STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345565	A. Building B. Wing	03/19/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, resident representative, staff, Medical Director and Nurse Practitioner (NP) interviews, when the facility notified the nurse practitioner (NP) and responsible party (RP) of knee pain on 1/30/26, the facility failed to inform the NP and RP the resident had fallen on 1/28/26. This affected medical diagnostics and treatment. The deficient practice affected 1 of 5 residents reviewed for accidents (Resident #33). The findings included:Resident #33 was admitted to the facility on [DATE] with diagnoses of non-Alzheimer's dementia, adult failure to thrive, history of falling, and hypertension. On 3/5/26 at 10:39 AM, a telephone interview was conducted with Nurse #7. She stated she had just gotten to work for her 3p-7p shift on 1/28/26 and had received the report from the previous first shift Nurse (Nurse #7 did not provide the Nurse's name but according to the nursing daily assignment sheet, the previous shift nurse was Nurse #5) when the Scheduler advised her of Resident #33's fall. She was unsure of what events took place prior to the fall. Nurse #7 stated she, the Medication Aide, and the Scheduler went into Resident #33's room to find Resident #33 sitting on the floor in front of her wheelchair. Nurse #7 stated she assessed Resident #33, checked her range of motion, and asked if she was having any pain. Resident #33 said no. Nurse #7 stated she was under the impression Resident #33's fall was witnessed because she thought the Scheduler saw it. Nurse #7 stated she did not notify the provider, the family, or the Director of Nursing (DON) on 1/28/26 of the fall. A review of the January Medication Administration Record (MAR) revealed Resident #33 started complaining of right knee pain on 1/30/26 at a level 4 out of 10 (0 - 10 pain scale with 10 being the worst possible pain) on evening shift. Resident was given Acetaminophen Oral Tablet 500 milligrams (MG). Review of the Health Status Note dated 1/30/26 entered by Nurse #11 indicated Nurse #11 notified the Nurse Practitioner (NP) of Resident #33's complaint of pain in her knee and that it was slightly swollen. An x-ray was ordered by NP #2. The resident's family visited and was also notified of the complaint of the right knee pain. A review of the February Medication Administration Record (MAR) showed Resident #33 continued to have reports of pain (location not specified on some of the dates). Pain was reported on 2/1/26 (pain level a 3 on evening shift and a 6 on night shift), 2/2/26 (pain level a 4 on day shift), 2/4/26 (pain level a 7 on evening shift, right lower extremity, thigh/knee pain), 2/5/26 (pain level a 5 on day shift), 2/6/26 (pain level a 5 on evening shift), 2/7/26 (pain level a 3 on night shift), 2/8/26 (pain level a 6 on night shift), and 2/9/26 (pain level a 5 on day shift and a 6 on evening shift). Resident #33 was given Acetaminophen 500mg on 2/3/26 and 2/4/26. She was given Tramadol HCL 25mg for pain on 2/4/26, 2/6/26, and 2/9/26. She was also given Hydrocodone-Acetaminophen Tablet 5-325mg on 2/9/26. Resident #33 was sent out for a computed tomography (CT) scan (a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) on 2/9/26. The results showed Resident #33 had multiple serious breaks in the right hip and pelvis, as well as additional fractures in the front part of the right pelvic bones, and flattening of the superior lateral right femoral head. On 3/3/26 at 5:01 PM, an interview was conducted with the Assistant Director of Nursing (ADON) and the Unit Manager. The ADON and Unit Manager stated Resident #33 had a fall on 1/28/26 which (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resulted in her hip fracture. The Unit Manager stated the fall on 1/28/26 was unwitnessed on the evening shift. The Nurse Aide (NA) notified Nurse #7. The Nurse assessed Resident #33 prior to any movement. The Unit Manager stated there were no injuries at the time of assessment. The Unit Manager stated according to the records, Resident #33 denied pain. Her vital signs were taken, and they continued to monitor her. The Unit Manager stated, while they were reviewing the medical record, Resident #33's family was notified of the fall but a specific date was not provided during this interview. The ADON stated on 1/30/26, Resident #33 complained of right knee pain, her leg was swollen. The ADON read in the records that the Nurse Practitioner (NP) was notified (date not provided) and assessed Resident #33. Pain medication was ordered. Upon further reading of the medical records, the Unit Manager reported the following. On 1/31/26, x-rays could not be completed due to the snow. The family requested the facility to wait on sending Resident #33 out at that time due to the snow. However, when the pain migrated to Resident #33's hip, the family then decided to further investigate as the hip pain was new for Resident #33. An x-ray of the knee was done on 2/5/26 and was fine. It showed Resident #33 needed a computed tomography (CT) scan. The Unit Manager further stated the CT scan was scheduled as outpatient on 2/9/26 and it was shown Resident #33 to have a broken hip. The ADON stated nurses should notify the provider, family, and management of a fall immediately after a fall or soon after. On 3/5/26 at 10:12 AM, a telephone interview was conducted with Nurse Practitioner (NP) #2. She stated she was never officially notified of Resident #33's fall on 1/28/26. She did not receive a call notifying her of Resident #33's fall on 1/28/26. NP #2 stated she ordered an x-ray due to Resident #33's complaints of pain on 1/30/26. NP #2 stated she was not notified that the x-ray had not been completed until after the fact. NP #2 visited the facility on Wednesdays. When she visited the facility on 2/4/26, she was notified the x-ray was not completed due to the snow. NP #2 stated typically, the facility would call her when a resident fell. NP #2 stated she felt there was a slight delay in when the fall occurred and when it was reported. She was unaware of any injury at that time. When they received the x-ray results from 2/4/26, NP #2 spoke with Resident #33's family to discuss the results and recommendations. Resident #33's family was given the opportunity to send Resident #33 to the emergency room for a CT scan. The fall incident was still unknown at that time. Resident #33's family was also unaware of the fall at the time. NP #2 stated when she was at the facility on 1/28/26, she was not made aware of the fall. She remembered asking if there had been a known injury and no one knew anything at that time. On 2/2/26, Resident #33 ?s family member sent a text to NP #2 regarding concerns about Resident #33's hip based on the way Resident #33 was sitting in the chair. NP #2 stated she and Resident #33's family member became aware of the fall after the fact. An additional telephone interview with Nurse Practitioner (NP) #2 on 3/5/26 at 12:01 PM revealed the Director of Nursing (DON) was the person who initially notified her about Resident #33's fall on 2/11/26. After receiving the CT scan results of Resident #33's fracture, the facility started their own internal investigation of Resident #33's injury and what caused it after a nurse admitted the incident. On 3/5/26 at 12:09 PM, a telephone interview was completed with Resident #33's representative (RR). The RR stated she was not notified of Resident #33's fall on 1/28/26. The first time she was ever made aware of the fall was in February after Resident #33's CT scan when she discussed the results with NP #2. The RR was not able to provide an exact date of the notification. Review of the hospital records revealed Resident #33 was admitted on [DATE] for a displaced transverse-posterior fracture of the right acetabulum (socket of the hipbone) and severe pain with functional decline after experiencing a fall at her nursing facility. An interview with the Medical Director on 3/4/26 at 10:35 AM revealed when a resident had a fall, they expected to receive a call. If it was after hours, staff would call the triage team. The providers would then visit the facility to see the residents. If residents complained of pain, they would order an x-ray. The Medical Director became aware of the 1/28/26 fall on 2/11/26 through record review in preparation of her visit with Resident #33. An interview with the DON on 3/5/26 at 9:30 AM revealed Resident #33's fall on 1/28/26 did not trigger the Fall Risk or the Fall Post Evaluations as the Nurse (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who assisted Resident #33 post fall recorded the incident as an injury and not a fall in their electronic medical records system. The DON stated the incident type of injury did not trigger their User-Defined Assessment (UDA) (fall assessments/evaluations). However, the DON stated when residents experienced a fall, staff were to complete an assessment, and communicate with the family, provider, and management immediately after a fall. An interview on 3/5/26 at 4:33 PM was held with the Administrator. She stated following a fall, the nurses assessed the resident. They were to notify the family, the provider, and nurse supervisor. They were to chart/document what happened and provide care. The Administrator stated she would expect her staff to follow the process. The facility implemented the following Corrective Action Plan.On 01/28/2026, Resident #1 was observed on the floor at approximately 3:20 pm. Nurse #7 observed Resident #1 on the floor but did not notify the provider or the resident representative. The provider and the resident representative were still not notified that the resident was noted on the floor on 1/28/2026 when they were notified of the pain beginning two days later.1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.Based on interviews with Nurse #7, Resident #1 was assessed for pain and injury by Nurse #7 at the time of the incident on 01/28/2026. No pain or injury was observed or noted by Nurse #7.On 1/30/2026, the electronic medical record reflects that Resident #1 reported pain to her right knee. Resident #1's daughter and the nurse practitioner were notified of the pain on this date; however, they were not notified that the resident had been observed on the floor two days prior. On 1/30/2026, the nurse practitioner ordered an x-ray. X-rays were obtained on the following dates: 1/30/26 and 2/5/26. No injuries noted on either of the x-rays. Resident #1's pain was being addressed and managed by the facility, and Resident #1 continued to be active and attempting self-transfers and walking. The second x-ray noted if pain persisted that a computerized tomography (CT) scan should be considered. The resident went for a computerized tomography scan on 2/9/26 at an outpatient clinic, the results showed fractures in several locations in Resident #1's pelvis and flattening of the femoral head due to impaction fracture. Nurse #7 was educated on the requirement to notify the provider and the resident representative of any incident including falls (whether observed or not) by the director of nursing on 2/10/2026. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.Any resident could be affected. The following audit was conducted to evaluate residents who had the potential to be affected:The director of nursing conducted a 100% audit of all reported falls from 12/1/25 through 02/13/26 in the electronic medical record to check compliance for appropriate notification. No issues identified that hadn't already been addressed. Completed on 2/13/2026. The director of nursing and the staff development coordinator interviewed all nurses to ask if they were aware of any potential fall or incident that may have occurred but was not reported. This was completed on 2/13/26. No issues identified. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.Education regarding Notification of Falls and Incidents was started on 2/11/2026 by the staff development coordinator and completed by 2/13/2026 for all nurses, certified nursing assistants and medication aides. Nurses, certified nursing aides, and medication aides who did not receive training by this date received it prior to their next working shift; the staff development coordinator was responsible for ensuring no one worked after 2/13/2026 without being trained. On 2/11/2026, the staff development coordinator added additional material to new hire orientation to include the following:The staff development coordinator now provides a hard copy of the policy related to Falls and Incidents and specifically reviews how to identify a fall and what to do when one occurs. Previously, the staff development coordinator facilitated training on falls and incidents but did not provide new teammates with a copy of the policy.A competency training document for risk management reporting in PointClickCare (electronic medical record system) was added to new hire orientation. Training for PointClickCare was previously a line item on the orientation checklist but the competency training information is now on its own document.4. Indicate how the facility plans to monitor its performance to make sure that (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	solutions are sustained. Effective 2/11/26, the director of nursing will audit the electronic medical record for appropriate notification to the provider and responsible party regarding falls at the following frequency:Five falls per week for five weeksTen falls per month for three monthsEffective 2/13/26, the director of nursing will interview staff for ongoing understanding of proper identification of a fall as well as reporting a fall to ensure proper documentation is captured in the record. The audit will be completed at the following frequency:Three interviews per week for five weeksTen interviews per month for three months Any issues found during the auditing process will be reported by the director of nursing during the Quality Assurance Performance Improvement meeting. Changes will be made immediately, if needed.Include dates when corrective action will be completed.Compliance Date: February 14, 2026 The Corrective Action Plan was validated on 3/6/26 by reviewing the education that was provided to staff regarding falls and who must be notified. The following documents were also reviewed: annual skills check for nurses, education on completing an incident report in PointClickCare (PCC), orientation and competency checklist on completing assessments in PCC, the orientation checklist for new hires on falls, audit of staff on proper fall identification and reporting, and the policies of What Constitutes a Fall and Fall Risk Reduction and Management. The compliance date of 2/14/26 was validated.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to code a Minimum Data Set (MDS) assessment in the areas of intravenous (IV) midline access (specialized vascular access device designed for patients requiring IV therapy for a moderate length of time), and IV antibiotic medication use (Resident #99) and insulin medication use (Resident #95) and behaviors (Resident #90) for 3 of 18 residents whose MDS assessments were reviewed.The findings included: 1. Resident #99 was admitted on [DATE] with a diagnosis of pneumonia (a severe, rapidly progressing lung infection) and meningitis (an inflammation of the brain lining and spinal cord) requiring IV access and IV antibiotic medications. Record review of the admission summary dated [DATE] at 3:35 PM by Nurse #4 for Resident #99 indicated he arrived at the facility with an IV access in his right antecubital fossa (the inner bend of the right elbow) and was to continue receiving IV antibiotic medication. Review of physician orders dated 12/10/2025 at 6:21 PM revealed an order for ceftriaxone sodium (an antibiotic) IV solution 2 grams to be given every 12 hours for meningitis for 13 days. An additional physician order dated 12/11/2025 at 10:01 AM indicated to flush the right arm IV access and then clamping off. Review of the Medication Administration Record (MAR) for December 2025 indicated antibiotic medication was administered intravenously (IV) on 12/10/2025, 12/11/2025, and 12/12/2025. The MAR further revealed orders for saline flush to the IV access every shift. Review of Nurse Practitioner progress note dated 12/11/2025 indicated Resident #99 was receiving IV antibiotic medications and had peripheral IV access in place in the right arm. The IV antibiotic medication was to continue through the midline catheter (a long peripheral venous access inserted into an upper arm vein). The discharge return not anticipated assessment dated [DATE] did not indicate Resident #99 had midline IV access or had received IV antibiotics upon admission, while a resident or at discharge from the facility. An interview conducted with the MDS Nurse on 3/3/2026 at 11:41 AM. The MDS Nurse indicated she completed the MDS for Resident #99. After reviewing the MDS dated [DATE] she stated the IV access and use of IV antibiotic medication was not marked for Resident #99 and this was an error. An interview conducted with the Director of Nursing (DON) 3/3/2026 at 2:31 PM revealed she was a part of an interdisciplinary team that worked together to comb though the resident's medical record to capture the full picture of the resident's overall condition. She further revealed coding correctly was the expectation with the MDS assessments. An interview conducted with the Administrator 3/5/2026 at 10:53 AM revealed she expected all MDS to be coded accurately. 2. Resident #95 was admitted to the facility on [DATE] with diagnoses that included Type 2 diabetes mellitus with hyperglycemia (high blood glucose). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders dated 1/25/26 revealed an order for Tirzepatide (a medication to improve blood sugar control) 0.5 milliliters subcutaneously on Sunday for diabetes mellitus type 2. A review of Resident #95's Medication Administration Record (MAR) from 1/23/26 to 1/29/26 revealed she was administered an injection of Tirzepatide 0.5 milliliters subcutaneously on 1/25/26. The MAR did not indicate Resident #95 had received an injection of insulin. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #95 was coded for one insulin injection. An interview was conducted with MDS Nurse #1 on 3/9/26 at 3:45 PM. She indicated she had coded one insulin injection on Resident #95's admission MDS because she thought Tirzepatide was considered insulin. MDS Nurse #1 further revealed that after a review she realized Tirzepatide was not insulin and that she had coded this incorrectly. An interview conducted with the Administrator 3/5/2026 at 10:53 AM revealed she expected all MDS to be coded accurately. 3. Resident #90 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder. Review of the Behavior Monitoring and Intervention Report for the month of November 2025 revealed Resident #90 demonstrated behaviors of grabbing others, hitting, physical aggression and agitation on 11/2/25. The report also indicated that behaviors of hitting others, physical aggression toward others, agitation, anxiousness, and exit seeking behavior occurred on 11/3/25. Review of a progress note authored by Nurse #10 dated 11/3/25 indicated Resident #90 has been yelling since this morning when gotten up by the nursing assistants and later threw her Med Pass (a nutritional supplement). Review of a progress noted authored by the Administrator dated 11/4/25 indicated Resident #90 demonstrated mood/behavior indicators of yelling, angry, throwing med, hitting, grabbing, agitated, anxious, restless, refusing care, and wandering on the unit. The admission Minimum Data Set with an Assessment Reference Date (ARD, the last day of the look-back period) of 11/5/25 revealed Resident #90 was severely cognitively impaired, received antianxiety medication and had no behaviors. A telephone interview was conducted with the previous Social Work Assistant on 3/4/26 at 10:43 AM. The Social Work Assistant indicated she was aware that Resident #90 had exhibited combative and resistive behaviors however during the admission MDS assessment period she did not observe these behaviors and therefore did not code them on the MDS. The previous Social Work Assistant further explained that she was not aware that she needed to review the electronic medical record for documented behaviors and was not aware that any behaviors had been documented. An interview was conducted with Administrator on 3/3/26 at 2:04 PM. The Administrator indicated she documented the progress note on 11/4/25 regarding Resident #90's behaviors and that these behaviors were discussed in their weekly meetings with administrative staff. She further revealed that due to Resident #90's behaviors and cognitive impairment she was transferred to the memory care unit on 11/10/25. The Administrator indicated that the Social Work Assistant should have coded (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #90's behaviors on the admission MDS assessment and did not know why the social worker did not code the MDS correctly.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident representative and staff interviews, the facility failed to develop a baseline care plan that addressed the resident's immediate needs related to fall prevention and pain management for 1 of 12 residents reviewed for baseline care plans (Resident #3).The findings included:Review of the FL2 (a North Carolina Medicaid form that documents a patient's medical condition and needs for long term care facilities) completed 12/18/25 revealed Resident #3 had a diagnosis of chronic neck pain, chronic pain syndrome, and mild dementia. A review of Resident #3's hospital discharge summary indicated his Resident Representative (RR) reported Resident #3 had experienced a cognitive and functional decline slowly over the past serval months and the week prior to hospitalization Resident #3 was not able to ambulate as easily with his walker and had increased confusion. The discharge summary also indicated Resident #3 was discharged on 12/22/25 with diagnoses of chronic pain syndrome, chronic neck pain, and mild dementia. A review of the hospital history and physical revealed a provider progress note dated 12/16/25 that indicated Resident #3 presented with generalized weakness, acute renal failure likely related to dehydration, that likely resulted from his balance disorder and severe major neurocognitive disorder. In addition, the progress note indicated an active problem of debility, other reduced mobility, and impaired mobility due to medical condition present on admission.Resident #3 was admitted to the facility on [DATE] with diagnoses that included chronic pain syndrome, and mild dementia with other behavioral disturbance. Review of Resident #3's fall risk evaluation completed on admission to the facility on [DATE] indicated Resident #3 was considered at high risk for potential falls and prevention protocol should be initiated immediately and documented on the care plan. Review of Resident #3's physician order dated 12/22/25 to administer acetaminophen extended released 650 milligrams (mg) by mouth every eight hours as needed for pain. Review of Resident #3's physician order dated 12/23/25 to apply lidocaine (a topical anesthetic used to provide temporary localized pain relief) 4 % patch to the lower back topically every morning for pain. Apply morning and remove it at bedtime. Review of the baseline care plan dated 12/23/25 completed by the Minimum Data Set (MDS) Nurse #1 revealed no goal or interventions for Resident #3's diagnosis of chronic pain syndrome and did not include a plan that addressed Resident #3's immediate need related to fall risk prevention. An interview with MDS Nurse #1 on 3/9/26 at 9:35 AM, indicated that the baseline care plan was completed within 48 hours of admission that included transfer status, therapy, and dietary and covered all disciplines. She further indicated that she felt Resident #3's baseline care plan met the minimum requirements for basic safety. An interview was conducted with Resident #3's Resident Representative on 3/5/26 at 10:14 AM. She indicated Resident #3 had a history of chronic pain and required pain medication to keep him comfortable. She explained that his pain continued after admission to the facility. The Resident Representative also expressed that she felt Resident #3 was at a high risk for falls due to his physical and mental condition. She stated she would have wanted staff to be aware of Resident #3's chronic pain and fall risk. An interview was conducted with the Director of Nursing (DON) on 3/5/26 at 10:48 AM. She indicated that the baseline care plan should include the minimum healthcare information necessary to meet a resident's needs. She further indicated that Resident #3's baseline care plan should have included information related to being at high risk for falls so that the staff would be aware of that risk and know what interventions were needed. The DON indicated she did not know why this was not included in the baseline care plan. A follow-up telephone interview was conducted with the DON on 3/13/26 at 11:41 AM. The DON indicated that Resident #3's baseline care plan should have also included information related to pain and she did not know why this had not been included. An interview was conducted with the Administrator on 3/04/2026 at 12:12 PM. She indicated that the baseline care plan should include the minimum healthcare information for a resident upon admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop a comprehensive care plan in the areas of communication and behaviors for 1 of 18 residents whose care plans were reviewed (Resident #90). Findings Included:Resident # 90 was admitted to the facility on [DATE].A review of Resident #90's behavior monitoring and interventions report revealed on 11/2/25 Resident #90 demonstrated behaviors of grabbing others, hitting others, physical aggression toward others, and agitation. On 11/3/25 Resident #90 demonstrated behaviors of hitting others, physical aggression toward others, agitation, anxiousness, and exit seeking behavior.A review of the admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #90 had adequate hearing with the use of hearing aids, was usually understood, usually understood others and had no behaviors.A review of Resident #90's Care Area Assessment (CCA) summary revealed it was completed on 11/5/25 by the previous Social Work Assistant. Further review revealed the area of communication was a triggered care area. It was indicated in the CAA summary that communication would be addressed in the care plan.A review of Resident #90's care plan dated 10/20/25 with a revision date of 11/13/25 revealed no care plan had been developed or interventions included in the areas of communication or behaviors.A telephone interview was conducted on 3/4/26 at10:53 AM with the previous Social Work Assistant. She indicated that she did complete Resident #90's communication CAA summary and confirmed that Resident #90 should have had a communication care plan and stated she did not know why one had not been developed. The previous Social Work Assistant indicated that she did not review the behavioral monitoring and intervention report that was in the electronic medical record. The previous Social Work Assistant explained she had based her answers on Resident #90's behavior during the assessment, and she did not show any behaviors at that time. She further revealed that she did not know she needed to review the electronic medical record for documentation of behaviors.An interview was conducted with the Director of Nursing (DON) on 3/4/26 at 11:08 AM. She indicated that Resident #90 should have had communication and behavior care plans and was not sure why they had not been completed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and resident representative, staff, Nurse Practitioner, and physician interviews, the facility failed to implement effective systems to effectively communicate and collaborate regarding the resident's care. The deficient practice affected 1 of 5 residents reviewed for accidents (Resident #33).The findings included:Resident #33 was admitted to the facility on [DATE]. Her diagnoses included hypertension, non-Alzheimer's Dementia, adult failure to thrive, muscle weakness (generalized), other abnormalities of gait and mobility, and history of falling. A review of the significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #33 was moderately cognitively impaired with no behaviors present. Resident #33 exhibited verbal behavioral symptoms directed towards others, and other behavioral symptoms not directed towards others. There was no impairment in functional limitations in range of motion (ROM). Resident #33 used a wheelchair as a mobility device. She was dependent in toileting hygiene, shower/baths, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. She was partial to moderate assist with personal hygiene. Resident #33 was on antidepressant medication. Review of the care plan dated 1/5/26 revealed a focus that Resident #33 was at moderate risk for falls related to gait/balance problems. The goal stated Resident #33 would be free of major injury through the review date. Interventions included a 1/4 wing tip mattress, be sure the Resident #33's call light was within reach and encourage Resident #33 to use it for assistance as needed. Resident #33 needed prompt response to all requests for assistance. An interview with the Scheduler on 3/5/26 at 11:01 AM indicated she made rounds on each hall every day to see how things were going with staffing (such as if there were any call-outs, any staffing concerns, etc.), The Scheduler stated on 1/28/26, sometime around 3:30p, she was making her rounds on the hall and as she was walking, she looked in Resident #33's room and resident was already on the floor sitting on her bottom. She asked resident if she was OK. Resident asked her to help her get up. The Scheduler left resident's room to get the nurse (Nurse #7) and medication (Med) aide (Med Aide #2). When the 3 of them arrived back to Resident #33's room, the resident's vital signs were taken, and an assessment was done prior to assisting resident back into her wheelchair. After that, the nurse took resident to the nurses' station. After getting the resident back into her wheelchair, the Scheduler left the unit to continue her rounds on another unit. On 3/5/26 at 10:27 AM, during a telephone interview with Medication Aide (MA) #2, she reported on 1/28/26, she was doing a medication pass. She stated Resident #33 had a behavior where she yelled out. MA #2 stated the Scheduler was walking on the unit and went to see what was going on with Resident #33. The Scheduler found Resident #33 on the floor. The Scheduler got the MA #2 and the nurse (Nurse #7). When asked what happened, Resident #33 stated she got onto the floor by herself. They got her up off the floor, and MA #2 stated she went back to doing her medication pass. MA #2 stated she was not sure what happened after that. MA #2 stated Resident #33 did not have any complaints of pain when they got her up. She stated she did not remember if Resident #33 complained of pain while on her shift and she did not recall if anything was given for pain. On 3/5/26 at 10:39 AM, a telephone interview was conducted with Nurse #7. She stated she had just gotten to work on the 1/28/26 evening shift and had received the report from the previous nurse when the Scheduler advised her of Resident #33's fall. She was unsure of what events took place prior to the fall. Nurse #7 stated she, the Medication Aide, and the Scheduler went into resident's room to find Resident #33 sitting on the floor in front of her wheelchair. Nurse #7 stated she assessed the resident, checked her range of motion, and asked if she was having any pain. Resident #33 said no. The resident had a cushion on her wheelchair and Nurse #7 wondered if it made Resident #33 slide out but the Scheduler told her the resident got onto the floor by herself. Nurse #7 stated she perceived that the Scheduler witnessed Resident #33 getting onto the floor based on their conversation.Record review revealed there was no documentation that an updated Post Fall Evaluation and a Fall Risk (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evaluation were completed following Resident #33's fall on 1/28/26. Nurse #7 stated once Resident #33 was back into her wheelchair, she was then taken to the nurse station with Nurse #7. She stated the resident stayed with her for about 10-15 minutes before she wheeled herself to the dining area. Resident ate outside of her room that day at the dining table. Nurse #7 stated resident ate fine. Nurse #7 stated she worked from 3p-7p on 1/28/26 on the memory care unit, then she was moved to a different hall. However, during the time Nurse #7 worked on the hall, resident did not report any pain. Nurse #7 stated Resident #33 usually yelled out when she was in pain, shouting mama mama. Nurse #7 stated during the time she worked with resident, she did not have any issues with her. Regarding falls, Nurse #7 stated when she was trained, for a witnessed fall, you do a full assessment. Nurse #7 stated she was under the impression resident's fall was witnessed because she thought the Scheduler saw it. Because of this, and in addition to the resident not reporting any pain, the Fall Risk/Post Fall Evaluations were not done. However, she did assess and monitor resident after the fall. A telephone interview was conducted with Resident #33's representative (RR) on 3/2/26 at 1:33 PM. On 1/30/26, Resident #33 complained of knee pain, and that she went to the nurse's station to advise the nurse of the pain. The RR stated the nurse (exact nurse unknown) said she asked Resident #33 if she wanted something for pain, and the resident said no. They also asked the resident if she wanted an x-ray, and the resident said no. However, the RR stated an x-ray was ordered but it was not done until after midnight on 2/4/26 (which would have been on 2/5/26). The RR stated they received the x-ray results, and a CT scan was ordered and completed that showed a trauma break. A review of the January Medication Administration Record (MAR) revealed Resident #33 started complaining of right knee pain on 1/30/26 at a level 4 out of 10 (0 - 10 pain scale with 10 being the worst possible pain) on evening shift. Resident was given Acetaminophen Oral Tablet 500 milligrams (MG). Review of the Health Status Note dated 1/30/26 entered by Nurse #11 indicated Nurse #11 notified the Nurse Practitioner (NP) of Resident #33's complaint of pain in her knee and that it was slightly swollen. An x-ray was ordered by NP #2. The resident's family visited and was also notified of the complaint of the right knee pain. Record review revealed on 1/30/26, an x-ray of the right knee was ordered by the Nurse Practitioner (NP) #2 based on Resident #33's complaints of knee pain. There was no evidence of documentation for the x-ray results completed on 1/30/26. Information regarding this x-ray was requested during the survey. However, the information was not provided by the facility. The only x-ray results provided by the facility during the survey were from 2/5/26. On 3/19/26, the facility provided a copy of the 1/30/26 x-ray results which showed there was evidence of a total knee replacement with intact femoral and tibial components. There was no radiographic evidence of acute fracture or dislocation, and no radiographic evidence of loosening or particle disease. There was a mild degree of osteopenia. A record review of the Practitioner note dated 1/31/26 written by Physician Assistant (PA-C) #1 indicated Resident #33's representative (RR) called with concern that resident had right knee pain and swelling, and she was unable to bend her knee. The RR wanted to know if an x-ray was ordered as she requested. The note stated PA-C #1 returned a call to the RR. She advised the RR that the provider had been notified, and an x-ray was ordered but had not yet been done due to weather. Review of the Practitioner note dated 2/4/26 written by Nurse Practitioner (NP) #2 revealed an order was placed for a right hip/pelvis x-ray, will evaluate once resulted. The NP note stated Resident #33 was alert and in no acute distress. She resided on the memory care unit and was unable to fully communicate her needs to staff. She appeared uncomfortable and was unable to sit still and tried to reposition herself frequently. She complained of pain and some limited range of motion (ROM) to the right (R) leg. The note stated staff reported no known injury. History and review of systems (ROS) were limited due to dementia and poor historian. The practitioner note indicated nursing staff had concerns for increasing behaviors and hollering out frequently. They noted resident was difficult to redirect and console. They noted Resident #33 could often become extremely agitated. She was recently tapered off Zoloft at family request. Resident was utilizing Ativan as needed (PRN) which was helping. A record review of the Practitioner Note dated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/5/26 written by Nurse Practitioner (NP) #2 indicated right (R) hip x-ray results note. Hip joints arthritic changes. Osteopenia of the bones. Limited study. If clinical suspicion for fracture persists, recommended CT for further evaluation. Results discussed with Resident #33 representative (RR). Resident still seemed to be in significant amount of pain. Will Continue Tramadol 25mg to help with pain at this time. The RR was given options to send out to the Emergency Department (ED) for CT scan or could schedule CT scan outpatient in a couple days. The RR chose to set up outpatient CT scan. Resident #33 was sent out for a computed tomography (CT) scan (a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) on 2/9/26. The results showed Resident #33 had multiple serious breaks in the right hip and pelvis, as well as additional fractures in the front part of the right pelvic bones, and flattening of the superior lateral right femoral head. A review of the February Medication Administration Record (MAR) showed Resident #33 continued to have reports of pain (location not specified on some of the dates). Pain was reported on 2/1/26 (pain level a 3 on evening shift and a 6 on night shift), 2/2/26 (pain level a 4 on day shift), 2/4/26 (pain level a 7 on evening shift, right lower extremity, thigh/knee pain), 2/5/26 (pain level a 5 on day shift), 2/6/26 (pain level a 5 on evening shift), 2/7/26 (pain level a 3 on night shift), 2/8/26 (pain level a 6 on night shift), and 2/9/26 (pain level a 5 on day shift and a 6 on evening shift). Resident #33 was given Acetaminophen 500mg on 2/3/26 and 2/4/26. She was given Tramadol HCL 25mg for pain on 2/4/26, 2/6/26, and 2/9/26. She was also given Hydrocodone-Acetaminophen Tablet 5-325mg on 2/9/26. On 3/5/26 at 10:12 AM, a telephone interview was conducted with Nurse Practitioner (NP) #2. She stated she was never officially notified of Resident #33's fall on 1/28/26. She stated she ordered an x-ray on 1/30/26 due to resident's complaints of pain, not because of the 1/28/26 fall. When the x-ray was ordered on 1/30/26, the NP stated she was not notified that the x-ray had not been completed until after the fact. The NP visited the facility on Wednesdays. When she visited the facility on 2/4/26, she was notified the x-ray was not completed due to the inclement weather. The NP stated typically, the facility would call her when a resident fell. The NP stated she felt there was a slight delay in when the fall occurred and when it was reported. She was unaware of any injury at that time. When they received the x-ray results from 2/4/26, the NP spoke with the resident's family to discuss the results and recommendations. The resident's family was given the opportunity to send resident to the emergency room for a CT scan. The fall incident was still unknown at that time. The resident's family was also unaware of the fall at the time. The NP stated when she was at the facility on 1/28/26, she was not made aware of the fall. She remembered asking if there had been a known injury and no one knew anything at that time. On 2/2/26, the resident's family sent a text to the NP regarding concerns about resident's hip based on the way resident was sitting in the chair. The NP stated she and the resident's family became aware of the fall after the fact. An additional telephone interview with Nurse Practitioner (NP) #2 on 3/5/26 at 12:01 PM revealed the Director of Nursing (DON) was the person who initially notified her about resident's fall. After receiving the CT scan results of resident's fracture, the facility started their own internal investigation of Resident #33's injury and what caused it after a nurse admitted the incident. The NP #2 stated she found out about the fall on 2/11/26 when she had a meeting with the DON and Administrator to discuss what happened and what was going on. Another interview on 3/13/26 at 10:49 AM was conducted with Nurse Practitioner (NP) #2. She confirmed she was Resident #33's primary provider and she saw her the most (although the Medical Director would see resident as well). Regarding the x-ray, NP #2 stated the facility had an outside company that did portable x-rays. NP #2 stated if she had known about the fall, and it was an emergent situation, then she would have sent Resident #33 out to have the x-rays done. NP #2 stated with the knee x-ray, it was not an emergency at the time, and there was no known injury. Plus Resident #33 had arthritis, so she was OK with having the x-ray on the next available date. NP #2 stated she was made aware that the x-ray was not done on 1/30/26 when she visited the facility on 2/4/26 and asked about the results. She stated if the situation was non emergent, then it was fine to wait to have x-rays completed. However, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if they had expected injury, she would have sent Resident #33 to the Emergency Room. NP #2 stated the x-ray in the facility did not show anything, it just recommended a CT scan. NP #2 revealed if she had known about the fall on 1/28/26, she possibly would have ordered a different x-ray. It would have still been determined by what Resident #33 was complaining of at the time. However, she cannot say for sure if they would have immediately gotten a hip x-ray. NP #2 then stated if a different x-ray was ordered, it possibly would have been an x-ray of the whole right leg (pelvis, knee, etc.), but again, it would be based on what staff had reported to her (such as the fall and complaints of pain). NP#2 stated she did not physically see Resident #33 on 1/30/26 but was going by what Resident #33's family member had reported to her about Resident #33 grabbing at her knee. Therefore, on 1/30/26, NP #2 ordered an x-ray of the right knee. On 2/4/26, when NP #2 visited the facility, she observed Resident #33 sitting at the nurse's station. NP #2 stated Resident #33 was really fidgety, irritable, and looked uncomfortable. Resident #33 appeared to not put any weight on her right side. NP #2 stated she completed a problem assessment where she physically touched Resident #33's leg, knee, hip, back, etc. NP #2 stated because she felt, based on her assessment and observations, Resident #33's pain was related more to the hip than her knee. Therefore, she ordered an x-ray of the right hip and pelvis. NP #2 stated Resident #33 was not able to verbalize pain but had signs of being uncomfortable and irritable. NP #2 stated irritability was not common for Resident #33. When she asked Resident #33 if she had pain, Resident #33 could say yes, yes, yes, but could not define where she was hurting. Regarding the timeframe between receiving the x-ray results and ordering the CT scan, NP #2 stated if she had known about Resident #33's fall on 1/28/26, she would have leaned towards sending Resident #33 to the hospital based on the complaints of pain and the injury, and that the x-ray results did not pick up the fractures. However, NP#2 stated she would had ultimately given Resident #33's family the options and let them decide on whether to send Resident #33 to the hospital for the CT scan or to the outpatient facility. Because NP#2 was unaware of the fall on 1/28/26, and sending residents to the emergency room is more stressful on them and it causes confusion, she felt sending Resident #33 to an outpatient facility for the CT scan at their next available date (following the x-ray) was the best option for her. An interview with the Medical Director on 3/4/26 at 10:35 AM revealed when a resident had a fall, they expected to receive a call. If it was after hours, staff would call the triage team. The providers would then visit the facility to see the resident. If residents complained of pain, they would order an x-ray. The Medical Director stated when she saw Resident #33 during her facility visit on 2/11/26, she did not appear to be in pain, nor was she complaining of pain but was agitated. The Medical Director stated her 2/11/26 visit was the first visit she had with resident after the 1/28/26 fall. Review of the hospital records revealed Resident #33 was admitted on [DATE] after a fall at the nursing facility. She had a serious break in the right hip socket and was experiencing severe pain and difficulty moving. A review of the medical record revealed a late entry Post Fall Note written by the Assistant Director of Nursing (ADON). The note was created on 2/12/26 for effective date of 1/28/26. The note indicated, nurse was notified by staff member that Resident #33 was noted to be on the floor in Resident #33's room. Nurse immediately went to assess and assist Resident #33 with staff member and medication (med) aide. Upon entering the room, Resident #33 was noted to be sitting on the floor on buttocks, positioned in front of wheelchair near entry hallway of the room. Resident #33 was assessed prior to any movement or assistance. Resident #33 was assessed prior to any movement. Resident #33 was alert and able to move all extremities or limitation beyond baseline. No apparent injuries noted at time of assessment. Wheelchair seat cushion was noted to be present on Resident #33's wheelchair. During assessment, nurse stated, ?I wonder if that made her slip out of her chair.' Staff member replied, ?She got down here by herself.' Resident #33 was assisted back into wheelchair by nurse and staff member, with med aide standing behind wheelchair for safety. Resident #33 tolerated intervention well with no indications of pain noted based on PAINAD scale. Resident #33's sneakers were placed on feet. Resident #33 was transported to nursing station for close observation. PAINAD is The Pain Assessment in Advanced Dementia (PAINAD) scale that is a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	validated, observational tool used to evaluate pain in patients with advanced dementia or severe cognitive impairment who cannot verbally communicate their pain. On 3/3/26 at 5:01 PM, an interview was conducted with the Assistant Director of Nursing (ADON) and the Unit Manager. The ADON and Unit Manager stated Resident #33 had a fall on 1/28/26 which resulted in her hip fracture. The Unit Manager stated the fall on 1/28/26 was unwitnessed on the evening shift. The Nurse Aide (NA) notified Nurse #7. The Nurse assessed Resident #33 prior to any movement. The Unit Manager stated there were no injuries at the time of assessment. The Unit Manager stated according to the records, Resident #33 denied pain. Her vital signs were taken, and they continued to monitor her. The ADON stated on 1/30/26, Resident #33 complained of right knee pain, her leg was swollen. The ADON read in the records that the Nurse Practitioner (NP) was notified (date not provided) and assessed Resident #33. Pain medication was ordered. Upon further reading of the medical records, the Unit Manager reported the following. On 1/31/26, x-rays could not be completed due to the snow. She stated pain medications were given to Resident #33 which were effective in pain management. The family requested the facility to wait on sending Resident #33 out at that time due to the snow. However, when the pain migrated to Resident #33's hip, the family then decided to further investigate as the hip pain was new for Resident #33. The Unit Manager continued reviewing the records and stated there was no fall between Resident #33 complaint of right knee pain and the hip. An x-ray of the knee was done on 2/5/26 and was fine. It showed Resident #33 needed a computed tomography (CT) scan. The Unit Manager further stated the CT scan was scheduled as outpatient on 2/9/26 and it was shown Resident #33 to have a broken hip. The ADON stated nurses should notify the provider, family, and management of a fall immediately after a fall or soon after. An interview with the DON on 3/5/26 at 9:30 AM revealed Resident #33's fall on 1/28/26 did not trigger the Fall Risk or the Post Fall Evaluations as the nurse [nurse #7] who assisted the resident post fall recorded the incident as an injury and not a fall in their electronic medical record (EMR) system. The DON stated the incident type of injury did not trigger their User-Defined Assessment (UDA) (fall assessments/evaluations). The DON also stated daily pain assessments were completed for Resident #33. They addressed the pain. If pain interventions were not effective, they would notify the provider. However, the DON stated when residents experienced a fall, staff were to complete an assessment, communicate with the family, provider, and management. An additional interview was completed on 3/5/26 at 4:07 PM with the Director of Nursing (DON) revealed when a resident had a fall, whoever found them had to ensure the resident was in a safe position. The nurse would do the assessment and UDA (Fall Risk and Post Risk evaluations). They would check vital signs. If the resident was in a safe secure place, staff were to notify the provider and the family. They would determine if the resident needed to go to the Emergency Room. If so, prior to going, staff would confirm with the provider and family. The DON stated once a resident was stable, whether the resident was at the facility or outside of the facility, staff would still complete the required assessments/evaluations. They would follow doctor orders and the protocol based on the situation. The DON stated Resident #33 had a CT scan on 2/9/26 and they received the results on 2/11/26. After looking at the results and resident's documented falls, they started looking at everything and started digging into what happened that resulted in the fractures. As soon as they found out about the actual fall, they notified the NP. The DON stated they figured out which nurse worked on 1/28/26 when the resident fell. However, the DON stated in the event of a fall, staff were expected to assess the resident. If a resident needed to be sent out, orders were obtained. They provided pain management as needed. The DON stated staff must notify the provider, family, and the DON of all falls. She stated they asked the nurses to do a mini investigation as to what happened (what resulted in the fall), including what the resident was doing at the time of the fall. Then staff would implement interventions. Following the fall and mini investigation, the entire management team would follow up and continue their investigation of the incident. They would ensure the proper interventions were in place. During a telephone interview on 3/13/26 at 1:18 PM, the Director of Nursing (DON) described the facility's xˆray ordering and scheduling process. She stated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that providers either entered imaging orders directly into the electronic medical record or instructed staff to enter them. Staff then confirmed the order and sent it to scheduling. The facility used an outside company for portable imaging. Once the company received the order, they would notify the facility of the scheduled date and time. Regarding Resident #33, the DON stated the facility had contacted the diagnostic company about the 1/30/26 ordered xˆray and were initially told no technician was available, and later that the company could not come due to inclement weather. She reported this occurred over two days and acknowledged that followˆup communication may not have been documented. The DON stated they followed up again while waiting for a return call. She stated the onˆcall provider was notified on 1/31/26 about the delay, though there was not any evidence of documentation that showed the nursing staff contacting the on-all provider. The DON stated the note could have been documented in their provider onˆcall book or it was not documented at all. She also stated the family had been informed of the weatherˆrelated delay by the on-call Nurse Practitioner. The DON stated the xˆray was reordered on 2/4/26 and results were received on 2/5/26 recommending a CT scan. The CT scan was completed on 2/9/26. The DON emphasized that if imaging was delayed, the facility expected staff to notify the provider, who would then determine whether new orders or alternative steps were needed. An interview on 3/5/26 at 4:33 PM was held with the Administrator. She stated following a fall, the nurses assessed the resident. They were to notify the family, the provider, and nurse supervisor. They were to chart/document what happened and provide care. The Administrator stated she would expect her staff to follow the process. The facility implemented the following Corrective Action Plan.On 01/28/2026, Resident #1 was observed on the floor at approximately 3:20 pm. Nurse #7 observed Resident #1 on the floor but did not notify the provider or the resident representative. Nurse #7 evaluated Resident #1 for pain and injury at the time of the 01/28/2026 incident. No pain or injuries were found, and the resident's vital signs were stable. However, Nurse #7 did not complete required documentation in PointClickCare, which would include the fall risk and post fall evaluation which triggers management to investigate, nor did she include the fall in the shift report.1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.According to interviews conducted by the director of nursing with nurse #7 on 2/10/2026, Nurse #7 evaluated Resident #1 for pain and injury at the time of the 01/28/2026 incident. No pain or injuries were found, and the resident's vital signs were stable. Nurse #7 brought Resident #1 to sit with her in the nursing station to continue to monitor her with no signs or symptoms of pain after the fall. However, Nurse #7 did not complete required documentation in PointClickCare, which would include the fall risk and post fall evaluation which triggers management to investigate, nor did she include the fall in the shift report.On 1/29/2026, the resident complained of pain in her right knee. Multiple x-rays were performed on 1/30/26 and 2/5/26, but no injuries were identified. During this time Resident #1 was having pain management done by facility as ordered by the nurse practitioner. On 2/9/2026, the resident underwent a computed tomography (CT) scan of the right hip and pelvis due to ongoing pain and subsequently returned to the facility. The CT scan showed multiple pelvic fractures and flattening of the femoral head.On 2/11/2026, the director of nursing educated Nurse #7 on what constitutes a fall and incident and what steps to follow when a fall occurs, including resident assessment and documentation to include the incident report with both the fall risk and the post fall evaluation, and notification of the resident's provider and responsible party.2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.Any resident has the potential to be affected. The following audit was conducted to evaluate residents who had the potential to be affected:The director of nursing audited all falls from 12/1/2025 to 2/13/2026 to ensure that all documentation was complete, including incident reports, assessments, fall risk and post fall evaluations and notifications. This was completed on 2/13/2026.The director of nursing and the staff development coordinator interviewed all nurses to ask about any falls or incidents that may have occurred but were not reported. This was completed on 2/13/2026. No issues identified. 3. Address what measures will (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345565	A. Building B. Wing	03/19/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be put into place or systemic changes made to ensure that the deficient practice will not recur.Education regarding What constitutes a fall and incident using Lutheran Services Carolinas' policy titled, Fall Risk Reduction and Management was started on 2/11/2026 by the staff development coordinator and completed by 2/13/2026 for all certified nursing assistants, nurses and medication aides. Nurses, medication aides and certified nursing assistants who did not receive training by this date received it prior to their next working shift. The staff development coordinator was responsible for ensuring this education was provided before the next working shift. The education included a review of:What constitutes a fallThe requirement to report a fall and incident to the resident's responsible party, physician, and director of nursing or the administrative nurse.Requirement to complete documentation in PointClickCare regarding falls assessment, which would include the fall risk and post fall evaluations. On 2/11/2026, the staff development coordinator added additional material to new hire orientation to include the following:The staff development coordinator now provides a hard copy of the policy titled, Fall Risk Reduction and Management which specifically reviews how to identify a fall and what to do when one occurs. Previously, the staff development coordinator facilitated training on falls and incidents but did not provide new teammates with a copy of the policy.A competency training document for risk management reporting in PointClickCare (electronic medical record system) was added to new hire orientation. Training for PointClickCare was previously a line item on the orientation checklist but the competency training information is now on its own document. This document includes specific training on the fall risk and post fall evaluations that will trigger management to investigate incidents. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.Effective 02/11/2026, the director of nursing began reviewing all falls and incidents during the clinical meeting with the Interdisciplinary team in the morning meetings to ensure all documentation and notification was complete. Any incomplete documentation will be corrected, and the director of nursing will ensure correction occurs. This will continue as an ongoing new process for the facility. Effective 2/13/2026, the director of nursing began interviewing staff for ongoing understanding of the fall management policy. Teammates were interviewed as to whether they had seen any resident on the floor and whether or not this was reported and whether they were aware of any falls that had not been reported and documented in PointClickCare. The plan was then revised on 02/25/26 to include interviewing teammates about what constitutes a fall per the policy and the steps to follow when a fall occurs including completion of a fall risk assessment which would then trigger management to investigate further. The director of nursing will complete three interviews per week for four weeks and then five interviews per month for three months.Any issues found during the auditing process will be reported by the director of nursing during the Quality Assurance Performance Improvement meeting. Changes will be made immediately, if needed.Include dates when corrective action will be completed.Compliance Date: February 14, 2026 The Corrective Action Plan was validated on 3/6/26 by reviewing the education that was provided to staff regarding falls and who must be notified. The following documents were also reviewed: annual skills check for nurses, education on completing an incident report in PointClickCare (PCC), orientation and competency checklist on completing assessments in PCC, the orientation checklist for new hires on