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 ______	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ELMS	7449 FAIR OAKS DRIVE CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The survey team entered the facility on 01/13/25 to conduct a recertification survey. The survey team was onsite 01/13/25 through 01/16/25. Additional information was obtained offsite on 01/17/25. Therefore, the exit date was changed to 01/17/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #T90L11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 01/13/25 to conduct a recertification survey. The survey team was onsite 01/13/25 through 01/16/25. Additional information was obtained offsite on 01/17/25. Therefore, the exit date was changed to 01/17/25. Event ID# T90L11.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		2/6/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/09/2025

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.

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F 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: 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). The findings included: Resident #48 was admitted to the facility on 12/6/24. Resident #48's electronic medical record (EMR) revealed a physician's order dated 12/12/24 that read "full code."	F 578	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provision of federal and state law. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated.	

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F 578	Continued From page 2 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. Resident #48's admission Minimum Data Set (MDS) dated 12/19/24 revealed Resident #48 was moderately cognitively impaired. Resident #48's EMR showed a communication banner on the top of Resident #48's opened EMR and her code status read "full code." 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." 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. 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.	F 578	Plan of Correction – F578 (D) Request/Refuse/Discontinue Treatment; Formulate Advanced Directives 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Code Status for Resident #48 was updated in Point Click Care (PCC) electronic record to reflect Do Not Resuscitate (DNR)/goldenrod paper in Code book by Director of Nursing (DON) on 1-15-25. 2. How you will identify other residents having the potential to be affected by the same deficient practice. An audit was conducted of 100% of the residents code status to match paper DNR/goldenrod code to PCC electronic record for accuracy. Audit was conducted by Director Of Nursing/Staff Development Coordinator (SDC)/Minimum Data Set Coordinator (MDS) and completed on 1-15-25. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; Education was provided for all providers by the DON on 1-15-25 to take any code status changes to the hall nurse for entry into electronic record and code book. Education was provided to hall nurses on steps to enter/change code status/order in PCC electronic medical record and to place original DNR/goldenrod in code status book with a copy for medical records to scan into chart. Education was	

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F 578	Continued From page 3	F 578	provided by SDC/DON in person and also on the message system that goes to personal phones. Education was completed 2-6-25. 100% Audit was completed at time of discovery. Audits of code status will continue by DON/Designee utilizing an audit tool as presented to survey team for 5 times per week for new admissions for one month, then two times per week for one month, then weekly for one month. 4. How the corrective actions will be monitored to make sure solutions are sustained. Quality Assurance Performance Improvement (QAPI) plan has been put in place for Monitoring Audits of Code Status by DON and results will be reported to QAPI committee by DON monthly for one quarter ending April 2025. The QAPI team will reevaluate at that time if further audits are needed. Date of completion: 2-6-25	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		2/6/25

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F 695	Continued From page 4 by: 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. The findings included: a. Resident #57 was admitted to the facility on 12/6/24 with pneumonia due to hemophilus influenzae (bacteria in the upper respiratory tract). 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. A review of the admission Minimum Data Set (MDS) dated 12/13/24 indicated Resident #57 was coded for receiving oxygen. 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. 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.	F 695	Plan of Correction – F695 (D) Respiratory/Tracheostomy Care and Suctioning 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. For Residents #57, 69 & 48, oxygen in use signs were added to the doorframe of the bedrooms by the Supply Coordinator on 1-15-25. 2. How you will identify other residents having the potential to be affected by the same deficient practice. Director Of Nursing (DON) obtained a list of all residents on oxygen from Point Click Care (PCC) orders and an audit was conducted on 100% of all residents receiving oxygen for signs on bedroom doorframe by Supply Coordinator on 1-15-25. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; Supply Coordinator was educated on oxygen signs to be on all bedroom doorframes for residents receiving oxygen on 1-15-25 by DON. Front door sign was updated to reflect no smoking - oxygen in use by DON on 1-15-25, (we are a smoke-free campus). An audit tool was developed as shown to the surveyor and audits will be conducted by DON/Supply Coordinator: Once per week for 4 weeks, then twice per month for one month, then once per month for one month. Oxygen signs will be attached with the stored	

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F 695	Continued From page 5 b. Resident #69 was admitted to the facility on 12/23/24 with acute respiratory failure with hypoxia. 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%. A review of the admission Minimum Data Set (MDS) dated 12/30/24 indicated Resident #69 was coded for receiving oxygen. 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. 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. c. Resident #48 was admitted to the facility on 12/12/24 with pneumonia, chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease. 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. A review of the admission Minimum Data Set (MDS) dated 12/19/24 indicated Resident #48	F 695	oxygen for use in case of any new orders for oxygen. All nursing staff were educated via personal message on 2-6-25 as to where the signs would be located and that they were to be on the doorframe for all residents using oxygen. 4. How the corrective actions will be monitored to make sure solutions are sustained. A Quality Assurance Performance Improvement (QAPI) Plan has been put into place by Director of Nursing (DON) on 1-15-25. DON will report the results of these audits and corrections made monthly to the Performance Improvement team, which will report results monthly to the QAPI committee for one quarter at which time the committee will re-evaluate for further audit frequency if needed. Date of completion: 2-6-25	

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F 695	Continued From page 6 was coded for receiving oxygen. 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. 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. 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. 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.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		1/20/25

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F 761	Continued From page 7 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: 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). The findings included: Resident #77 was admitted to the facility on 9/13/24 with diagnoses that included cerebral infarction, hypertension, hyperlipidemia, anxiety, pleural effusion, and polyneuropathy. 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.	F 761	Plan of Correction – F761 (D) Label/Store Drugs 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. For Resident #77, was assessed by the provider on 1-13-25 with no adverse effects. A new self-administration of medications assessment was done for resident #77 by Minimum Data Set Coordinator (MDS) on 1-14-25. 2. How you will identify other residents having the potential to be affected by the same deficient practice. Director Of Nursing completed a review for self-administration of medication assessments for all residents on 1-13-25. 3. What measures will be put into place or what systemic changes you will make	

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Continued From page 8

A quarterly Minimum Data Set (MDS) assessment dated 12/2/24 indicated that Resident #77 was cognitively intact.

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.

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.

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.

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.

F 761

to ensure that the deficient practice will not recur;
An education/coaching was provided to nurse #1 by Director Of Nursing (DON) on 1-13-25 regarding medication administration policies and procedures and that all medications must be witnessed for ingestion or application by administering personnel. All Registered Nurses, Licensed Practical Nurses and Medication Aides were in-serviced regarding medication administration policies and procedure and that all medications must be witnessed for ingestion or application by administering personnel by DON/Staff Development Coordinator (SDC) in person or by phone or personal message on 1-13-25. An audit tool was developed as shown to surveyors and audits will be conducted of med pass once per week for 4 weeks, then twice per month for one month, then once per month for one month.
4. How the corrective actions will be monitored to make sure solutions are sustained.
A Quality Assurance Performance Improvement (QAPI) Plan has been put into place by Director of Nursing on 1-13-25. Director Of Nursing will report the results of these audits and corrections made monthly to Performance Improvement team, which will report results monthly to the QAPI committee for one quarter at which time the committee will re-evaluate for further audit frequency if needed.
Date of completion: 1-13-25

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F 851	Continued From page 9	F 851		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5)	F 851		

§483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format.
Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

§483.70(p)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(p)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each

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F 851	Continued From page 10 category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: 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). Findings included: 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,	F 851	Past noncompliance: no plan of correction required.	

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F 851	Continued From page 11	F 851		

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.

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.

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.

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

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 ______	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ELMS	7449 FAIR OAKS DRIVE CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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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.

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.

The facility implemented the following Corrective Action Plan with a completion date of 11/15/24.

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.

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.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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The results of the audits will be discussed during the QAPI monthly meetings for the next two quarters and reevaluated for resolution.

The facility's alleged compliance date was 11/15/24.

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.

The correction date of 11/15/24 was validated.