordered. b. Review of Resident #4's PCP's progress note dated 07/30/24 revealed: -Resident #4 weighed 86 pounds in June 2024 and in July 2024, her weight was down to 81 pounds. -Resident #4 was a vegan which left her with minimal food choices, but she did have a special menu for her diet. -The PCP spoke to Resident #4's family member about her weight loss and the family member stated she weighed Resident #4 in her room on 07/29/24 and her weight was 84 pounds. -The PCP provided education that she had to calculate weight according to the facility's scale.	D 273		

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D 273	Continued From page 18 Review of Resident #4's physician's orders dated 07/30/24 revealed an order to weigh Resident #4 on the facility scale every morning once daily for weight loss for 7 days. Review of Resident #4's eMAR for July 2024 revealed: -There was an entry to weigh Resident #4 on the facility scale once daily every morning for 7 days at 6:00am. -There was no documentation of weights for Resident #4. Review of Resident #4's eMAR for 08/01/24 through 08/07/24 revealed: -There was an entry to weigh Resident #4 on the facility scale once daily every morning for 7 days. -There was documentation Resident #4 was weighed for 2 of 7 opportunities. -Resident #4 was weighed on 08/01/24 and her weight was 81.8; Resident #4 was weighed on 08/02/24 and her weight was 81.8. -There was no documentation why Resident #4 was not weighed for the remaining 5 days as ordered. Interview with Resident #4 on 08/29/24 at 10:03am revealed: -She weighed herself in her bathroom daily. -She weighed herself this morning, 08/29/24, in her bathroom and she was 84 pounds. -The facility did not weigh her daily and had not weighed her for 7 days in succession at any time. Interview with a MA on 08/29/24 at 2:42pm revealed: -She did not know about Resident #4's order for daily weights for 7 days. -The daily weights for 7 days for Resident #4 should have been completed on third shift at	D 273		

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D 273	Continued From page 19 6:00am. Interview with the DON on 08/29/24 at 6:30pm revealed: -She did not know Resident #4's weights had not been checked as ordered. -MAs were responsible to ensure weights were checked when there was an order. -The order for weights was schedule for 6:00am which was during third shift and was not usually scheduled for third shift, so she did not know what happened. Interview with Resident #4's PCP on 08/29/24 at 8:16am revealed: -She ordered daily weights for Resident #4 per her family member's request. -There had been a discrepancy between the scales that Resident #4 had in her room and the facility's scales and she wanted accurate documentation of weights. -Resident #4 weighed 83.3 pounds when she was admitted in May 2024. -In June 2024, her weight increased to 86.4 and in July and August 2024 her weight has been around 81 pounds. Interview with the Administrator on 08/29/24 at 5:41pm revealed: -She did not know staff had not followed the physician's order to weigh Resident #4 daily for 7 days. -She expected staff to follow Resident #4's physician's orders. c. Review of Resident # 4's physician's orders dated 06/04/24 revealed PreserVision AREDS 2 capsule (used for eye health) 1 capsule twice daily.	D 273		

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D 273	Continued From page 20 Review of Resident #4's eMAR for June 2024 revealed: -There was an entry for PreserVision AREDS 2, 1 capsule twice daily scheduled for administration at 11:30am and 8:00pm. -There was no documentation PreserVision AREDS 2 was administered for 7 of 26 opportunities at 11:30am. -There was no documentation PreserVision AREDS 2 was administered for 4 of 27 opportunities at 8:00pm. Review of Resident #4's eMAR for July 2024 revealed: -There was an entry for PreserVision AREDS 2, 1 tablet twice daily scheduled for administration at 11:30am and 8:00pm. -There was no documentation PreserVision AREDS 2 was administered for 12 of 31 opportunities at 11:30am due to "resident refused". -There was no documentation PreserVision AREDS 2 was administered for 6 of 31 opportunities at 8:00pm due to "resident refused". Review of Resident #4's August 2024 eMAR for 08/01/24 through 08/27/24 revealed: -There was an entry for PreserVision AREDS 2, 1 tablet twice daily scheduled for administration in the morning and at bedtime (no time indicated). -There was no documentation PreserVision AREDS 2 was administered for 1 of 27 opportunities at 8:00pm due to "refused". Observation of Resident #4's medication available for administration on 08/29/24 revealed PreserVision AREDS 2 1 tablet twice daily was available for administration on the medication cart.	D 273		

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D 273	Continued From page 21 Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/29/24 at 11:50am revealed: -Resident #4 had an order for PreserVision AREDS 2, 1 capsule twice daily. -PreserVision was dispensed to the facility on 06/24/24 with a quantity of 30 capsules, and on 07/23/24 and 08/25/24 with a quantity of 30 tablets each time. -The pharmacy changed Resident #4's PreserVision capsules to chewable tablets on 07/23/24 because the soft gel tablets were on a manufacturer back order. Interview with Resident #4 on 08/29/24 at 10:03am revealed: -She had refused the PreserVision tablet a lot because it was a large table and she had difficulty swallowing it. -The PreserVision capsules were changed to a chewable tablet, so she did not need to refuse any longer. Interview with a medication aide (MA) on 08/29/24 at 2:42pm revealed: -Resident #4 used to refuse PreserVision because the capsules were too big, and she could not take them in apple sauce; she had not refused since the capsules were changed to chewable tablets. -When a resident refused medications, MAs were to document the refusal in the eMAR progress notes and contact the resident's PCP after the resident refused a medication a total of 3 times. -She did not let the DON or Resident #4's PCP know that Resident #4 was refusing PreserVision tablets because she could not swallow them. Interview with a second MA on 08/29/24 at 4:22pm revealed:	D 273		

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D 273	Continued From page 22 -Resident #4 refused her PreserVision a lot when it was dispensed in the capsule form. -She did not tell the DON or Resident #4's PCP that Resident #4 refused her PreserVision. -The facility's policy was to call the resident's provider after 3 consecutive refusals. -She must have forgotten to contact Resident #4's PCP. Interview with the DON on 08/29/24 at 6:30pm revealed: -The facility's policy was to notify a resident's PCP if the resident refused medication for 3 consecutive days. -MAs did not always work consecutive days and would not have know there were 3 consecutive refusals. -MAs should have notified her of any refusals and she would notify the PCP when there were 3 consecutive refusals. Interview with Resident #4's PCP on 08/29/24 at 8:16am revealed: -PreserVision was ordered for Resident #4's eyes. -She did not know Resident #4's PreserVision had not been administered as ordered due to Resident #4 refused the medication. -Sometimes Resident #4 took her medications and sometimes she did not. -The facility's refusal policy was to contact her if a medication was refused 3 days in a row. -There were no outcomes of Resident #4 refusing PreserVision. Interview with the Administrator on 08/29/24 at 5:41pm revealed: -She did not know Resident #4 had refused PreserVision. -If a resident refused a medication, 2 other MA's	D 273		

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D 273	Continued From page 23 should try to administer the medication. -The MA should have contacted the resident's PCP after 3 consecutive refusals. -MAs should have looked for refusals on the eMAR and created a note to the facility's PCP. -If the resident had a different PCP, then that PCP should have been contacted. 3. Review of Resident #5's current FL-2 dated 02/06/24 revealed: -Diagnoses included hypothyroidism, atrial fibrillation, and hypertension. -There was an order to check weight before breakfast one time a day every Tuesday and Friday for edema and notify the provider if there was a three-pound weight gain in between weights. Review of Resident #5's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for check weight before breakfast one time a day every Tuesday and Friday; notify provider if three-pound weight gain in between weights. -There was documentation Resident #5's weight was not documented on 07/19/24 and 07/23/24. Review of Resident #5's August 2024 eMAR revealed: -There was an entry for check weight before breakfast one time a day every Tuesday and Friday; notify provider if three-pound weight gain in between weights. -There was documentation Resident #5's weight was not documented on 08/02/24, 08/06/24 and 08/16/24. Interview with Resident #5's primary care provider (PCP) on 08/29/24 at 4:20pm revealed:	D 273		

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D 273	Continued From page 24 -She did not know Resident #5's weights were not documented as ordered two times in July 2024 and 3 times in August 2024. -She expected staff to complete all provider orders for Resident #5's. Interview with Resident #5 on 08/29/24 revealed she did not know if there were any days when staff did not check her weight. Interview with a medication aide (MA) on 08/29/24 at 3:40pm revealed: -She did not complete and document weights for Resident #5 on 07/19/24, 07/23/24, 08/02/24, 08/06/24, and 08/16/24. -She did not complete the order for weights because she thought the weights must be completed before breakfast as ordered. -Resident #5 had already eaten breakfast on the dates her weight was not completed so she did not check Resident #5's weight on those dates. -It was her responsibility as a MA to complete and document weights for Resident #5. Interview with the Director of Nursing on 08/29/24 at 6:30pm revealed: -She did not know Resident #5's weights were not completed as ordered for 2 days in July 2024 and 3 days in August 2024. -MAs were responsible for recording weights on the eMAR and ensuring weights were completed for residents. Interview with the Administrator on 08/29/24 revealed: -She did not know there were 2 days in July 2024 and 3 days in August 2024 where Resident #5's weight was not obtained and documented by staff. -She expected staff to obtain Resident #5's	D 273		

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D 273	Continued From page 25 weight as ordered and document weights on the eMAR.	D 273	PLAN OF CORRECTION	9/26/2024
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there were matching therapeutic diet menus for food service guidance for 4 of 5 sampled residents with physician's orders for a low concentrated sweets (LCS) diet (#3 and #6), a vegetarian LCS diet (#4), and a no added salt (NAS) diet (#5). The findings are: Observation of the kitchen on 08/28/24 at 10:04am revealed there were regular and therapeutic menus available, but there was not a therapeutic menu for a LCS diet, a vegetarian LCS diet, or a NAS diet. Review of the regular menu for the lunch meal service on 08/28/24 revealed lasagna, tossed salad, garlic toast, chocolate mousse, choice of dressing, margarine, and beverage of choice	D 296	Measures to correct deficient area: • Audit all current physician orders for therapeutic diets. • Consult with Registered Dietician to create menu for any diets deemed therapeutic. Measures to prevent problem from occurring again: • Administrator and Dietary Manager to discuss any therapeutic diets prior to admission. Medical Records to alert Administrator and Dietary Manager of any new orders for therapeutic diets. Who will monitor the situation: • Orders for therapeutic diets will be monitored by the Administrator, Dietary Manager and Medical Records. How often monitoring will take place: • Audits will be completed weekly x 4 weeks then monthly x 6 months, then quarterly until compliance sustained. Findings will be reviewed in quarterly QAPI meeting.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2024
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
D 296	Continued From page 26 were to be served. 1. Review of Resident #3's current FL2 dated 07/24/24 revealed: -Diagnoses included Type II diabetes mellitus with diabetic kidney disease and diabetic neuropathy. -There was an order for a LCS diet. Review of the facility's therapeutic diet list dated 07/03/24 revealed Resident #3 was to be served a LCS diet. Observation of the lunch meal service on 08/28/24 between 11:55am and 12:31pm revealed Resident #3 was served lasagna, garlic bread, salad with thousand island dressing, and a square of a chocolate dessert cake which was smaller than the other squares of cake served to residents at her table, and a diet, caffeine free beverage. It could not be determined if Resident #3 was served the appropriate diet because there was no LCS therapeutic diet menu available for staff guidance. Interview with Resident #3 on 08/29/24 at 10:21am revealed: -She was on a LCS diet because she was diabetic. -She was served the same meal as the other residents, but she was served half a dessert and everyone else was served a bigger portion of dessert. Refer to the interview with the Dietary Manager (DM) on 08/29/24 at 9:41am. Refer to the interview with a cook on 08/29/24 at 9:49am.	D 296	Completion dates: • Audit took place on 8/29/2024. • RD consultation completed on 9/3/2024. • Audits have been initiated and will continue until compliance is sustained.	9/26/2024

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NAME OF PROVIDER OR SUPPLIER TRINITY ELMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3750 HARPER ROAD CLEMMONS, NC 27012		
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D 296	Continued From page 27 Refer to the interview with the Director of Nursing (DON) on 08/29/24 at 6:30pm. Refer to the interview with the facility's primary care provider (PCP) on 08/29/24 at 8:16am. Refer to the interview with the Administrator on 08/29/24 at 5:41pm. 2. Review of Resident #6's current FL2 dated 05/17/24 revealed: -Diagnoses included dementia and type II diabetes. -There was an order for a LCS diet. Review of the facility's therapeutic diet list dated 07/03/24 revealed Resident #3 was to be served a LCS diet. Observation of the lunch meal service on 08/28/24 between 11:55am and 12:31pm revealed Resident #6 was served lasagna, garlic bread, salad with thousand island dressing, nutritional supplement, water, and milk. It could not be determined if Resident #6 was served the appropriate diet because there was no 1800 calorie ADA therapeutic diet menu available for staff guidance. Based on observations, record reviews and interviews, it was determined Resident #6 was not interviewable. Refer to the interview with the Dietary Manager (DM) on 08/29/24 at 9:41am. Refer to the interview with a cook on 08/29/24 at 9:49am.	D 296		

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D 296	Continued From page 28 Refer to the interview with the Director of Nursing (DON) on 08/29/24 at 6:30pm. Refer to the interview with the facility's primary care provider (PCP) on 08/29/24 at 8:16am. Refer to the interview with the Administrator on 08/29/24 at 5:41pm. 3. Review of Resident #4's current FL2 dated 05/29/24 revealed: -Diagnoses included chronic atrial fibrillation and constipation. -There was an order for a vegetarian LCS diet. Review of Resident #4's physician's orders dated 06/25/24 revealed an order for a vegetarian LCS diet. Review of the facility's therapeutic diet list dated 07/03/24 revealed Resident #4 was to be served a vegetarian LCS diet. Observation of the lunch meal service on 08/28/24 between 11:55am and 12:31pm revealed Resident #4 was served tuna fish salad with cucumbers and tomatoes and grape juice. It could not be determined if Resident #4 was served the appropriate diet because there was no 1800 calorie ADA therapeutic diet menu available for staff guidance. Interview with Resident #4 on 08/28/24 at 12:04pm revealed: -She was supposed to be on a vegetarian diet. -The facility served her vegetables, soy milk, salmon, and tuna. -Prior to her meals, she wrote down what she	D 296		

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D 296	Continued From page 29 wanted to eat on a piece of paper and gave it to dietary staff. -If the dietary staff did not have available what she wanted, they made substitutions. Interview with Resident #4 on 08/29/24 at 10:03am revealed for the lunch meal on 08/29/24, there was nothing that she could eat on the menu, so she requested tuna fish salad with tomatoes, cucumbers and a whole leaf of lettuce. Refer to the interview with the Dietary Manager (DM) on 08/29/24 at 9:41am. Refer to the interview with a cook on 08/29/24 at 9:49am. Refer to the interview with the Director of Nursing (DON) on 08/29/24 at 6:30pm. Refer to the interview with the facility's primary care provider (PCP) on 08/29/24 at 8:16am. Refer to the interview with the Administrator on 08/29/24 at 5:41pm. 4. Review of Resident #5's current FL2 dated 07/03/24 revealed: -Diagnoses included hypertension, hypothyroidism, hyperlipidemia, dysphagia, osteoporosis, neuropathy, and atrial fibrillation. -There was an order for a NAS diet. Review of the facility's therapeutic diet list dated 07/03/24 revealed Resident #5 was to be served a NAS diet. Observation of the lunch meal service on 08/28/24 between 11:55am and 12:31pm revealed:	D 296		

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D 296	Continued From page 30 -Resident #5 was served the meal in her room. -Resident #5 was served lasagna, garlic bread, and salad with thousand island dressing. -Resident #5 requested a different meal and was served a peanut butter and jelly sandwich, a banana, water, and a nutritional supplement. It could not be determined if Resident #5 was served the appropriate diet because there was no NAS therapeutic diet menu available for staff guidance. Interview with Resident #5 on 08/29/24 at 10:27am revealed: -She was not on a special diet. -She was served the same meal as the other residents at her table at meal times. Refer to the interview with the Dietary Manager (DM) on 08/29/24 at 9:41am. Refer to the interview with a cook on 08/29/24 at 9:49am. Refer to the interview with the Director of Nursing (DON) on 08/29/24 at 6:30pm. Refer to the interview with the facility's care provider (PCP) on 08/29/24 at 8:16am. Refer to the interview with the Administrator on 08/29/24 at 5:41pm. Interview with the DM on 08/29/24 at 9:41pm revealed: -The facility had therapeutic menus, but there were no menus for a LCS, vegetarian LCS, or a NAS diet. - She used the regular menu for guidance to prepare meals for all the resident.	D 296		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/29/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TRINITY ELMS

**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
D 296	Continued From page 31 -She prepared LCS meals by cutting the serving size of the dessert in half. -She prepared NAS meals by not adding salt to the prepared food items. -She prepared the vegetarian LCS meal according to the requested food items of the resident. -She was responsible for ensuring the facility had therapeutic menus available for guidance in preparing meals. -If she needed to change or add a menu, she let the corporate dietician know and she sent her the needed menus. -She had not reached out to the corporate dietician for any menus. Interview with a cook on 08/29/24 at 9:49am revealed: -He used the regular menu to prepare meals for the residents. -There were no menus available for LCS, vegetarian LCS, or NAS. -He did not cook with salt for NAS, gave half portions of desserts for LCS, and served the resident with orders for vegetarian LCS whatever she requested to eat. Interview with the DON on 08/29/24 at 6:30pm revealed: -The DM was responsible for ensuring the facility had matching menus for all therapeutic diets. -She did not know there were no menus available for staff guidance in preparing meals for the residents with LCS, vegetarian LCS, or NAS diet orders. Interview with facility's PCP on 08/29/24 at 8:16am revealed: -She expected the dietary staff to follow therapeutic menus that match the residents'	D 296		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/29/2024
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D 296	Continued From page 32 therapeutic diet orders. -She did not know there were no therapeutic menus available for a LCS, vegetarian LCS, or NAS diets. Interview with the Administrator on 08/29/24 at 5:41pm revealed: -She did not know there were no menus available that matched the residents' therapeutic diet orders. -She expected the DM to reach out to the corporate dietician to let her know that therapeutic diet menus were needed.	D 296		9/26/2024
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#2 and #5) related to an order for a sleep aide and an eye drop (#2) and a thyroid hormone (#2 and #5). The findings are: 1. Review of Resident #2's current FL2 dated 07/03/24 revealed diagnoses included macular	D 358	1. Educate all med techs on refill process and missing medication process. 2. Medications/treatments/physician orders will be monitored for omissions, holds or refusals by the HCC, MCC, shift supervisors. Audits will be completed weekly x 4 weeks then monthly x 6 months, then quarterly until compliance sustained. Findings will be reviewed in quarterly QAPI meetings.	

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D 358	Continued From page 33 degeneration, hypertension, hypothyroidism, hyperlipidemia, dysphagia, osteoporosis, neuropathy, and atrial fibrillation. a. Review of Resident #2's current FL2 dated 07/03/24 revealed an order for mirtazapine 7.5mg (used to treat sleep disturbances) 1 tablet daily. Review of Resident #2's electronic medication administration record (eMAR) for June 2024 revealed: -There was an entry for mirtazapine 7.5mg 1 tablet daily scheduled for administration at 7:00pm. -There was documentation mirtazapine was not administered for 1 of 30 opportunities on 06/28/24 due to "ordered from the pharmacy". Review of Resident #2's eMAR for July 2024 revealed: -There was an entry for mirtazapine 7.5mg 1 tablet daily scheduled for administration at 7:00pm. -There was documentation mirtazapine was not administered for 3 of 31 opportunities on 07/29/24, 07/30/24, and 07/31/24 due to "ordered from the pharmacy", and "on order". Review of Resident #2's August 2024 eMAR for 08/01/24 thorough 08/27/24 revealed: -There was an entry for mirtazapine 7.5mg 1 tablet daily scheduled for administration at 7:00pm. -There was documentation mirtazapine was not administered for 2 of 31 opportunities on 08/01/24 and 08/02/24 due to "ordered from the pharmacy", "on order", and "on order-pharmacy needs a doctor's prescription". Observation of medication available for Resident	D 358	Who will monitor the situation: • HCC and MCC will monitor MARs for omissions, holds or refusals of any physician order. How often monitoring will take place: 1. Audits will be completed weekly x 4 weeks then monthly x 6 months, then quarterly until compliance is sustained. Findings will be reviewed in quarterly QAPI meeting. Completion dates: • Review of past 30 days of MARS completed 9/5/2024. • Education completed on 9/6/2024. • Audits have been initiated and will continue until compliance is sustained.	9/26/2024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TRINITY ELMS

**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
D 358	Continued From page 34 #2 on 08/29/24 at 3:10pm revealed: -There was a bubble pack of mirtazapine 7.5mg 1 tablet daily. -Mirtazapine was dispensed from the pharmacy on 08/05/24 with a quantity of 30 tablets and 6 tablets were remaining. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/29/24 at 11:50am revealed: -Resident #2 had an order for mirtazapine 7.5mg 1 tablet daily. -Mirtazapine was dispensed to the facility on 05/29/24, 06/27/24, and 08/05/24 with a quantity of 30 tablets each time. Interview with Resident #2 on 08/29/24 at 3:46pm revealed: -She did not know if she missed any doses of mirtazapine. -Sometimes she had trouble sleeping, but some nights she slept pretty good. Interview with a medication aide (MA) on 08/29/24 at 4:22pm revealed: -Resident #2 was out of mirtazapine about 2 weeks ago for about 2 days. -She reordered mirtazapine when she saw it was out and it came on the next day. -MAs were to reorder medication when the pills were down to a designated black line on the bubble pack. Interview with the Director of Nursing (DON) on 08/29/24 at 6:30pm revealed: -She did not know Resident #2 had been out of mirtazapine. -MAs were expected to administer medication as ordered.	D 358		

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D 358	Continued From page 35 Interview with Resident #2's primary care provider (PCP) on 08/29/24 at 8:16am revealed she expected medications to be administered as ordered. Interview with the Administrator on 08/29/24 at 5:41pm revealed: -She expected staff to reorder medications a week before the medication ran out. -There were medications in overstock, and she expected staff to check the overstock before reordering. -She did not know Resident #2 had been out of mirtazapine. Refer to the interview with a MA on 08/29/24 at 2:42pm. Refer to the interview with the DON on 08/29/24 at 6:30pm. b. Review of Resident #2's current FL2 dated 07/03/24 revealed an order for latanoprost 0.005% (used to treat glaucoma) instill 1 drop in both eyes once daily. Review of Resident #2's eMAR for July 2024 revealed: -There was an entry for latanoprost 0.005% instill 1 drop in both eyes once daily scheduled for administration at bedtime (no time documented on the eMAR). -Latanoprost was documented as not administered on 5 of 30 opportunities on 07/02/24, 07/06/24, 07/07/24, 07/09/24, and 07/10/24 due to "eye drops are not in the facility". Review of Resident #2's August 2024 eMAR for 08/01/24 through 08/27/24 revealed: -There was an entry for latanoprost 0.005% instill	D 358		

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D 358	Continued From page 36 1 drop in both eyes once daily scheduled for administration at bedtime (no time documented on the eMAR). -Latanoprost was documented as not administered on 3 of 27 opportunities on 08/23/24, 08/24/24, and 08/26/24 due to "medication is not in the facility; it has been ordered and will be picked up on morning of 08/24/24", "not in the facility", and "eye drops are not on the med cart, in the med room, or in the facility". Observation of medication available for Resident #2 on 08/29/24 at 3:10pm revealed: -There was a bottle of latanoprost 0.005% eye drops. -Latanoprost was dispensed from the pharmacy on 08/28/24 with a quantity of 2.5ml and it could not be determined how much was left. Interview with a pharmacist from the facility's contracted pharmacy on 08/29/24 at 11:50am revealed: -Resident #2 had an order for latanoprost 0.005% 1 drop in both eyes daily. -Latanoprost with dispensed on 06/20/24, 07/12/24, and 08/28/24. -On 07/12/24, Resident #2's ophthalmologist wrote an order for a 1 time fill. -When a new prescription was needed to refill a medication, the pharmacy contacted the provider to request a new order and let the facility know that a new order was needed so that "the ball did not get dropped". -A bottle of latanoprost could last from 25 to 32 days. Telephone interview with Resident #2's ophthalmologist on 08/29/24 at 12:25pm revealed:	D 358			

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D 358	Continued From page 37 -Resident #2 was prescribed latanoprost due to a diagnosis of glaucoma. -Latanoprost helped to control the pressure in her eyes so she did not lose more vision. -The facility had not reached out to the ophthalmologist office for a refill of her latanoprost. -On 08/26/24, Resident #2 left a message on the online portal stating that she had not received her eye drops for the last week. -The message was that Resident #2 had asked the facility staff about her latanoprost and was told that the pharmacy sent a refill request to the ophthalmologist's office and had not received a response; she would like to get her latanoprost so she could take her medication as ordered. -An order was sent to the pharmacy for latanoprost on 08/28/24. Interview with Resident #2 on 08/29/24 at 3:46pm revealed: -She was administered latanoprost eye drops for glaucoma, but the MAs had not administered the eye drops in almost a week. -She asked the MAs for her eye drops and was told that they were waiting on the pharmacy to send them. -The facility had been out of her drops before, about 6 to 8 months ago. Interview with a MA on 08/29/24 at 4:22pm revealed: -Resident #2 was out of latanoprost for about a week. -Another MA said they ordered latanoprost from a backup pharmacy over the weekend prior to 08/29/24, but when she called the backup pharmacy prior to picking up the latanoprost, a pharmacy representative stated that they did not have any information regarding the latanoprost.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/29/2024
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
D 358	Continued From page 38 -She thought latanoprost would be delivered from the pharmacy on the following Monday. Interview with the DON on 08/29/24 at 6:30pm revealed: -She did not know Resident #2 had been out of latanoprost. -MAs were expected to administer medication as ordered. Interview with Resident #2's PCP on 08/29/24 at 8:16am revealed she expected medications to be administered as ordered. Interview with the Administrator on 08/29/24 at 5:41pm revealed: -She expected staff to reorder medications a week before the medication ran out. -There were medications in overstock, and she expected staff to check the overstock before reordering. -She did not know Resident #2 had been out of latanoprost for a week. -If she had known, she would have reached out to the provider herself. Refer to the interview with a MA on 08/29/24 at 2:42pm. Refer to the interview with the DON on 08/29/24 at 6:30pm. c. Review of Resident #2's current FL2 dated 07/03/24 revealed an order for levothyroxine sodium 50mcg (used to treat hypothyroidism) 1 tablet daily . Review of Resident #2's eMAR for July 2024 revealed: -There was an entry for levothyroxine sodium	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/29/2024
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
D 358	Continued From page 39 50mcg 1 tablet daily scheduled for administration at 6:30am. -Levothyroxine was documented as not administered on 3 of 30 opportunities on 07/06/24, 07/07/24, and 07/09/24 due to "waiting on pharmacy", "medicine has not arrived yet", and "not available". Review of Resident #2's August 2024 eMAR for 08/01/24 through 08/28/24 2024 revealed: -There was an entry for levothyroxine sodium 50mcg 1 tablet daily scheduled for administration at 6:30am. -There was no documentation Levothyroxine was administered on 5 of 31 opportunities on 08/07/24, 08/08/27, 08/11/24, 08/12/24, and 08/21/24 due to "not available" and there were 3 blank spaces. Observation of medication available for Resident #2 on 08/29/24 at 3:10pm revealed: -There was a bubble pack of Levothyroxine 50mcg 1 tablet daily. -Levothyroxine was dispensed from the pharmacy on 08/06/24 with a quantity of 30 tablets and 14 tablets were remaining. Interview with a pharmacist from the facility's contracted pharmacy on 08/29/24 at 11:50am revealed: -Resident #2 had an order for levothyroxine 50mcg 1 tablet daily. -Levothyroxine was dispensed to the facility on 06/06/24, 07/06/24, and 08/06/24 with a quantity of 30 tablets each time. Interview with Resident #2 on 08/29/24 at 3:46pm revealed she did not know if she missed any doses of levothyroxine.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER TRINITY ELMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3750 HARPER ROAD CLEMMONS, NC 27012		
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D 358	Continued From page 40 Interview with a MA on 08/29/24 at 4:22pm revealed: -Medications should have been reordered when they were down to the black line on the medication bubble pack. -She did not know if Resident #2 had been out of levothyroxine. Interview with the DON on 08/29/24 at 6:30pm revealed: -She did not know Resident #2 had been out of levothyroxine. -She expected Resident #2's medications to be administered as ordered. Interview with Resident #2's PCP on 08/29/24 at 8:16am revealed she expected medications to be administered as ordered. Interview with the Administrator on 08/29/24 at 5:41pm revealed: -She expected staff to reorder medications a week before the medication ran out. -There were medications in overstock, and she expected staff to check the overstock before reordering. -She did not know Resident #2 had been out of levothyroxine. Refer to the interview with a MA on 08/29/24 at 2:42pm. Refer to the interview with the DON on 08/29/24 at 6:30pm. 2. Review of Resident #5's current FL-2 dated 02/06/24 revealed: -Diagnoses included hypothyroidism, atrial fibrillation, and hypertension. -There was an order for levothyroxine sodium (a	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER TRINITY ELMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3750 HARPER ROAD CLEMMONS, NC 27012		
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D 358	Continued From page 41 medication used to treat hypothyroidism) 50mcg take one tablet daily. Review of a signed physician's order dated 04/04/24 revealed there was an order for levothyroxine sodium 50mcg take one time a day on Tuesday, Thursday, Saturday, and Sunday. Review of Resident #5's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for levothyroxine sodium 50mcg take one time a day on Tuesday, Thursday, Saturday, and Sunday, scheduled for administration at 6:30am. -There was documentation levothyroxine sodium 50mcg was not administered and the eMAR was blank on 06/09/24, 06/16/24, 06/25/24, 06/27/24, and 06/30/24. Review of Resident #5's July 2024 eMAR revealed: -There was an entry for levothyroxine sodium 50mcg take one time a day on Tuesday, Thursday, Saturday, and Sunday, scheduled for administration at 6:30am. -There was documentation levothyroxine sodium 50mcg was not administered and the eMAR was blank on 7/04/24 and 07/06/24. -There was documentation levothyroxine sodium 50mcg was not administered with the reason as "medicine on order" on 07/07/24. -There was documentation levothyroxine sodium 50mcg was not administered with the reason as "medication not available on 07/09/24 and 07/13/24". Review of Resident #5's August 2024 eMAR revealed: -There was an entry for levothyroxine sodium	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/29/2024
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NAME OF PROVIDER OR SUPPLIER TRINITY ELMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3750 HARPER ROAD CLEMMONS, NC 27012
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D 358	Continued From page 42 50mcg take one time a day on Tuesday, Thursday, Saturday, and Sunday, scheduled for administration at 6:30am. -There was documentation levothyroxine sodium 50mcg was not administered and the eMAR was blank on 08/11/24 with no reason documented for not administered. Observation of Resident #5's medications on hand on 08/29/24 at 4:10pm revealed: -There were two medication cards of levothyroxine sodium 50mcg tablets available for administration. -The first medication card of levothyroxine sodium 50mcg was dispensed on 07/24/24 and there were 13 of 30 tablets remaining. -The second medication card of levothyroxine sodium 50mcg take one time a day on Tuesday, Thursday, Saturday and Sunday was dispensed on 08/06/24 and there were 2 of 16 tablets remaining. Telephone interview with a representative from the facility's contracted pharmacy on 08/29/24 at 11:55am revealed: -Resident #5's current active order for levothyroxine sodium 50mcg were take one time a day on Tuesday, Thursday, Saturday, and Sunday. -Levothyroxine sodium 50mcg was dispensed for Resident #5 on 08/29/24, 08/06/24, 07/15/24, 06/05/24, and 05/14/24 with a quantity of 16 tablets dispensed each time which was a 28-day supply. -The facility entered all their medication orders onto the eMAR. Interview with Resident #5's primary care provider (PCP) on 08/29/24 at 4:20pm revealed: -She was not aware Resident #5 was not	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/29/2024
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D 358	Continued From page 43 administered her levothyroxine sodium as ordered. -She expected there to be no side effects from Resident #5 missing a few weeks of levothyroxine sodium. -She expected staff to administer medications as ordered. Interview with Resident #5 on 08/29/24 at 7:10pm revealed she did not know which of her medications was levothyroxine sodium. Interview with a medication aide (MA) on 08/29/24 at 3:46pm revealed: -She was not sure why Resident #5's levothyroxine sodium was not administered as ordered. -She thought staff may have administered the levothyroxine sodium and forgotten to document administration on the dates the eMAR was blank. Interview with the Director of Nursing (DON) on 08/29/24 at 6:30pm revealed she did not know Resident #5's levothyroxine sodium was not administered as ordered for 6 of 17 doses in June 2024, 5 of 17 doses in July 2024, and 1 of 16 doses in August 2024. Interview with the Administrator on 08/29/24 at 6:12pm revealed: -She did not know Resident #5's levothyroxine sodium was not administered as ordered 6 of 17 doses in June 2024, 5 of 17 doses in July 2024, and 1 of 16 doses in August 2024. -If levothyroxine sodium was not available to be administered to Resident #5, staff should have let her know. -She expected staff to administer medications as ordered and document medication administration on the eMAR.	D 358		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TRINITY ELMS

**3750 HARPER ROAD
CLEMMONS, NC 27012**

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D 358	Continued From page 44 Refer to the interview with a MA on 08/29/24 at 2:42pm. Refer to the interview with the DON on 08/29/24 at 6:30pm. Interview with a MA on 08/29/24 at 2:42pm revealed: -MAs were to reorder medications 2 weeks prior to the medication running out and reordered on the eMAR system. -All new medications delivered to the facility from the pharmacy were placed in bins in the medication room until the medication ran out on the medication cart. -Once the last pill was popped and administered on a bubble card, the MA was to go to the overstock and find the new medication bubble card to put on the medication cart. -If the MA did not see the new medication bubble card in overstock, the MA was to call the pharmacy to see if the medication was reordered. -New medication bubble cards were not kept on the medication cart because there was not enough room to store them on the medication cart. Interview with the DON on 08/29/24 at 6:30pm revealed: -All MAs were recently retrained and had new medication clinical skills competencies completed with return demonstration. -Each medication bubble pack was marked with a black line by the pharmacy and MAs were responsible for reordering medications when the pill count got to the black line. -If a resident was out of medication, MAs checked in the overstock room to see if the medication had recently been delivered from the	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/29/2024
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D 358	Continued From page 45 pharmacy. -If the medication was not in the overstock room then the MA was to contact the pharmacy. -If it was after hours or on a weekend and a resident was out of medication, staff should contact her so she could try to get the medication from the backup pharmacy. -The third shift MA/Supervisor was expected to audit the medication carts weekly and the facility's contracted pharmacy audited the medication carts monthly. -She expected staff to reorder medication before it ran out, about a week in advance.	D 358		9/26/2024
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication aides (MA) observed a resident (#4) take their medications related to the resident's medications were left in the resident's room by a MA. The findings are: Review of Resident #4's current FL2 dated 05/29/24 revealed diagnoses included chronic	D 366	1. Educate all med-techs on regulation to observe residents taking their medication. 2. Medication administration (from pulling medications, delivery to resident and subsequent documentation) will be monitored by HCC, MCC and shift supervisors. Audits will be completed weekly x 4 weeks then monthly x 6 months, then quarterly until compliance sustained. Findings will be reviewed in quarterly QAPI meetings.	

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D 366	Continued From page 46 atrial fibrillation, depression, anxiety disorder, dry eye syndrome, and constipation. Review of Resident #4's physician's orders dated 06/04/24 revealed: -There was an order for flecainide acetate (used to treat atrial fibrillation) 50mg 1 tablet once daily. -There was an order for vitamin D3 (used to treat vitamin D deficiency) 50mcg 1 tablet daily. -There was an order for PreserVision AREDS 2 (used for eye health) 1 capsule twice daily. -There was an order for multivitamin women 50+ tablets (for supplement) 1 tablet twice a day. -There was an order for senna 8.6mg (used to treat constipation) 1 tablet twice daily. Review of Resident #4's electronic medication administration record (eMAR) for 08/01/24 through 08/28/24 revealed: -There was an entry for flecainide acetate 1 tablet daily scheduled for administration in the am (no time documented on the eMAR). -There was an entry for vitamin D3 50mcg 1 tablet daily schedule for administration in the am (no time documented on the eMAR). -There was an entry for PreserVision AREDS 2, 1 tablet twice daily scheduled for administration in the am and at bedtime (no time documented on the eMAR). -There was an entry for multivitamin women 50+ 1 tablet twice daily scheduled for administration in the am and pm (no time documented on the eMAR). -There was an entry for senna 8.6mg 1 tablet twice daily scheduled for administration in the am and at bedtime (no time documented on the eMAR). Observation of Resident #4's room on 08/29/24 at 10:03am revealed:	D 366	Who will monitor the situation: • HCC, MCC and shift supervisors will observe medication administration to ensure compliance. How often monitoring will take place: 1. Audits will be completed weekly x 4 weeks then monthly x 6 months, then quarterly until compliance sustained. Findings will be reviewed in quarterly QAPI meeting. Completion dates: • Education/disciplinary action took place on _____ • Staff education was completed on 9/6/2024. • Audits have been initiated and will continue until compliance is sustained.	9/26/2024

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D 366	Continued From page 47 -Resident #1 was sitting in front of a side table. -There was a pill crusher pouch on the table with a white residue, a cup of a beverage with a spoon in it, a medication cup with a large pink tablet, an orange tablet sitting on top of an unopened container of applesauce, an empty medication cup, and Resident #2 was placing a white tablet in her mouth. Interview with Resident #4 on 08/29/24 at 10:03am revealed: -She had a multivitamin crushed and mixed in her beverage, the pink tablet was PreserVision, and the orange tablet was a stool softener that she took with her applesauce. -She went down to the medication cart to get her medications from the MA. -Usually when it took a long time to get her medicine, she went to the medication cart instead of waiting for the MA to come to her. Interview with a MA on 08/29/24 at 2:42pm revealed: -When she administered medications to residents, she first looked at the medication, popped it into a medication cup, administered the medication to the resident, watched the resident take the medication, and then documented the medication administration on the eMAR. -Resident #4 was administered a multivitamin, flecainide, PreserVision AREDS 2, Senna, and Vitamin D during the morning medication pass; she crushed the multivitamin for Resident #4. -She took Resident #4's medications to her room and was supposed to watch her take them. -She did not watch Resident #4 take her morning medications on 08/29/24. -"I guess I was in a hurry." -She carried Resident #4's morning medications to her room on 08/29/24 and when she got to her	D 366		

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D 366	Continued From page 48 room, she sat the medications down on Resident #4's side table. -She knew she should not have left the medications in Resident #4's room without watching her take them. Interview with the Director of Nursing (DON) on 08/29/24 at 6:30pm revealed: -All MAs were recently retrained and had new medication clinical skills competencies completed with return demonstration. -Watching residents take their medication was a part of the medication training. -She expected all MAs to watch residents take their medications. Interview Resident #4's primary care provider (PCP) on 08/29/24 at 11:14am revealed she thought Resident #4 was capable of taking her medications independently, but she expected staff to administer Resident #4's medications and watch her taken them. Interview with the Administrator on 08/29/24 at 5:41pm revealed: -She just provided a refresher course 3 days ago on medication administration including staff watching residents take their medications. -All MAs signed off to confirm their understanding of the information provided in the course. -It was the facility's policy for MAs to watch residents take their medication and she expected staff to follow the policy.	D 366			