

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025
NAME OF PROVIDER OR SUPPLIER Trinity Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 820 Klumac Road Salisbury, NC 28144	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49160 Based on observations, resident and staff interviews, the facility failed to maintain a clean shower room for 1 of 4 shower rooms reviewed for a safe, clean, comfortable, and homelike environment (The C-Hall shower room). The findings included: An interview with Resident #8 on 2/17/25 at 2:27 PM revealed the shower room on the C-Hall where she resides was dirty and there was black mold visible on the walls. Resident #8 stated she did not like using the shower room because it was dirty, and she did not feel clean after her showers. An observation of the C-Hall shower room on 2/18/25 at 11:20 AM revealed there was a buildup of black grime observed around the shower fixtures, along the edges of the floor, and around areas on the wall where the paint was peeling. There was a buildup of black grime around a cabinet hanging on the wall and in the crevices around the cabinet doors. There was also a buildup of black grime observed on the feet of the shower chair and along the bottom of the shower curtain. An interview conducted with Housekeeper #1 on 2/18/25 at 12:30 PM revealed she was assigned the C-Hall shower room and cleaned it on Mondays, Wednesdays and Fridays. She indicated when she cleaned the shower room, she sprayed the walls, the floor, and the shower fixtures with a bleach solution, let it soak, and then wiped everything down. Housekeeper #1 stated she did not monitor the condition of the shower curtain, and the nursing staff were responsible for cleaning the shower chair. She revealed she did not clean the C-Hall shower room on 2/10/25 (Monday), 2/12/25 (Wednesday), or 2/14/25 (Friday) but was unable to recall why. Housekeeper #1 stated she did not work on 2/17/25 (Monday). A phone interview was conducted with Housekeeper #2 on 2/19/25 at 4:15 PM. Housekeeper #2 revealed she covered for Housekeeper #1 on 2/17/25 (Monday) and was assigned to clean the C-Hall shower room. She stated she attempted to clean the shower room after lunch, but it was being used for a resident shower. Housekeeper #2 indicated she had other areas to clean and was unable to clean the shower room before her shift ended at 3:00 PM. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview was conducted in the C-Hall shower room with the Director of Housekeeping on 2/18/25 at 12:02 PM. He revealed Housekeeper #1 was assigned to the C-Hall shower room, and she was responsible for cleaning it daily including wiping down all surfaces with a disinfectant and mopping the floors. He further revealed Housekeeper #1 was responsible for deep cleaning the shower room on Mondays, Wednesdays and Fridays which included spraying the fixtures, the walls and the floor with a bleach solution, letting it soak, wiping everything down and mopping the floors. He stated the areas observed with a buildup of black grime on walls, around the fixtures and along the edge of the floor needed to be cleaned. The Director of Housekeeping observed the black grime on the cabinet, shower chair and shower curtain and stated Housekeeper #1 was responsible for monitoring these items and should have notified him they were in poor condition and needed to be replaced. A phone interview with the Administrator on 2/20/25 at 10:55 AM revealed the Director of Housekeeping managed the cleaning schedule for the shower rooms and the tasks to be completed when it was cleaned. He stated he was not aware there were several areas observed in the C-Hall shower room with a buildup of black grime or the condition of the cabinet, the shower chair or the shower curtain. The Administrator revealed the housekeepers should be cleaning the shower rooms as scheduled and if they observed equipment that was in poor condition they should report it to the Director of Housekeeping.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review, and staff and the Responsible Party (RP) interviews, the facility failed to protect a resident's right to be free from staff to resident abuse. While Nurse Aide (NA) #5 was providing care for a cognitively impaired resident, the resident became agitated, was whining and crying. NA #5 placed part of her hand over the resident's mouth and told the resident to Hush, quit that whining. This deficient practice was found for 1 of 3 residents reviewed for abuse (Resident #16). The findings included: Resident #16 was admitted to the facility on [DATE] with diagnoses which included anxiety, cognitive communication deficit, muscle weakness, dementia, and generalized osteoarthritis. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #16 was severely cognitively impaired and required extensive assistance transfers and toilet use. The MDS further revealed Resident #16 was not coded for any behaviors through the look back period. Review of Resident #16's care plan revised on 11/18/24 revealed the resident may have had altered behaviors, mood, or psychological wellbeing related to changes with health, functioning, and cognitive skills. Resident #16 had the potential or was at risk to be resistive to care, medicines, yelling out, crying and sadness, disrobing, attempting to get out of bed, difficulty to redirect with agitation and anger. The goal was for Resident #16 to maintain comfort and dignity daily by a calm, relaxed manner, and a neat and clean appearance. Interventions included always approaching Resident #16 in a calm and relaxed manner, encouraged activity distraction, explaining all procedures and care before beginning to assist, and monitor and observe and report. Interventions also included when the resident becomes agitated staff would intervene before agitation escalate by guiding away from source of distress, engage calmly in conversation, and if response were aggressive staff would need to walk calmly away, and approach later. Review of the initial facility reported incident dated 01/18/24 at 5:30 PM revealed it was reported that a NA (Nurse Aide) mistreated a resident during care. The report further revealed the employee was suspended during the investigation. It was indicated that residents who were not alert and oriented on the unit of the incident were assessed for visible and mental signs of abuse and residents who were alert and oriented were interviewed. It was revealed Resident #16 showed no signs of physical or mental abuse found during the assessment on 1/18/24. Review of the investigation completed by the Administrator related to Resident #16's incident revealed the following: (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nurse Aide (NA) #5 statement undated read in part, On Thursday 01/18/24 NA #5 was asked to assist to care for Resident #16 because she had tried to take her clothes off and smelled of urine. NA #5 revealed she and a Personal Care Assistant (PCA) #1 took Resident #16 to her room and put her in the resident's bed to be changed. NA #5 further revealed she got the resident laid down in the bed and reassured the resident she was going to be okay once they changed her. NA #5 stated Resident #16 continued to cry while she got a washcloth and started to clean the resident and PCA #1 asked what was wrong with Resident #16. NA #5 indicated she continued to speak to Resident #16 that everything was going to be okay and to stop crying but Resident #16 continued to cry as PCA #1 continued to assist and NA #5 patted her mouth to get her to stop because they were unable to understand what the resident was saying but continued to reassure the resident that everything was okay. NA #5 revealed once care was completed on Resident #16 they got the resident in bed and comfortable to lay down and rest. - Personal Care Assistant (PCA) #1 statement dated 01/18/22 read in part, NA #5 put her hands over Resident #16's mouth while she was crying today and told her to be quiet around 2 PM. A phone interview was conducted with Nurse Aide (NA) #5 on 02/17/25 at 2:50 PM and she revealed on 01/18/25 she and PCA #1 had gone into Resident #16's room and completed incontinence care. NA #5 stated when care began Resident #16 began whining and was agitated. NA #5 indicated throughout care the resident continued to be agitated and she consistently tried to calm the resident down. NA #5 stated halfway through care Resident #16 seemed upset and she took two fingers and tapped Resident #16 on the mouth three times and stated to the resident to hush, quit that whining you are going to be fine. NA #5 indicated looking back she should have never tapped Resident #16 on the mouth. NA #5 revealed she was eventually let go by the facility. NA #5 stated she was not trying to be mean to the resident but should not have tapped her on the mouth. A phone interview conducted with PCA #1 on 02/18/25 at 12:00 PM revealed on 01/18/24 she and NA #5 went into Resident #16's room to give incontinence care. PCA #1 Resident #16 was often upset when staff changed her. PCA #1 further revealed the resident was cognitively impaired and she was unable to understand the resident. PCA #1 indicated Resident #16 started to whine and become agitated at the beginning of care. PCA #1 stated halfway through care NA #5 took her right hand and placed it over Resident #16's mouth and held it for almost 30 seconds and stated, hush, quit that whining, in an aggressive tone. PCA #1 indicated Resident #16's eyes observed to become large in size and appeared to be petrified. PCA #1 indicated she did not say anything to NA #5 and the care continued about 15 more minutes. PCA #1 revealed Resident #16 seemed agitated throughout the whole-time receiving care. A phone interview conducted with Nurse #3 on 02/20/25 at 1:25 PM revealed on 01/18/24 around 5:00 PM it was reported to her by PCA #1 that NA #5 had put her hand over the resident's mouth during care and told the resident to be quiet. Nurse #3 indicated she notified the Administrator and completed an assessment on Resident #16 and found no issues or concerns during her assessment. Nurse #3 indicated Resident #16 was unable to recall any events that occurred that date. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with Director of Nursing (DON) on 02/18/25 at 12:15 PM revealed on 01/18/24 she was not present in the facility but was notified there had been an incident with Resident #16 and NA #5 had put her hand over the resident's mouth and told her to hush and stop crying. The DON further revealed on 01/19/24 she spoke to PCA #1 who stated NA #5 had placed her hand over Resident #16's mouth and told the resident to shhhhh, in an aggressive manner. The DON revealed she had completed NA #5's statement and NA #5 stated she admitted to tapping Resident #16 on the mouth three times. The DON indicated the next day skin assessments and interviews were conducted with alert and oriented residents on Resident #16's unit and no concerns were found. The DON indicated after their investigation that the facility did not feel like the incident was considered abuse due to conflicting stories by staff and there were no signs of abuse of the resident. The DON revealed Resident #16 was often confused and was resistive with care. The DON indicated NA #5 and PCA #1 should have walked away if Resident #16 was upset and agitated during care. A phone interview conducted with the Responsible Party (RP) on 02/20/25 at 4:25 PM revealed they had not been notified of the incident that occurred on 01/18/24. The RP further revealed Resident #16 would have been very upset if she was alert and oriented and a facility staff had told her to be quiet or put their hands on her mouth. An interview conducted with the Administrator on 02/20/25 at 1:55 PM revealed on 01/18/24 he was notified later during first shift around 5:00 PM that PCA #1 had observed NA #5 had spoken to Resident #16 harshly and put her hand over the residents' mouth during care. The Administrator revealed when he discussed the incident with NA #5 she denied holding her hand over the residents mouth but touched and patted the residents lips. The Administrator indicated a skin assessment was completed on Resident #16 and no concerns were found. It was revealed after the investigation that the facility did not substantiate the concern due to conflicting stories by staff and no signs of mental anguish.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 43643 Based on record review and staff interviews, the facility failed to follow and implement abuse policies in the area of identification, protection and reporting for 1 of 3 residents reviewed for abuse (Resident #16). While Resident # 16 was being abused, Personal Care Assistant (PCA) #1 did not stop Nurse Aide (NA) #5 or intervene and did not report the incident immediately to licensed nursing staff or administrative staff. As a result, NA #5 worked the rest of her shift putting other residents at risk for abuse. The findings included: A review of the facility policy and procedure titled Abuse Investigation and Reporting for Senior Services, with a revised date of 04/26/22, read in part 1.) under Identification and Investigation if the person(s) observing or suspecting incidents of resident abuse, neglect, exploitation or misappropriation of property must report such knowledge or suspicion to the nursing supervisor or his/her department manager as soon as he or she is aware of an incident or potential incident. Read in part 2.) Under Protection while the investigation is pending, accused individuals employed by the facility will be suspended, pending the results of the investigation. Review of the investigation completed by the Administrator related to Resident #16's incident revealed the following: - Nurse Aide (NA) #5 statement undated read in part, On Thursday 01/18/24 NA #5 was asked to assist to care for Resident #16 because she had tried to take her clothes off and smelled of urine. NA #5 revealed she and a personal care assistant (PCA) #1 took Resident #16 to her room and put her in the residents bed to be changed. NA #5 further revealed she got the resident laid down in the bed and reassured the resident she was going to be okay once they changed her. NA #5 stated Resident #16 continued to cry while she got a washcloth and started to clean the resident and PCA #1 asked what was wrong with Resident #16. NA #5 indicated she continued to speak to Resident #16 that everything was going to be okay and to stop crying but Resident #16 continued to cry as PCA #1 continued to assist and NA #5 patted her mouth to get her to stop because they were unable to understand what the resident was saying but continued to reassure the resident that everything was okay. NA #5 revealed once care was completed on Resident #16 they got the resident in bed and comfortable to lay down and rest. - Personal Care Assistant (PCA) #1 statement dated 01/18/22 read in part, NA #5 put her hands over Resident #16's mouth while she was crying today and told her to be quiet around 2 PM. A phone interview was conducted with NA #5 on 02/17/25 at 2:50 PM and she revealed on 01/18/25 she and PCA #1 had gone into Resident #16's room and completed incontinence care. NA #5 stated halfway through care Resident #16 seemed upset and she took two fingers and tapped Resident #16 on the mouth three times and stated to the resident to hush, quit that whining you are going to be fine. NA #5 indicated she worked the rest of the shift. Review of NA #5's time card for 1/18/25 revealed she clocked in at 6:57 AM and clocked out at 3:39 PM. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview conducted with PCA #1 on 02/18/25 at 12:00 PM revealed on 01/18/24 at an estimated time of 2:00 PM she and NA #5 went into Resident #16's room to give incontinence care. PCA #1 Resident #16 was often upset when staff changed her. PCA #1 further revealed the resident was cognitively impaired and was unable to understand the resident. PCA #1 indicated Resident #16 started to whine and become agitated at the beginning of care. PCA #1 stated halfway through care NA #5 took her right hand and placed it over Resident #16's mouth and held it for almost 30 seconds and stated, hush, quit that whining, in an aggressive tone. PCA #1 indicated Resident #16's eyes observed to become large in size and appeared to be petrified. PCA #1 indicated she did not say anything to NA #5 and care continued for about 15 more minutes. PCA #1 revealed she failed to intervene and report the incident immediately due to being shocked. Once care ended PCA #1 did not report the incident she observed until between 5 to 5:30 PM to Nurse #3. A phone interview conducted with Nurse #3 on 02/20/25 at 1:25 PM revealed on 01/18/24 around 5:00 PM it was reported to her by PCA #1 that NA #5 had put her hand over the residents' mouth during care and told the resident to be quiet. Nurse #3 indicated PCA #1 did not report the incident immediately and and she educated the PCA that she should have. An interview conducted with the Administrator on 02/20/25 at 1:55 PM revealed on 01/18/24 he was notified later during first shift, around 5:00 PM, that PCA #1 had observed NA #5 speaking to Resident #16 harshly and put her hand over the residents' mouth during care. The Administrator revealed he was aware PCA #1 had waited to report the incident and did not report immediately after the incident occurred. The Administrator indicated as soon as he was aware he suspended NA #5 pending the investigation.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43643 Based on record review and staff interviews, the facility failed to include reported allegations in the initial report to the State Agency. Details were not accurately reflected for 1 of 3 residents reviewed for abuse (Resident #16). The findings included: Review of the initial facility reported incident dated 01/18/24 at 5:30 PM revealed it was reported that a Nurse Aide (NA) #5 mistreated a resident during care. It was revealed Resident #16 showed no signs of physical or mental abuse found during the assessment on 1/18/24. A phone interview conducted with Nurse #3 on 02/20/25 at 1:25 PM revealed on 01/18/24 around 5:00 PM it was reported to her by Personal Care Assistant (PCA) #1 that NA #5 had put her hand over the resident's mouth during care and told the resident to be quiet. Nurse #3 indicated she notified the administrator immediately what NA #5 had alleged. An interview conducted with the Administrator on 02/20/25 at 1:55 PM revealed he completed the initial report to the State Agency. The Administrator further revealed on 01/18/24 he was notified by Nurse #3 that NA #5 had put her hand over the resident's mouth during care and told the resident to be quiet. The Administrator indicated he did not include the information on the initial State Agency report due to the staff statements were conflicting and did not think to add the alleged allegations.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160 Based on record review and staff interviews, the facility failed to provide a safe transfer for 1 of 6 residents (Resident #69) reviewed for accidents. The findings included: Resident #69 was admitted to the facility 1/07/25 with diagnoses including muscle weakness, abnormalities of gait and mobility, and mild cognitive impairment. The admission Minimum Data Set (MDS) dated [DATE] indicated Resident #69 was severely cognitively impaired and dependent on staff for transfers. The care plan dated 1/21/25 revealed Resident #69 required 2-person assistance for all transfers. An incident report dated 2/07/25 12:25 PM completed by Nurse #2 revealed Nurse Aide (NA) #1 was transferring Resident #69 from the wheelchair to a shower chair when Resident #69 was unable to support herself and NA #1 lowered her down to the floor. NA #1 was transferring Resident #69 without a second person and did not use a gait belt. Resident #69 was assessed, and no injuries were noted. A phone interview conducted with NA #1 on 2/19/25 at 2:38 PM indicated she was assigned to Resident #69 on 2/07/25. She revealed Resident #69 was able to stand and pivot to transfer with 2-person assistance. NA #1 stated on 2/07/25 Resident #69's friend was coming to do her hair, and she needed to give Resident #69 a shower. She stated she was unable to find anyone to help her, so she attempted to transfer Resident #69 on her own. She stated she assisted Resident #69 to a standing position, but her legs started to give out. NA #1 revealed she lowered Resident #69 gently to the floor and called for assistance. She stated Nurse #2 and Nurse #3 responded, completed an assessment and Resident #69 was not injured. NA #1 indicated she knew that she should have waited until she was able to find someone to help, but she felt rushed, so she proceeded to transfer Resident #69 without a second person. An interview with Nurse #2 on 2/18/25 at 2:38 PM revealed she was not Resident #69's assigned nurse on 2/07/25 but she responded to assist when Resident #69 was lowered to the floor. She stated NA #1 was transferring Resident #69 by herself from the wheelchair to a shower chair when Resident #69's legs gave out and she had to lower her to the floor. She indicated Resident #69 was assessed and no injuries were noted. Nurse #2 revealed Resident #69 was able to stand and pivot to transfer with 2-person assistance. She indicated when she asked NA #1 why she transferred Resident #69 without a second person she stated she was unable to find anyone to help. Nurse #2 stated she was at the nurse's station with Nurse #3, and both were available to help, however NA #1 did not ask them for assistance. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview with Nurse #3 on 2/19/25 at 4:01 PM revealed she was Resident #69's assigned nurse on 2/07/25. She stated NA #1 called for assistance from Resident #69's room and when she responded she found Resident #69 sitting on the floor. She stated NA #1 reported she was attempting to transfer Resident #69 by herself from her wheelchair to the shower chair when Resident #69's legs gave out and she had to lower her to the floor. She stated she assessed Resident #69, and no injuries were noted. Nurse #3 revealed Resident #69 was able to stand and pivot to transfer with 2-person assistance. She indicated NA #1 reported she was transferring Resident #69 without a second person because she was unable to find someone to assist her. Nurse #3 indicated she was at the nurse's station with Nurse #2 and available to help, however NA #1 did not ask them for assistance. Nurse #3 revealed she told NA #1 she should have asked them to assist her and that transferring Resident #69 on her own was unsafe. A phone interview was conducted with the Director of Nursing (DON) on 2/19/25 at 2:11 PM. She revealed Resident #69 was able to stand and pivot to transfer with 2-person assistance. She stated on 2/07/25 NA #1 reported she was unable to find another staff member to assist, attempted to transfer Resident #69 by herself and had to lower her to the floor. The DON indicated Resident #69 was not injured. She revealed NA #1 stated she was aware that Resident #69 required two staff members for all transfers, and she should not have transferred her until she was able to find a second person to assist. A phone interview was conducted with the Administrator on 2/20/25 at 10:55 AM. He stated if a resident was able to stand and pivot with 2-person assistance to transfer then two staff members should be present during the transfer to ensure the resident was safe.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42007 Based on record review, observations and staff interviews, the facility failed to secure medicated treatment supplies in a locked treatment cart for 1 of 1 treatment cart. Additionally, the facility failed to remove loose pills from a medication cart and failed to label medications which were not stored in their pharmacy or manufacturer packaging for 1 of 3 medication carts reviewed for medication storage (Unit B medication cart). The findings included: 1. During wound care observation on 2/18/25 at 9:30 AM on the D hall, the treatment cart was observed to be in the hallway outside of room D5, unsecured. Residents were noted to be ambulating past the cart without any staff members present. Observation on 2/18/25 at 9:35 AM of the treatment cart revealed it consisted of three- 4 drawer plastic towers, two recycled bedside tabletops (one sitting on top of the plastic towers and one on the bottom) and it was held together by PVC (polyvinyl chloride) piping surrounding the perimeter. There was no locking mechanism on the cart. Observation of the items in the treatment cart drawers on 2/18/25 at 10:15 am with the wound nurse present revealed the following pertinent items: Plastic tower #1 1st drawer-iodine and skin prep pads 2nd drawer-triple antibiotic ointments 3rd drawer-boric acid solution, normal saline, and hydrogen peroxide bottles 4th drawer-resident specific prescription creams and ointments Plastic tower #3 2nd drawer-antibacterial petroleum gauze 3rd drawer-medicated/infused dressings and collagen powders During an interview with the Wound Nurse on 2/18/25 at 10:15 am, she stated she had been in her position for several months. She reported she had used the facility-made treatment cart daily since she started. The Wound Nurse added that she did have the ability to partially lock the cart. She reported during the day, the cart would sit outside various residents' rooms throughout the facility and she would take the necessary items to perform wound care in the rooms with her. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025
NAME OF PROVIDER OR SUPPLIER Trinity Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 820 Klumac Road Salisbury, NC 28144	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with the Director of Nursing (DON) on 2/18/25 at 2:30 PM she stated she was unaware the treatment cart was unsecured throughout the day. She stated all drawers on the facility treatment cart should have the ability to be secured at all times when there wasn't a staff member present. 49295 2. An observation of the Unit-B medication cart was conducted on 2/18/25 at 10:21 AM in the presence of Medication Aide (MA) 1 and Nurse #1. The medication cart contained 3 loose pills of various shapes, colors and sizes laying in the bottom of cart drawers. The medication cart contained two green caplets that were placed in a white clear bag that did not include the medication name, resident name, and/or dosage instructions. MA #1 was interviewed on 2/18/25 at 10:36 AM indicated that someone placed the two green caplets in the clear white bag and left them in the medication cart. MA #1 further stated that facility will usually place medications in the clear white bag for any over the counter medications that need to be given to residents who were being discharged home. Nurse #1 was interviewed on 2/18/25 at 10:40 AM and indicated each nurse assigned to the medication cart was responsible for cleaning the medication cart and ensuring each medication was labeled. An interview was conducted with the Director of Nursing (DON) on 2/18/25 at 11:11 AM. The DON indicated the medication carts were to be cleaned by the nurses on duty. The DON indicated each nurse should clean, organize the medication carts, and discard any loose pills. The DON indicated the nurses oversaw the medication aides. The DON further indicated each nurse and medication aide must use medication from a labeled container and after removing the medication from the original container, must administer the medication to residents immediately per physician orders.		