STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034085	A. BUILDING: _____ B. WING _____	03/04/2026

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 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 03/03/26 to 03/04/26.	D 000		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at each meal for the assisted living (AL) residents in addition to other beverages. The findings are: Observation of the lunch meal service on 03/03/26 for the AL dining room between 11:45am and 12:30pm revealed: -There were 43 residents present for the lunch meal service. -The beverages were served by the personal care aides (PCA). -Beverages included soda drinks, milk, juice, coffee, and water. -The PCAs poured soda and juice for all the residents and offered milk to each resident. -Seven residents were served water upon the resident's request and all the other residents were	D 306		

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served other beverages.
-No other residents were served water.

Observation of the breakfast meal service on 03/04/26 for the AL dining room between 7:40am and 8:20am revealed:
-There were 34 residents present for the breakfast meal service.
-The beverages were served by the PCAs.
-Beverages included juice, milk, coffee, and water.
-The PCAs poured juice and coffee for all the residents and offered milk to each resident.
-Three residents were served water upon the resident's request and all the other residents were served other beverages.
-No other residents were served water.

Interview with a resident on 03/04/26 at 8:00am revealed:
-Beverages served with meals usually included coffee, juice, and soda drinks.
-If she wanted water with her meals, she had to ask for it.
-She would drink water with every meal if it was served to her with each meal.

Interview with a second resident on 03/04/26 at 8:05am revealed:
-Residents were not usually offered or served water with each meal.
-He would drink water with his meals if it was served to him.
-He drank what was served to him and did not ask for water.

Interview with a PCA on 03/04/26 at 8:10am revealed:
-She assisted in the AL dining room during meals.
-Water was always available as a beverage for all

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residents.
-She offered water because some of the AL residents refused to drink the water.
-She was not aware water should have been served to all residents with each meal because she thought water was optional for the residents.

Interview with a second PCA on 03/04/26 at 8:15am revealed:
-She assisted in the AL dining room during meals.
-Water was always available as a beverage for all residents.
-The PCAs usually served the residents beverages.
-She did not know water should have been served to all residents with each meal because she thought water was optional for the residents.

Interview with the Dietary Manager (DM) on 03/04/26 at 8:20am revealed:
-She was aware water should have been served daily to all AL residents with each meal.
-Water was always available as a beverage for the AL residents.
-She was aware water was not served with the lunch meal service on 03/03/26 or with the breakfast meal service on 03/04/26 because residents had previously refused water when PCAs served them water.
-She expected water to be served to the AL residents during every meal but communication had been overlooked between the dietary department and the PCAs.

Interview with the Resident Care Coordinator (RCC) on 03/04/26 at 8:39am revealed:
-She was aware residents should have been served water daily with each meal.
-She was not aware AL residents had not been served water with each meal.

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D 306	Continued From page 3 -She expected water to be served to all residents during every meal according. Interview with the Director of Nursing (DON) on 03/04/26 at 8:32am revealed: -She was aware water should have been served daily to all residents with each meal. -She was aware water was not served with the lunch meal service on 03/03/26 or with the breakfast meal service on 03/04/26. -Residents had refused water previously when served by the PCAs so water was offered to the residents in the AL. Interview with the Administrator on 03/04/26 at 10:05am revealed: -She knew water was on the cart to be served water with each meal and expected water to be offered to the residents. -She knew residents were to be served water with each meal but most AL residents had refused water previously.	D 306		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by:	D 378		

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Based on observations, record reviews, and interviews, the facility failed to ensure all medications were maintained under locked security except when under the direct physical supervision of staff in charge of medication administration, including a resident (#1) who stored medications in an unlocked bathroom cabinet.

The findings are:

Review of Resident #1's current FL2 dated 03/03/26 revealed diagnoses included chronic kidney disease, anemia, hypertension (HTN), hypothyroidism, chronic obstructive pulmonary disease (COPD), proteinuria, osteoporosis, nephritic syndrome and glaucoma.

Review of Resident #1's most recent Licensed Health Professional Support (LHPS) assessment completed on 01/08/26 revealed Resident #1 was alert and oriented x3.

Observation of the room where Resident #1 resided on 03/03/26 at 9:44am revealed:
-There were 6 medications in her bathroom cabinet, including an over-the-counter (OTC) pain relief medication, a calcium and vitamin D supplement, a vitamin B12 supplement, a triple antibiotic ointment, a pain relief roll-on gel and a bottle of eye drops used to treat glaucoma.
-The door to Resident #1's room was unlocked.

Observation of room where Resident #1 resided on 03/04/26 at 9:03am revealed:
-There were 10 medications in her bathroom cabinet including an OTC pain relief medication, a calcium and vitamin D supplement, a vitamin B12 supplement, a triple antibiotic ointment, a pain relief roll-on gel, 5 bottles of eye drops used to

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D 378	Continued From page 5 treat glaucoma, laxative suppositories, antacid tablets, 2 vials of inhalation aerosol used to treat COPD and 3 rescue inhalers used to treat sudden breathing problems. -Resident #1's door was unlocked, and she was in the room. Interview with Resident #1 on 03/03/26 at 3:09pm revealed: -She knew there were some medications in her bathroom cabinet but could not recall how many. -Her family put them there when she first moved in and she only got into the cabinet to get a band aid when needed. -Facility staff administered all of her medications daily and she never used any medications from the bathroom cabinet. -She was unable to lock the door to her room when she left but would like to do so because someone came into her room by mistake on at least one occasion. -She would like to keep some medications in her room and self-administer them. Interview with Resident #1's family member on 03/04/26 at 9:03am revealed: -She was aware of the medications in Resident #1's bathroom cabinet but could not recall how long they had been there. -She was unaware if Resident #1 had ever used any of the medications in the bathroom cabinet. Interview with a housekeeper on 03/04/26 at 9:27am revealed: -She cleaned Resident #1's room daily, including her bathroom cabinet. -She did not open the cabinet or Resident #1's drawers. -She had not seen any medications in Resident #1's room and would do nothing if she did.	D 378		

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D 378	Continued From page 6 Interview with a Personal Care Assistant (PCA) on 03/04/26 at 9:31 am revealed: -She provided care to Resident #1 on her scheduled workdays. -She was unaware of medications in Resident #1's bathroom cabinet. -She looked in Resident #1's cabinets and drawers on shower days. -If medications were found in resident rooms, she would notify the Medication Aide (MA) and discard the medications. Interview with an MA on 03/04/26 at 10:54am revealed: -She administered all of Resident #1's medications on her scheduled workdays. -She never looked in Resident #1's cabinets or drawers and was unaware of the medications in her bathroom cabinet. -She found eye drops beside Resident #1's bed on 03/03/26 and removed them, storing them in the medication room. -If medications were found in resident rooms, she removed them and notified the RCC and Director of Nursing (DON) via text message. Interview with Resident Care Coordinator (RCC) on 03/04/26 at 9:14am revealed: -She was not aware of the medications in Resident #1's bathroom cabinet. -Facility staff did not check bathroom cabinets for medications. -All resident medications required physician orders and Resident #1's Primary Care Provider (PCP) was required to write an order to allow her to keep medications in her room. -When medications were discovered in resident rooms, they were immediately removed, the resident and their responsible party (RP) were	D 378		

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D 378	Continued From page 7 informed, the incident was documented, the PCP notified and both staff and the resident were educated. Interview with the DON on 03/04/26 at 9:00am revealed: -She was unaware Resident #1 had medications in her bathroom cabinet until 03/04/26. -An MA had reported medications beside Resident #1's bed on 03/03/26. -Resident room searches are not conducted without consent, and none had been conducted since her employment at the facility. -Families were informed upon admission that all medications required orders and should not be brought in to residents. -She expected PCAs to report medications in resident rooms to the MA, RCC or DON. Interview with the Administrator on 03/04/26 at 11:02am revealed: -She was not aware of medications in Resident #1's bathroom cabinet. -Whoever found medications in resident rooms should report the incident to the RCC, DON and Administrator. -Families were informed verbally upon admission and in writing via the Resident Handbook regarding the facility's policy for medication storage. -There was no monitoring in place for medication storage. -She expected the DON to speak to residents and responsible parties to explain why medications could not be in resident rooms without a doctor's order.	D 378		