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 _____	C 04/30/2025

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TRINITY ELMS	7449 FAIR OAKS DRIVE CLEMMONS, NC 27012

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 4/29/25 through 4/30/25. Event ID# RQE511. The following intake was investigated: NC00229765. One (1) of the 1 complaint allegation resulted in deficiency.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interviews with the staff, Nurse Practitioner (NP), and Medical Doctor (MD), and Emergency Medical Services (EMS), hospital, and facility record reviews, the facility failed to correctly identify a resident when the medications ordered for one resident were inadvertently administered to another resident. This occurred for 1 of 3 resident (Resident #1) whose medications were reviewed. The findings included: Resident #1 was admitted to the facility on 4/15/25 with cumulative diagnoses which included a history of hypertensive heart disease with heart failure, atrial fibrillation (a type of heart arrythmia), and dementia with behaviors. A review of the resident's electronic medical record (EMR) indicated her 4/15/25 admission physician's orders included the following: --17 micrograms (mcg) per actuation ipratropium	F 760	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 facilitys allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. 1. For those affected: Medication aide #1 removed from cart until retrained/new check off sheet completed. Resident #1 was immediately assessed	4/30/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/06/2025

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F 760	Continued From page 1 (an oral inhalation medication used to treat asthma and/or chronic obstructive pulmonary disease) to be inhaled as two puffs orally every 6 hours as needed for shortness of breath; --6.25 milligrams (mg) carvedilol (an antihypertensive medication used to treat high blood pressure and/or atrial fibrillation) to be given as one tablet by mouth twice daily; --125 mcg (5000 units) cholecalciferol (a Vitamin D supplement) to be given as one capsule by mouth one time a day; --40 mg citalopram (an antidepressant medication) to be given as one tablet by mouth one time a day; --5 mg apixaban (an oral anticoagulant) to be given as one tablet by mouth two times a day; --600 mg guaifenesin (an expectorant used to thin mucous secretions) extended release (ER) to be given as one tablet by mouth every 12 hours as needed for congestion; --20 mg pantoprazole (a medication used to treat acid reflux) to be given as one tablet by mouth one time a day; and, --100 mg quetiapine (an antipsychotic medication) to be given as one tablet by mouth at bedtime. An order was also received on 4/15/25 to check the resident's vital signs every day and evening shift. The resident's 4/22/25 admission Minimum Data Set (MDS) reported Resident #1 had severely impaired cognition. Resident #1's EMR included her vital sign results from 4/15/25 through 4/23/25. This review revealed Resident #1's blood pressure (BP) and pulse (P) readings were variable. The low and high readings for her BP and pulse from 4/15/25 -	F 760	by nurse #1 at 10:50AM and no negative findings were noted. Provider made aware at 10:55AM by Nurse #1 and assessed and no negative findings noted. Resident Responsible Party made aware at 11:00AM by Nurse #1. Resident was sent to hospital for further evaluation. 2. Those with potential to be affected On 4/24/25 Director of Nursing, checked the Medication Administration Record to ensure all residents on that assignment were given their medications. No issues found. Nurse #1 assessed all residents on 4/24/25 and no issues were noted. Resident #2 Did receive her medications correctly. 3. Systemic changes All nurses and medication aides were educated on 4/24/25 by Staff Development Coordinator on the 6 rights of medication administration. Any nurse or medication aide not in-serviced on this date will be educated prior to their next working shift. Education was sent out via text message with response to the personal cell phones of all Nurses and Medication Aides as well as a verbal, in-person education by Staff Development Coordinator. The 6 rights flyer was also placed on all Medication carts for staff to view on 4/24/25 by Staff Development Coordinator. 4. Monitoring Starting 4/24/25 medication administration	

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F 760	Continued From page 2 4/23/25 included the following: --On 4/16/25 at 9:46 AM, her BP was documented to be 147/84 (a high BP reading for this resident); --On 4/16/25 at 9:46 AM, her pulse was documented to be 61 beats per minute (lowest pulse reading); --On 4/18/25 at 9:54 AM, the resident's pulse was documented to be 81 beats per minute (highest pulse reading); --On 4/21/25 at 3:40 PM, the resident's BP was documented to be 105/64 (a low BP reading for this resident). A Medication (Med) Error Report dated 4/24/25 at 10:50 AM documented that a medication error was reported to have occurred on 4/24/25 at 10:00 AM by Medication Aide (Med Aide) #1. The Medication Error Report indicated this med error involved the wrong medication, administration procedure not followed, and the wrong resident. Medications mistakenly administered to Resident #1 included the following: --1 tablet of 10 mg amlodipine (an antihypertensive medication); --1 tablet of 81 mg aspirin; --1 tablet of 5 mg benazepril (an antihypertensive medication); --1 tablet of 10 mg buspirone (an antianxiety medication); --1 tablet of 20 mg citalopram (an antidepressant); --1 tablet of 5 mg oxybutynin XL (an extended release formulation of a medication used to treat overactive bladder); --2 tablets of 100 mg docusate (a stool softener); --1 spray in each nostril of 50 mcg fluticasone nasal spray (a steroid used to treat inflammation due to allergies);	F 760	audits will be conducted by Staff Development Coordinator / designee. Audits to be conducted 2x/week for 4 weeks, 1x/week for 4 weeks, 2x/month for 4 weeks (1 month). Audits will be done for up to 2 Medication Aides working on the shift of the audit. Audits will include all shifts in which Medication Aides work to include weekend shift. These audits are to be completed by 7/14/2025. Results to be reviewed and submitted to QAPI committee with changes made if necessary, to ensure compliance. 5. Completion date 4-30-25	

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--1 tablet of 40 mg pantoprazole (a medication used to treat acid reflux);
--1 tablet of 0.5 mg risperidone (an antipsychotic medication);
--1 tablet of 100 mg trimethoprim (an antibiotic);
--1 drop of 0.4-0.3% Systane eye drops (a lubricant eye drop) instilled into each eye;
--1 tablet of 10 mg hydralazine (an antihypertensive medication).
The Med Error Report noted the resident's NP was notified of the error on 4/24/25 at 10:55 AM and the MD was notified on 4/24/25 at 11:00 AM. The provider spoke with the resident's Responsible Party (RP) and ordered the resident to be sent to the Emergency Department (ED).

An initial interview was conducted on 4/29/25 at 2:10 PM with Med Aide #1 in the presence of the facility's Director of Nursing (DON). Med Aide #1 was identified as the staff member who mistakenly administered another resident's medications to Resident #1 on 4/24/25. The Medication Aide reported she administered Resident #1's morning medications to her around 8:20 AM. At that time, the resident was not wearing her glasses or holding a stuffed animal. During the morning medication pass, she noticed a therapist had come to the hall to get Resident #2 for a therapy session, so she initially "skipped over" giving Resident #2 her morning medications. A while later (around 10:00 AM), she saw Resident #1 sitting in the TV room. She thought Resident #1 was Resident #2 because she looked quite different (she was now wearing her glasses and holding a stuffed animal). Med Aide #1 stated when she approached Resident #1, she addressed her by Resident #2's name, and Resident #1 responded. She then administered Resident #2's morning medications

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to Resident #1. Med Aide #1 reported that about one hour or so later, she realized she had made an error and reported it to the nurse (Nurse #1).

Resident #1's EMR included a Health Status Note dated 4/24/25 at 11:57 AM and authored by Nurse #1. Nurse #1 was the hall nurse assigned to care for Resident #1 on the first shift of 4/24/25. The note read, "Resident was given the wrong medications this am [morning], NP notified and advised for resident to be sent out to be evaluated, POA [Power of Attorney] notified and came to the building. BP 110/68, resident is alert no signs of pain or distress at this time. EMT [Emergency Medical Technicians] were called and are taking resident to [name of hospital]."

A telephone interview was conducted on 4/29/25 at 2:26 PM with Nurse #1. When asked, Nurse #1 recalled what transpired the morning of 4/24/25. She reported that Med Aide #1 came and told her that she thought she accidentally gave Resident #1 someone else's medications. The nurse told the med aide to check Resident #1's blood pressure a couple of times to be sure she was doing okay while she herself informed the facility's Director of Nursing (DON), NP (who happened to be in-house), and resident's RP of the incident. She stated the DON and NP joined her as they came to check on Resident #1 and talk with the resident's family member (who came to the facility). When asked if the resident had a change in condition, Nurse #1 stated she did not. Nurse #1 recalled her first BP was a little low (99/63), but when her BP was taken again it was 110/68. However, she reported the decision was made to send the resident out for evaluation as a precautionary measure. Meanwhile, staff stayed with the resident at the nursing station until

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Emergency Medical Services (EMS) arrived.

An NP Encounter Note dated 4/24/25 reported the resident was seen on this date per staff request due to a medication error. The notes read, in part: "Staff nurse reports that resident was given her scheduled am [morning] medication and was also administered another resident's am [morning] medication ..." She reported the resident was sitting up in a wheelchair and described her as, "alert and oriented at her baseline. She is in no acute distress. She denies pain, dizziness, headache, light-headedness. She is speaking in full sentences. No apparent adverse reactions. Staff nurse reports BP of 99/63." The NP's plan of care noted, " ...She was stable, at her baseline, in no acute distress. BP 110/68 prior to transfer..."

An interview was conducted on 4/29/25 at 12:02 PM with the NP. During the interview, the NP recalled she initially saw Resident #1 as a new admission on 4/21/25. On 4/24/25, the nurse notified her that the resident accidentally received her own morning medications plus those intended for another resident. The NP stated she reviewed the additional medications given to the resident and was primarily concerned about a potential drop in her blood pressure. The NP also noted that since Resident #1 was accidentally given another antipsychotic med, she wanted to have her monitored for potential drowsiness. She reported that although the decision was made to send Resident #1 out to the hospital for further evaluation, her BP was 110/68 prior to leaving the facility and the resident was "very stable." The NP added, "Absolutely she's had no reactions."

The EMS Report related to the transportation of

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Resident #1 from the facility to the hospital ED on 4/24/25 was reviewed. The Incident Times listed indicated the call was received from the facility on 4/24/25 at 11:50 AM with EMS "on scene" at 12:00 PM and departing the scene at 12:13 PM. The resident's vital signs were noted at 12:21 PM to include a BP of 118/58 and pulse of 59 bpm. EMS arrived at the hospital ED at 12:25 PM. A narrative of the EMS Report read in part, "No interventions were rendered at this time. The pt [patient] was monitored in route to the facility of family's choice. Care was transferred to the ED RN [Registered Nurse]."

The hospital ED records were received and reviewed. An ED Provider Note dated 4/24/25 at 12:55 PM noted the resident was alert and at baseline. Vital signs taken at 12:36 PM included BP 113/54 and at 12:40 PM her pulse was 59. The provider noted he reviewed the meds given incorrectly and noted "There are couple antihypertensives and some medicine that can cause sedation. Discussed with family will give IV [intravenous] fluid bolus and monitor overnight." An ED Extended Stay Discharge Note dated 4/25/25 at 9:04 AM read, in part: "There were all single dose meds and none were especially worrisome. She remained stable overnight. This morning she is asymptomatic and her family feels that she is at her baseline. Her vitals remained normal overnight and she has been stable during the 20 hour ED visit."

Resident #1 was discharged back to the facility on 4/25/25.

An interview was conducted on 4/29/25 at 2:41 PM with the facility's Medical Director, who was also Resident #1's Medical Doctor (MD). During

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the interview, the MD reported she was made aware of the 4/24/25 medication error involving Resident #1. When asked, the MD reported the main concern with this situation was about the extra BP medications the resident received. She stated she agreed with the NP in recommending the resident be sent out to the hospital. The MD reported sending her out was more precautionary than anything else. The resident wasn't dizzy, light-headed, or showing any concerning signs or symptoms prior to leaving the facility and she was at her baseline. Upon inquiry, the MD stated she was told the resident did receive fluids in the ED. She added that Resident #1 did not experience any adverse drug effects.

An interview was conducted on 4/30/25 at 8:55 AM with the facility's DON. During the interview, the DON was asked what her expectations were for the nursing staff when conducting medication administration. She responded by saying, "That they follow their administration guidelines related to the 6 rights [referring to the right person, right medication, right dose, right time, right route, and right documentation]."