| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345565 | A. Building<br>B. Wing | 01/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Trinity Elms | 7449 Fair Oaks Drive<br>Clemmons, NC 27012 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49007<br><br>Based on staff interviews and record reviews the facility failed to maintain accurate advance directive information (code status) throughout both the electronic medical record and paper medical record for 1 of 1 resident reviewed for advance directive (Resident #48).<br><br>The findings included:<br><br>Resident #48 was admitted to the facility on [DATE].<br><br>Resident #48's electronic medical record (EMR) revealed a physician's order dated 12/12/24 that read full code.<br><br>Review of Resident #48's paper medical record located at the nurse's station revealed Resident #48 had a signed Do Not Resuscitate (DNR) form dated 12/16/24.<br><br>Resident #48's admission Minimum Data Set (MDS) dated [DATE] revealed Resident #48 was moderately cognitively impaired.<br><br>Resident #48's EMR showed a communication banner on the top of Resident #48's opened EMR and her code status read full code.<br><br>An interview was conducted with Nurse #1 on 1/15/25 at 9:01 AM. During the interview, Nurse #1 indicated if there was an emergency she needed to know code status she would check the hard chart (paper medical record) first. Nurse #1 indicated that if there was a discrepancy between the hard chart and EMR she would check with the Director of Nursing (DON). Nurse #1 verified discrepancy that Resident #48's paper medical record indicated a DNR and her EMR read full code.<br><br>An interview was conducted on 1/15/25 at 9:07 AM with the DON and revealed if an emergency were to happen, staff should check the hard chart located in the binder at the nurse's station to see if there is a DNR. The interview further revealed it was her expectation that the EMR and paper medical record match.<br><br>An interview was conducted on 1/16/25 at 3:16 PM with the Administrator and it was revealed it was her expectation that the paper medical record and EMR should match. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49007<br><br>Based on observations, record review, and staff interviews the facility failed to post cautionary and safety signage outside of resident rooms that indicated the use of oxygen for 3 of 3 residents (Residents #57, #69, and #48) reviewed for respiratory care.<br><br>The findings included:<br><br>a. Resident #57 was admitted to the facility on [DATE] with pneumonia due to hemophilus influenzae (bacteria in the upper respiratory tract).<br><br>A review of Resident #57's physician orders revealed an order dated 12/10/24 for oxygen to be administered continuously via nasal cannula at 1 Liter/minute.<br><br>A review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #57 was coded for receiving oxygen.<br><br>An observation on 1/15/25 at 10:52 AM revealed Resident #57 was sitting in her wheelchair by her door with oxygen being administered via portable oxygen tank via nasal cannula at 1 L/minute. There was no cautionary or safety signage posted at the entrance to Resident #57's room to indicate oxygen was in use.<br><br>An observation of Resident #57 conducted on 1/16/25 at 8:56 AM revealed she was sitting in a wheelchair in her room with oxygen being administered via nasal cannula at 1 L/minute. There was no cautionary or safety signage posted at the entrance to Resident #57's room to indicate oxygen was in use.<br><br>b. Resident #69 was admitted to the facility on [DATE] with acute respiratory failure with hypoxia.<br><br>A review of Resident #69's physician orders revealed an order dated 12/23/24 for oxygen that may titrate up to 2 Liters/minute continuously via nasal cannula to maintain oxygen saturation of greater than 90%.<br><br>A review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #69 was coded for receiving oxygen.<br><br>An observation on 1/13/25 at 11:15 AM revealed Resident #69 was sitting in his wheelchair in his room with oxygen being administered via nasal canula at 1.5 L/minute. There was no safety signage posted at the entrance to Resident #69's room to indicate oxygen was in use.<br><br>An observation on 1/15/25 at 2:29 PM revealed that Resident #69 was sitting in his wheelchair in his room with oxygen being administered via nasal canula at 2 L/minute. There was no safety signage posted at the entrance to Resident 69's room to indicate oxygen was in use.<br><br>c. Resident #48 was admitted to the facility on [DATE] with pneumonia, chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident #48's physician orders revealed an order dated 12/13/24 for 2 L/minute of oxygen continuously via nasal cannula.<br><br>A review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #48 was coded for receiving oxygen.<br><br>An observation on 1/13/25 at 10:44 AM revealed Resident #48 was sitting in her wheelchair in her room with oxygen being administered via nasal cannula at 2 L/minute. There was no safety signage posted at the entrance to Resident #48's room to indicate oxygen was in use.<br><br>An observation on 1/15/25 at 2:16 PM revealed Resident #48 was sitting in her wheelchair in her room with oxygen being administered via nasal canula at 2 L/minute. There was no safety signage posted at the entrance to Resident #48's room to indicated oxygen was in use.<br><br>An interview with the Director of Nursing (DON) was conducted on 1/16/25 at 10:15 AM. She indicated that it was her expectation that the required oxygen signage be posted for residents who received oxygen.<br><br>An interview was conducted with the Administrator on 1/16/24 at 3:19 PM. Interview further revealed that it was her expectation that the facility had the required oxygen signage posted for residents who received oxygen. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725<br><br>Based on record review, observations, and interviews with resident and staff, the facility failed to secure medications observed at bedside for 1 of 1 resident reviewed for medication storage (Resident #77).<br><br>The findings included:<br><br>Resident #77 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, hypertension, hyperlipidemia, anxiety, pleural effusion, and polyneuropathy.<br><br>A review of the electronic medical record revealed an assessment to self-administer medications which was completed on 9/13/24. The assessment indicated that Resident #77 required assistance to administer oral medications and therefore was not approved to self-administer medications or to keep medications at bedside.<br><br>A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #77 was cognitively intact.<br><br>On 1/13/25 at 10:38 AM, an observation was made of medications spread out in a line on Resident #77's overbed table. Resident #77 stated that the medications had been sitting there since this morning. Resident #77 further explained that it was normal for the nurse to leave the medications sitting on the overbed table and the plan was to take the medications when Resident #77 was ready to take them.<br><br>An interview was conducted with Nurse #1 on 1/13/25 at 10:44 AM. She verified she was the nurse that left Resident #77's morning medications on the overbed table for her to take. She also indicated that she thought Resident #77 had been assessed to be safe to self-administer her medications.<br><br>A review of Resident #77's January 2024 medication administration record revealed the medications left on Resident #77's over the bed table included the following: Gabapentin 100 milligrams (mg), Labetalol 100 mg 1 tablet, Clopidogrel 75 mg 1 tablet , Zetia 10 mg 1 tablet, Lasix, Isosorbide 60 mg 1 tablet, Cozaar 100 mg 1 tablet, Multivitamin 1 tablet, Zoloft 50mg 1 tablet.<br><br>The Director of Nursing (DON) was interviewed on 1/13/25 at 11:38 AM. The DON indicated Resident #77's medications should not have been left at bedside. |

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| F 0851<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.<br><br>46725<br><br>Based on record review and staff interviews, the facility failed to submit accurate payroll data on the Payroll Based Journal (PBJ) report to the Centers for Medicare and Medicaid Services (CMS) related to Registered Nurse (RN) hours, licensed nursing coverage 24-hours per day. This was for 1 of 3 quarters reviewed for sufficient nurse staffing (Quarter 4 2024 July 1-September 30).<br><br>Findings included:<br><br>Review of the PBJ for Fiscal Year Quarter 4 2024 (July 1- September 30) revealed there were no Registered Nurse (RN) hours for 9/1/24, 9/4/24, 9/5/24, 9/6/24, 9/10/24, 9/11/24,9/12/24, 9/13/24, 9/14/24, 9/15/24, 9/16/24, 9/18/24, 9/19/24 9/23/24, 9/24/24 9/26/24, 9/27/24, 9/28/24, 9/29/24, and 9/30/24. The PBJ report also noted the facility failed to have licensed nursing coverage 24 hours per day for 9/1/24, 9/2/24, 9/3/24, 9/4/24, 9/5/24, 9/6/24, 9/10/24, 9/11/24, 9/12/24, 9/13/24, 9/14/24, 9/15/24, 9/16/24, 9/17/24, 9/18/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24, 9/23/24, 9/24/24, 9/25/24, 9/26/24, 9/27/24, 9/28/24, 9/29/24, and 9/30/24.<br><br>Review of the Posted Daily Nursing Staffing Forms, Daily Staffing Sheet, and the nursing staff time detail reports for 9/1/24, 9/4/24, 9/5/24, 9/6/24, 9/10/24, 9/11/24,9/12/24, 9/13/24, 9/14/24, 9/15/24, 9/16/24, 9/18/24, 9/19/24 9/23/24, 9/24/24 9/26/24, 9/27/24, 9/28/24, 9/29/24, and 9/30/24 were reviewed and revealed there were RN hours for Quarter 4 of the fiscal year 2024.<br><br>The Posted Daily Nursing Staffing Forms, Daily Staffing Sheet, and the nursing staff time detail reports for 9/1/24, 9/2/24, 9/3/24, 9/4/24, 9/5/24, 9/6/24, 9/10/24, 9/11/24, 9/12/24, 9/13/24, 9/14/24, 9/15/24, 9/16/24, 9/17/24, 9/18/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24, 9/23/24, 9/24/24, 9/25/24, 9/26/24, 9/27/24, 9/28/24, 9/29/24, and 9/30/24 were reviewed and revealed there were 24-hour per day licensed nursing coverage for Quarter 4 of the fiscal year 2024.<br><br>An interview was conducted on 1/16/25 at 9:37 AM with the Human Resources Payroll Manager who revealed she was responsible for entering all nursing hours into the payroll system. The Human Resources Payroll Manager stated she recalled that she received notice on 10/10/24 that PBJ data file she submitted for September of 2024 was rejected. She further revealed that she was able to make the corrections and resubmitted the file on 11/14/24 and it was accepted.<br><br>During an interview on 1/16/25 at 10:31 AM with the Administrator she revealed the PBJ data was submitted based on the information entered by the Human Resources Manager. The Administrator stated the facility had RN hours and licensed nursing staff as required but there must have been an error when the data was reported. She further revealed that the error was corrected as of 11/14/24.<br><br>The facility implemented the following Corrective Action Plan with a completion date of 11/15/24.<br><br>On 10/10/24 Validation for PBJ report with an error code. The error was noted and corrected prior to midnight of 11/15/24 deadline. An accepted validation report was received on 11/14/24.<br><br>(continued on next page) |

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| F 0851<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 11/14/24, a monthly PBJ report audit was initiated by the Human Resources Payroll Manager and the Administrator for the previous months July 2024 and August 2024 to determine if any errors occurred . The audit revealed no errors for July 2024 and August 2024. Education on PBJ reporting accuracy was provided to the Human Resources Payroll Manager by the Administrator on 11/14/24.<br><br>The Administrator will audit monthly PBJ Validation Reports for the months of October 2024-January 2025 to confirm that the reports were accepted without error.<br><br>The results of the audits will be discussed during the QAPI monthly meetings for the next two quarters and reevaluated for resolution.<br><br>The facility's alleged compliance date was 11/15/24.<br><br>The Corrective Action Plan was validated on 1/17/25 and concluded the facility had implemented an acceptable corrective action plan on 11/15/24. An Interview was conducted with the Human Resource Payroll Manager revealed she received education on PBJ reporting accuracy on 11/14/24. The audits conducted on 11/14/24 revealed no errors for the months of July 2024 and August 2024. The audits conducted for October 2024 through December 2024 revealed errors for October 2024 and November 2024 which were all corrected and accepted. A review of the Quality Assurance and Performance Improvement (QAPI) minutes on 11/15/24 revealed the PBJ validation audits were discussed.<br><br>The correction date of 11/15/24 was validated. |