

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-1391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		RECEIVED MAR 25 2015 Division of Health Facilities		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702				
(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	
F 000	INITIAL COMMENTS	F 000					
F 157 SS=D	For the standard Medicare/Medicaid recertification survey and complaint survey, started on 02/09/15 and completed on 02/12/15, the sample included 5 residents for complete review, 22 residents for focused review, and 3 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey. 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	F 157 All nursing staff have reviewed the education on the notification of providers. All residents have the potential to be affected. Resident # 14's provider was contacted and did come to visit with the resident on 2/10/15, did an assessment and provided orders. To prevent delay in treatment when a fax is sent to the provider's office, the office nurse will be called by the Trinity Homes nurse and informed when a fax will be sent. Any fax sent to the provider that does not have a return response in 24 hours must be followed up by nursing staff with a call to the provider. No faxes will be sent on the weekends or when the office is closed, the provider will be paged.				

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

TITLE

(X6) DATE

Rhonda Walker Administrator

3/12/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to ensure timely physician notification for 1 of 13 sampled residents (Resident #14) identified with pain. Failure to notify the physician of Resident #14's pain resulted in delayed treatment, and pain management. Findings include: Review of the facility policy and procedure titled "CALLING PROVIDER" occurred on 02/12/15. The policy, dated 01/15, stated "During regular office hours, the nurse should contact the provider's office directly. If the provider is not on duty, contact the switchboard to see who is taking the calls. For non-emergencies, a FYI [for your information] may be faxed to the provider's office. After hours, on weekends or holidays, or in an emergency, the nurse should contact the hospital switchboard and ask that the provider, or the on call provider be paged." - Review of Resident #14's record occurred on all days of survey. A hospital discharge summary, dated January 6, 2015 included diagnoses of a recent cerebrovascular accident, and status post repair of both an abdominal aortic and brain aneurysm. Current pain medications included Tylenol 1,000 milligrams (mg) three times daily as needed (PRN).	F 157	QA will be done weekly for 4 weeks or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. All QA will be reported monthly to the QA Meetings. Completion date is March 12, 2015. The DON is responsible for this process.		

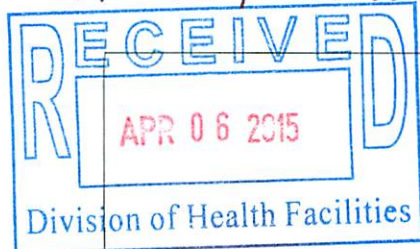
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 157	Continued From page 2 Record review showed documentation of new onset of pain in Resident #14's left groin on 01/18/15. Further monitoring identified the presence of a "large tender lump left lower groin" on 01/24/15. Progress notes identified groin pain on January 29-30, 2015 as moderate (scale of mild, moderate, severe, very severe/horrible). A "Skin Status Questionnaire," completed on 02/02/15, identified a "Large tender lump to left groin." A progress note showed a nurse faxed Resident #14's physician on 01/30/15 at 3:55 a.m. regarding a palpated pulse to the left groin accompanied with tenderness. The progress notes stated, on 02/09/15 at 9:38 a.m., a nurse again faxed Resident #14's physician regarding the left groin. Record review showed the physician did not respond to either fax. During interview on 02/10/15, a staff nurse (#13) stated she had no way of knowing if the physician actually sees the faxes, but only that the clinic received the fax. On 02/11/15 at 4:50 p.m., an interview occurred with two administrative staff members (#10 and #11). The staff member (#11) stated when the nursing home staff sent the fax to the doctor at the clinic (on two separate occasion, 01/30/15 and 02/09/15), the facility expects the clinic nurse to inform the physician. The current facility policy ("CALLING PROVIDER") failed to identify how and when the facility nurse should receive feedback from the physician regarding the fax/message. This failure resulted in Resident #14 waiting 12 days before a response from the physician occurred. During the survey, on 02/10/15, Resident #14's physician came to assess and provide orders regarding the	F 157			

OMB NO. 0938-0391

If continuation sheet Page 4 of 40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 278	Continued From page 4 interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 1 sampled resident (Resident #4) coded with delusions. Failure to accurately assess Resident #4 regarding delusions and code the MDS correctly does not reflect the resident's current status and may affect the accuracy of the care plan and the level of care provided to the resident. Findings include: The Long-Term Care Facility RAI User's Manual (Version 3.0), October 2014, page E-2 stated, "... E0100: Potential Indicators of Psychosis ... Coding Instructions ... Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply. ... *Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. ..." Review of Resident #4's medical record occurred on February 09-11, 2015 and diagnoses included stroke with right sided weakness and aphasia. The quarterly MDS, dated 11/30/14, identified the resident had delusions. The resident's medical record lacked evidence to support the coding of the delusions on the MDS. During an interview on 02/11/15 at 2:28 p.m., a social services staff member (#14) confirmed Resident #4's medical record lacked evidence to support the coding of the delusions on the quarterly MDS, dated 11/30/14.	F 278	<i>see attached revised POC for F278</i> All residents have the potential to be affected. Resident #4's MDS was revised to reflect that she did not have delusions during the 7 day look back period. On any MDS's that are due to be completed, the Social Worker will review each chart for completion of any Behavioral Tracking Intervention Assessments. Section E of the MDS will then be reviewed for delusions (as well as completion for the rest of the section). If the delusions are marked as present, the social worker will verify that this is accurate by locating the supporting documentation in the 7 day look back period. The MDS nurse will check Section E and if delusions are documented, the MDS nurse will notify the Social Worker and verify that the proper documentation is in place on the care plan and care guide. This is a double check system. QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. MDS nurses and social workers are responsible for ensuring correct and appropriate documentation to support hallucinations and/or delusions during the 7 day look back period on the MDS. All QA is to be reported to the monthly QA meeting. Completion date is March 23, 2015. The Director of Social Services and Director of Resident Information/MDS is responsible for the process.		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281			

Trinity Homes



F 278

All social workers and MDS nurses have received written education regarding hallucinations and delusions that are marked as present on the MDS, within the 7 day look back period. The occurrences must have supporting documentation demonstrating that hallucinations and/or delusions occurred during the 7 day look back period.

All residents have the potential to be affected.

Resident #4's MDS was revised to reflect that she did not have delusions during the 7 day look back period. All residents in the facility during the dates of the State Health Dept survey had their previous MDS reviewed for delusions. It was found that nine residents had flagged for delusions on the MDS and three of them had supporting documentation. The other 6 MDS' were modified to reflect the resident did not have delusions during the 7 day look back period. See attachment for resident list and supporting documentation.

Section E of the MDS will be completed by Social Services ; along with all appropriate supporting documentation for the seven day look back period. The MDS nurse will check Section E and if hallucinations and/or delusions are documented the MDS nurse will notify the Social Worker and verify that the proper documentation is in place. Nursing will also be notified and the care plan and care guide will be updated as required.

QA will be done weekly for 4 weeks, or

Trinity Homes
received 04/06/15

until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. MDS nurses and social workers are responsible for ensuring correct and appropriate documentation to support hallucinations and/or delusions during the 7 day look back period on the MDS. All QA is to be reported to the monthly QA meeting.

Completion date is March 12, 2015.

The Director of Social Services and Director of Resident Information/MDS are responsible for the process.

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 281 SS=D	Continued From page 5 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: INSULIN ADMINISTRATION 1. Based on observation, review of manufacturer's patient information, and staff interview, the facility failed to ensure administration of insulin occurred within the recommended time for 1 of 2 sampled residents (Resident #11) observed during insulin administration. Failure to administer NovoLog (a rapid-acting insulin) at the correct time may result in low blood sugar levels (hypoglycemia). This practice may negatively impact diabetic residents residing at the facility. Findings include: The manufacturer's "Patient Information," dated 2011, stated "Take NovoLog exactly as prescribed. You should eat a meal within 5 to 10 minutes after using NovoLog to avoid low blood sugar. NovoLog is a fast-acting insulin. The effects of NovoLog start working 10 to 20 minutes after injection . . . Do not inject NovoLog if you do not plan to eat right after your injection . . ." Observation of medication pass on 02/10/15 at 11:11 a.m. showed a nurse (#1) administered five units of NovoLog insulin to Resident #11. When asked, the nurse (#1) identified residents will eat between 11:30 a.m. and 11:45 a.m. (19 to 34 minutes after insulin administration). Staff	F 281	<i>F278 - (see revised POC for F278)</i> QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. MDS nurses and social workers are responsible for ensuring correct and appropriate documentation to support hallucinations and/or delusions during the 7 day look back period on the MDS. All QA is to be reported to the monthly QA meeting. Completion date is March 12, 2015. The Director of Social Services and Director of Resident Information/MDS are responsible for the process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 281	Continued From page 6 delivered Resident #11's meal tray to her room at 11:50 a.m. (39 minutes after the insulin administration). Facility staff failed to ensure Resident #11 received her meal within 5-10 minutes of insulin administration. This may result in unstable blood sugar levels for Resident #11 and other insulin dependent residents in the facility. MEDICATION ADMINISTRATION AND RESPONSE TO AS NEEDED (PRN) MEDICATIONS 2. Based on record review and review of facility policy and procedure, the facility failed to ensure staff assessed the response to prn pain medications for 1 of 13 sampled residents (Resident #14) identified with pain. Failure to assess the effectiveness of pain medications may result in the resident experiencing unrelieved pain. Findings include: Review of the facility policy and procedure for the "ADMINISTRATION OF MEDICATIONS" occurred on 02/12/15. The policy, dated 04/07, stated, "... STEPS IN PROCEDURE ... PRN medications are given and effect of drug on PRN record. . . ." Review of Resident #14's medical record occurred on all days of survey. Observation and record review identified the resident received Tylenol 1000 milligrams prn for pain. The medication administration record identified between January 07, 2015 and February 08, 2015 nursing administered 10 doses of the prn	F 281	F 281 All nursing staff has received written education on how to administer Novolog insulin at the correct time to prevent low blood sugars. All residents have the potential to be affected. Resident #11 & any other residents on Novolog Insulin will receive their insulin 5-10 minutes before their meals. Nursing staff will be observed that residents receiving Novolog are fed 5-10 min. after receiving their insulin injection. QA will be done weekly X 4 or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. All nursing staff is responsible for making sure residents are receiving their meals within 5 - 10 min. after receiving their Novolog Insulin. All audits will be reported to the monthly QA Committee. Completion date is March 12, 2015. The DON is responsible for this process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 281	Continued From page 7 Tylenol. Nursing staff failed to assess the effectiveness of the pain medication on 3 of the 10 occasions.	F 281	F281 All nursing staff has received the education on assessing the effectiveness of pain medications to prevent the residents from experiencing unrelieved pain.		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: PAIN 1. Based on observation, record review, policy and procedure review, resident and staff interview, the facility failed to provide necessary care and services to promote optimal well-being for 1 of 13 sampled residents (Resident #14) identified with pain. Failure to assess and determine causative factors for an acute onset of pain resulted in occasional complaints of pain. Findings include: Review of the facility policy and procedure for "Pain Management" occurred on 02/12/15. The policy, dated 04/2012, stated, "When a resident is receiving prn [as needed] medications more than three times a day . . . 1. Schedule pain monitoring every shift [times] 3 days. . . . 4. Update resident's doctor on pain control, and if no response is received, call the	F 309	All residents on prn pain medication have the potential to be affected. Resident #14 & residents using prn pain medications will have their pain assessed after receiving (prn) pain medication. The Unit Manager's will do audits on the residents receiving prn pain medications to review if the nurse has completed the assessment and residents are obtaining relief (as stated in the post pain assessment). QA will be done weekly X 4 or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. All nursing is responsible to make sure the policies are being completed as written. All audits will be reported to the monthly QA Committee. Completion date is March 12, 2015. The DON is responsible for the process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 309	Continued From page 8 doctor for steps to ensure pain relief. . . . 7. Verbal and nonverbal responses, facial expressions, and protective body movements can be documented in response to pain medication." - Review of Resident #14's record occurred on all days of survey. A discharge summary following a hospitalization from January 02-06, 2015, included diagnoses respiratory and heart failure, recent cerebrovascular accident, and status post repair of both an abdominal aortic and brain aneurysm. A Minimum Data Set, dated 02/03/15, identified Resident #14 as cognitively intact. Review of the Medication Administration Record from 01/18/15 to 02/10/15 (when seen by the physician) identified Resident #14 received 11 out of 72 possible doses of Tylenol ordered for PRN. On 02/10/15, observations, record review, resident and staff interview included: * 8:45 a.m., a certified nursing assistant (CNA) (#12) transferred Resident #14 from a wheelchair to bed. During the transfer, the resident complained of pain in her legs. * 10:50 a.m., during interview a CNA (#12) stated she informed the nurse regarding Resident #14's pain. The CNA stated Resident #14 complains of pain in her groin. At 11:00 a.m., during personal cares, Resident #14 stated "I have to do something with this pain." The resident stated she was not going to eat "When I have pain like this." Upon completion of personal cares, the CNA (#12) transported Resident #14 by wheelchair to the dining room. * 12:05 p.m., while seated in her wheelchair at the dining room table, Resident #14 complained of a sharp pain in her left groin. When asked if the	F 309	F 309 All residents with acute pain have the potential to be affected. Resident #14, her acute pain has been assessed and the provider updated. Post pain assessment template has been modified to investigate "acute pain & causative factors", with a reminder to notify the provider if he has not been updated. The Unit Manager's will monitor post pain acute assessments to verify residents triggering for acute pain and causative factors. They will also review that the providers have been updated and making sure the residents have good pain control. QA will be done weekly X 4 or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months, then quarterly. All nurses are responsible for assessing & determining causative factors for acute onset of pain & to notify the provider to achieve resident comfort. Completion date is March 12, 2015. The DON is responsible for this process.		

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 9 nurse provided her anything for pain, Resident #14 stated she failed to tell/inform the nurse she needed a pain medication. The resident asked the surveyor to tell the nurse regarding her discomfort. * 12:10 p.m., the surveyor approached a staff nurse (#13) regarding Resident #14's pain in her left groin. The nurse stated Resident #14's pain is getting worse. The nurse provided a copy of a fax sent to Resident #14's physician on 01/30/15 and again on 02/09/15. The faxes (second one a duplicate of the first) stated, "Resident has a large round protruding bump to her left groin. It is tender to touch & has a Really [sic] strong pulse to it. She said it really bothers her. She has been medicated [with] PRN Tylenol. Please Advise." The nurse stated she planned to send another fax today. Review of Resident #14's medication administration record (MAR) and progress notes showed nursing staff medicated Resident #14 for "groin pain" on 02/08/15. The MAR (on 02/10/15), showed the nurse medicated Resident #14 for pain at 12:41 p.m. and 3:30 p.m. * 12:35 p.m., nursing progress note, "Paged [physician] regarding Lt. [left] groin, continue to monitor and will make a visit to see resident on Thursday 2/12/15 [two days later] Resident voiced C/O [complaints of] of [sic] pain to Lt. groin, medication with prn medication. . . ." * 1:57 p.m., nursing progress note identified the physician "here" A preliminary report identified the physician assessment as "Pulsatile mass in the left groin, secondary aneurysm." * 2:25 p.m., an unidentified transport staff member at the nurse's station called the physical	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 10 therapy department to inform them Resident #14 would not be attending therapy "because she has so much pain." Review of Resident #14's MAR and progress notes showed: * the first documented onset of left groin pain on 01/18/15 at 11:54 p.m. The note on 01/18/15 stated "Observations noted: restlessnessNon [sic] verbal indicators of pain grimace" moderate in nature. * On 01/24/15 at 10:13 p.m. "at [10:00 p.m.] noted large tender lump left lower groin, will monitor for changes." * On 01/29/15 at 4:18 p.m., "... C/O groin pain . . . Lying in bed rubbing groin . . . moderate [pain scale] . . ." * On 01/30/15 at 3:00 a.m., "... pain: requested for . . . L [left] groin discomfort, Observations noted . . . grimace . . . moderate . . ." On 01/30/15 at 3:55 a.m. a nurse faxed Resident #14's physician regarding the pain and palpated pulse to the left groin and at 9:18 p.m. "Monitoring - Monitor Skin. C/O tenderness to area." (Location of tenderness not identified.) *On 01/31/15 at 6:05 p.m. "Monitoring - Monitor Skin. Resident C/O tenderness to area when touched." (Location of tenderness not identified.) * A "Skin Status Questionnaire," completed on 02/02/15 identified a "Large tender lump to left groin." * On 02/09/15 at 9:38 a.m., a nurse faxed a copy of the previously sent fax (from 01/30/15) to the	F 309			

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 11 physician. The progress note stated, "... Will continue to monitor." * On 02/10/15 at 12:35 p.m., the nurse "Paged [Resident #14's physician] regarding Lt. groin, continue to monitor and will make a visit to see resident on Thursday 2/12/15. ... Resident voiced C/O of pain to Lt. groin, medication with prn medication. ..." * On 02/10/15 at 2:39 p.m.: "[Resident #14's physician] here new order rec'd [received] and obs'd [observed]." The physician ordered a computerized tomography (CT) at that time. Resident #14's care plan identified the problem of occasional complaints of pain related to the diagnosis of osteoporosis however failed to address the acute pain to the resident's left groin area. On 02/11/15 at 4:50 p.m., during interview with two administrative staff members (#10 and #11). The staff members stated they expected nursing staff to manage Resident #14's pain. The staff member (#10) voiced awareness that Resident #14 does not complain of pain and often will not ask for anything. Facility staff failed to manage Resident #14 pain by not consistently assessing the pain and not ensuring the physician was aware of the acute pain. In the absence of a response from Resident #14's physician following the fax sent 01/30/15, nursing staff waited another 10 days (02/09/15) to attempt to get a response from the physician regarding the resident's pain. POSITIONING FOR FLUIDS/MEDICATIONS	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 12 2. Based on observation, record review, staff interview, and professional literature review, facility staff failed to provide care and services to maintain the residents' highest practicable physical well-being for 3 of 7 sampled residents (#10, #11, #12) and one supplemental resident (#31) observed to receive water and/or medications while in bed. Failure to provide fluids to a resident seated at a 90-degree angle has the potential to cause choking and placed residents at risk for aspiration. Findings include: Nancy B. Swigert, The Source for Dysphagia, third edition, LinguiSystems, Inc., East Moline, IL, 2007, page 125, stated "During the oral intake of medicines, foods and/or liquids, it is optimal for a patient to be seated at a 90 [degree] angle, whether in a bed or in a chair." - Review of Resident #10's medical record occurred on February 09-12, 2015. Diagnoses included Alzheimer's disease and dysphagia. The resident's annual Minimum Data Set (MDS), dated 12/11/14, identified severely impaired cognitive skills and extensive assist of one person for eating. Observation of care for Resident #10 occurred on 02/10/15 at 9:08 a.m. Two certified nurse aides (CNAs) (#4 and #5) provided personal care as she lay in bed. After cares, the CNA (#4) gave Resident #10 a drink of water while the resident laid on her left side and the head of the bed elevated less than 20-degrees. - Review of Resident #11's medical record	F 309	F-309 All nursing staff have received written education on proper positioning of residents when in bed if they are to receive any oral intake. All residents have the potential to be affected. Resident #10, #11, #12, #31 (when in bed) will receive fluids, medication, etc. in bed only when the head of the bed is positioned between 45 and 90 degrees. Residents that are in bed and are going to be taking medications, liquids, etc., are to be positioned in Fowlers or High-Fowlers position (45-90 degrees). QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. All nursing is responsible for making sure residents are positioned appropriately while in bed for receiving liquids, etc. All audits will be reported to the monthly QA Committee. Completion date is March 12, 2015. The Director of Nursing is responsible for the process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 13 occurred on February 09-12, 2015. Diagnoses included Parkinson's disease and esophageal reflux. The resident's quarterly MDS, dated 01/28/15, identified extensive assist of one person for eating. Observation of care for Resident #11 occurred on 02/10/15 at 3:10 p.m. Two CNAs (#7 and #8) assisted the resident with personal care as she lay in bed. The CNA (#7) gave Resident #11 a drink of water while the resident laid on her back with the head of the bed flat and the resident raising her head to drink. - Review of Resident #12's medical record occurred on February 09-12, 2015. Diagnoses included dementia and debility. The resident's quarterly MDS, dated 11/17/14, identified supervision and assistance of one person for eating. Observation of care for Resident #12 occurred on 02/10/15 at 3:28 p.m. A CNA (#6) assisted the resident with personal care as she lay in bed, and then turned her to her right side. The CNA (#6) gave Resident #12 a drink of water with the head of the bed flat, her head on a pillow and some water ran down the side of her face. The CNAs (#4, #5, #6, #7, and #8) failed to assure the physical well-being of Resident #10, #11, and #12 by providing fluids when not positioned upright. - Review of Resident #31's care plan occurred on 02/12/15. The care plan identified monitoring the resident for swallowing problems. During observation on 02/11/15 at 5:22 p.m., a	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 14 nurse (#17) administered six medications (five pills and one liquid) to Resident #31 while the resident laid flat in bed. The nurse instructed the resident several times to swallow the medications and then asked the resident if he swallowed the medications. During an interview on the morning of 02/12/15 at 2:00 p.m., an administrative staff member (#10) agreed staff should not provide fluids and/or medications when residents are in a recumbent position. THIS IS A REPEAT DEFICIENCY FROM THE COMPLAINT SURVEY COMPLETED ON 08/05/14 BOWEL MANAGEMENT 3. Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to provide necessary care and services to prevent constipation for 10 of 27 sampled residents (Resident #1, #5, #11, #13, #16, #18, #20, #21, #23, and #25). Failure to provide timely interventions for constipation and follow the facility's bowel protocol resulted in constipation and a manual extraction for Resident #5 and #16 and unrelieved constipation for Resident #1, #11, #13, #18, #20, #21, #23, and #25. Findings include: Review of the facility protocol titled "Bowel Protocol" occurred on 02/11/15. This undated protocol stated, "... If a resident is on day 2 of no BM [bowel movement], he/she is to receive prune juice, or a provider's standing order for bowel	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 15 aide. On day 3 of no BM, the resident is to receive an oral laxative, such as MOM [milk of magnesia], or a provider's standing order for a bowel aide. Also a consult to dietary is to be completed. On day 4 of no BM, the resident is to receive a fleet's enema or Dulcolax suppository, depending on provider orders. The nurse may also do a digital rectal exam prior to see if stool is present. . . . If a resident's bowel pattern does not follow a typical pattern this should be documented in the resident care plan. . . ." "Nursing 2015 Drug Handbook," 35th edition, Wolters Kluwer, Pennsylvania, page 607, states regarding ferrous sulfate, "Therapeutic class: Iron supplements . . . Adverse Reactions: . . . constipation, black stools . . ." and on pages 599 - 603, states regarding fentanyl transdermal system, "Therapeutic class: Opioid analgesics . . . Nursing Considerations: . . . Drug may cause constipation. Assess bowel function and need for stool softeners and stimulant laxatives. . . ." - Review of Resident #5's medical record occurred on February 9-11, 2015. Diagnoses included dementia and a history of urinary tract infections (UTIs). Admission orders did not include scheduled or as needed (prn) medications for constipation. The current care plan stated, ". . . Nutrition/Feeding - . . . Follow dietary bowel protocol. . . (October 20, 2014) . . . Approach . . . Increase fluid intake q shift (Started November 5, 2014 - continuing) . . ." Physician's orders stated the following: *11/05/14: "Docusate/Senna [a laxative] 50/8.6 mg [milligrams] 2 Oral Tablet [at] bedtime" *11/05/14: "MiraLax 17 g [grams] Oral Powder Two times daily continuous prn"		F 309 All nursing staff have received education on administering prn medications for BM protocol & following BM protocol guidelines to prevent constipation. All residents have the potential to be affected. Resident's #1, #5, #11, #13, #16, #18, #20, #21, #23 & #25 have had their BM records & dietary consults reviewed. Interventions were added to the care plans & staff reeducated on the BM Protocol procedure to prevent constipation. Resident's will continue to be monitored for BM's every shift. A BM list is kept on all nursing units and staff will write any resident BM on this list. CNA's will chart the resident results in the computer under monitoring for BM's. Nurses/Med Aides will chart any interventions in the computer in the questionnaire "Bowel Protocol Questionnaire". The night shift nurse will review and update the BM list as to which residents are requiring bowel protocol interventions. The day nurse/ Med Aide will review the BM list and administer the appropriate intervention. The night nurse will copy the updated BM list and give a copy to Dietitians for their consults, the medication nurse/Med Aide & the Unit Manager from that unit. The Unit Manager will verify daily the protocol is followed by checking the residents on the list provided to her. The provider shall be notified if the Bowel Protocol does not fit the individual resident. Any refusal of care on the resident's part will be documented in the EHR under the Bowel Protocol Questionnaire. The MDS nurse will continue to send an email to the nurse		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 309	Continued From page 16 *11/05/14: "Increase fluid intake q [every] shift continuous" *11/11/14: "Offer fluids EVERY time you are in room" Bowel records identified a bowel movement on 10/29/14 and not again until 11/04/14 (six days later). Nurses' notes identified the following: *10/29/14 at 9:54 p.m.: "... new order for Zofran [anti-nausea medication] 4 mg. Resident continues to c/o [complain of] nausea. ..." *10/30/14 at 1:30 p.m.: "... [Resident #5] had complained of dry heaves and nausea this am [morning] and was medicated with Zofran with good relief. ..." *11/01/14 at 6:11 p.m.: "... Monitoring - BMs on Evenings ... prune juice given ..." *11/04/14 at 2:58 a.m.: "... Resident continues to go without BM. Last BM six days. Resident received Marlex [sic] 17g PO [orally] after refusing suppository. ..." *11/04/14 at 10:26 a.m.: "... Resident was administered PRN Dulcolax suppository this AM due to 6 days without BM. ... Around 0940 [9:40 a.m.], resident stated that she needed to go to the bathroom. CNA [certified nursing assistant] assisted resident to toilet; transferred okay. Over next 5 minutes, resident started slumping over, crying out. CNA, CMA [certified medication aide], and writer then assisted resident into w/c [wheelchair]. Once placed in w/c, resident became unresponsive, head drooping back. BP [blood pressure] 62/42, P [pulse] 92. During next 30 seconds, resident became more responsive. ... At 1015 resident hollering out 'I have to poop!' Bedpan placed and resident unable to comprehend use of bedpan. Writer then digitally	F 309	manager, charge nurse & dietary on any resident who triggers for constipation on the MDS. The chart will then be reviewed and recommendations addressed in the care plan. If a resident's bowel pattern does not follow a typical pattern, this should be documented in the resident's care plan. QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. All nursing is responsible for making sure the residents are following the Bowel Protocol. All audits will be reported to the monthly QA Committee. Completion date is March 23, 2015. The DON is responsible for the process.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/12/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

TRINITY HOMES

STREET ADDRESS, CITY, STATE, ZIP CODE

305 8TH AVE NE
MINOT, ND 58702

(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
F 309	Continued From page 17 assisted resident, resulting in a small BM. Abdomen continues to be firm. . . ." Record review identified staff gave Resident #5 prune juice on 11/01/14; however, staff failed to administer other pm constipation medication per facility policy until 11/04/14 (six days after the resident's last bowel movement). Observation in Resident #5's room on all days of survey identified a sign posted above the resident's bed which stated, "Give me water when you enter and leave my room please. Thank You." Observation of cares on 02/10/15 at 8:12 a.m. and 10:25 a.m. and on 02/10/15 at 2:40 p.m. identified staff failed to offer Resident #5 water or fluids during these interactions. - Review of Resident #13's medical record occurred on all days of survey. The current care plan, stated, "Problem: Nutrition/Feeding . . . Follow dietary bowel protocol" Medications included MiraLax 17 grams twice daily, ordered 02/04/15. Resident #13's bowel record for the last three months showed the following days without a BM: * November 05-08 = 4 days; no bowel protocol initiated on day 3, as needed (PRN) Colace given on day 4 * November 24-26 = 3 days; no bowel protocol initiated on day 3 * December 09-12 = 4 days; no bowel protocol initiated on day 3 or 4 * December 18-22 = 5 days; no bowel protocol initiated on day 4, refused on day 3 and 5 * December 26-29 = 4 days; no bowel protocol initiated on day 3 or 4	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 18 * January 04-07 = 4 days; no bowel protocol initiated on day 3, refused on day 4 * January 19-23 = 5 days; no bowel protocol initiated on day 3, 4, or 5; PRN Colace given on day 6 (January 24) Resident #13's nurses' notes, dated 01/08/15 at 9:56 a.m., stated, "... Resident [sic] has gone 2-4 days with no BM. Resident [sic] does not have scheduled bowel medication. ..." Failure to initiate the bowel protocol on day 3 of no BM may lead to unresolved constipation and has the potential to cause Resident #13 unnecessary pain and discomfort. - Review of Resident #16's medical record occurred on all days of survey. Diagnoses included hemiplegia. The current care plan stated, "Problem: Elimination . . . prone to constipation . . . Goal: Resident will have normal BM's q [every] 2-3 days . . . Problem: Nutrition/Feeding . . . Follow dietary bowel protocol . . ." Medications included ferrous sulfate 325 mg daily (ordered 02/05/14), and the laxatives MiraLax 17 gm twice daily (ordered 06/09/14), Senna S 2 tablets daily and Dulcolax 10 mg suppository PRN to use if greater than 72 hours without a BM (both ordered 12/04/14), and Colace 100 mg twice daily (ordered 01/02/15). Resident #16's bowel record for the last three months showed the following days without a BM: * December 04-06 = 3 days; no bowel protocol initiated on day 3 * December 08-10 = 3 days; no bowel protocol initiated on day 3 * December 12-14 = 3 days; no bowel protocol initiated on day 3	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 19 * December 17-19 = 3 days; no bowel protocol initiated on day 3 * December 24-27 = 4 days; no bowel protocol initiated on day 3 or 4; PRN Dulcolax suppository given on day 5 (January 28) * January 06-08 = 3 days; no bowel protocol initiated on day 3 * January 18-21 = 4 days; no bowel protocol initiated on day 3; PRN Milk of Magnesia 30 milliliters (ml) given on day 4 per physician standing order Resident #16's nurses' notes, dated 01/01/15 at 11:22 a.m., stated, "Digitally remove her stool this am. will sent [sic] a update to doctor to trial something daily." Failure to initiate the bowel protocol on day 3 of no BM or administer Dulcolax suppository per physician order when greater than 72 hours without a BM may have resulted in constipation and manual extraction for Resident #16. - Review of Resident #20's medical record occurred on 02/11/15. The current care plan stated, "... Elimination - incontinent of both bladder and bowel, totally dependent ... Approach ... Milk of Magnesia 30 ml oral suspension daily PRN (ordered 01/21/10) ... MiraLax 17 GM oral powder two times daily PRN (ordered 04/09/14) ... Nutrition/Feeding ... Follow dietary bowel protocol ... " Review of Resident #20's physician's orders identified no scheduled bowel medications. Review of Resident #20's bowel records and PRN Medication Administration Records (MARs) from September 2014 to February 12, 2015 identified the following:	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 20 *BM on 09/17/14 and again on 09/21/14 (four days later) *BM on 09/22/14 and again on 09/26/14 (four days later) *BM on 10/10/14 and again on 10/14/14 (four days later) *BM on 11/12/14 and again on 11/17/14 (five days later) *BM on 12/09/14 and again on 12/14/14 (five days later) *BM on 12/27/14 and admitted to the hospital on 12/31/14 for dehydration, urinary tract infection, and probable congestive heart failure exacerbation (at least four days without) *Returned from the hospital on 01/02/15 and first BM recorded on 01/11/15 (at least nine days without) (PRN MiraLax administered on 01/08/15) *BM on 01/18/15 and again on 01/24/15 (six days later) (Nurses' notes identified the resident refused a bowel aid on 01/22/15) *BM on 02/07/15 and none recorded yet upon conclusion of survey (at least five days without) (PRN MiraLax administered on 02/11/15) Progress notes identified the following: *10/01/14 - Dietary - "... Res [resident] gets prune juice and apple slices daily ..." Staff failed to follow their bowel protocol and provide additional bowel interventions/medications to Resident #20 to promote regular bowel movements. - Review of Resident #21's medical record occurred on 02/11/15 and diagnoses included hemiplegia. The current care plan stated, "... Elimination - incontinent of both bladder and bowel, totally dependent ... Approach ... MiraLax 17 g oral powder daily PRN (ordered	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 21 04/16/13) . . . Senna 8.6 mg oral tablet daily (ordered 11/04/14) . . . Nutrition/Feeding . . . Follow dietary bowel protocol . . . Potential for dehydration . . . Approach . . . Increase fluid intake . . ." Bowel records identified a bowel movement on 09/09/14 and not again until 09/13/14 (four days later). Progress notes identified the following: *09/12/14 - Dietary - "Received notice res is on day 3 no BM, last recorded BM on [09/09/14]. Res does receive fruitball with breakfast daily . . ." *09/13/14 - Nursing - "Reason for medication: to promote BM . . . Dulcolax . . . Rectal Suppository . . ." Staff failed to follow the facility's bowel protocol and administer/offer Resident #21 an oral laxative prior to administering a suppository. - Review of Resident #11's medical record occurred on February 9-12, 2015. Diagnoses included Parkinson's disease and constipation. Resident #11's current "Care Guide" stated, "Toileting: . . . Assist to toilet as requested by [Resident #11], uses bedpan., Monitor bowel movements, . . ." Resident #11's current "Care Planning Report" stated, "Elimination - incontinent of both bladder and bowel, self care deficit for toileting . . . Approach . . . Colace 100 mg Oral Capsule daily PRN x1 [one time] (Started January 9, 2012 - continuing) . . . MiraLax 1 Scoop Oral Powder - (17 gm) orally daily as needed PRN (Started January 9, 2012 - continuing) Colace 100 mg Oral Capsule - q [every] HS-[hour of sleep] daily	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 22 (Started January 26, 2012 - continuing) . . ." Review of Resident #11's bowel records from August 2014 to February 12, 2015 identified the following: * BM on 08/15/14 and again on 08/20/14 (five days later) no PRN laxatives offered. * BM on 08/21/14 and again on 08/25/14 (four days later) with a suppository given on day four without an oral laxative first. * BM on 09/01/14 and again on 09/06/14 (five days later) no PRN laxatives offered. * BM on 11/10/14 and again on 11/14/14 (four days later) no PRN laxative offered. * BM on 11/22/14 and again on 11/26/14 (four days later) no PRN laxative offered. * BM on 11/29/14 and again on 12/04/14 (five days later) no PRN laxatives offered. * BM on 12/18/14 and again on 12/22/14 (four days later) no PRN laxative offered. * BM on 01/13/15 and again on 01/17/15 (four days later) no PRN laxative offered on day three without a BM. * BM on 01/20/15 and again on 01/24/15 (four days later) with a suppository given on day four without an oral laxative first. * BM on 01/31/15 and again on 02/04/15 (four days later) no PRN laxative offered. * BM on 02/07/15 and again on 02/11/15 (four days later) no PRN laxative offered. Staff failed to follow the facility's bowel protocol and failed to administer/offer Resident #11 an oral laxative prior to administering a suppository on two occasions. - Review of Resident #18's medical record occurred on all days of survey. Diagnoses included constipation. The current care plan	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 23 stated, "... ELIMINATION ... self care deficit for toileting ... DIAGNOSES: ... CONSTIPATION Goal: Resident will have normal BM's q 2-3 days ... Approach ... MiraLax 17 g Oral Powder daily (Started September 27, 2013 - continuing). ..." Physician's orders stated, "MiraLax 17 g Oral Powder daily continuous. Start Date Sep 27, ... 2013." Review of Resident #18's BM reports and MARs from October 2014 through February 12, 2015 identified: * November 2014 - three occasions of three days with no BM and no PRN laxative administered * 12/07/14 - MOM administered on day four of no BM. No PRN laxative administered on day three * 12/10/14 - MOM administered on day four of no BM. No PRN laxative administered on day three * 12/14/14 - Dulcolax suppository administered on day four of no BM. No PRN laxative administered on day three * 12/22/14 - Dulcolax suppository administered on day six of no BM. No PRN laxative administered on day three, four, or five * 01/08/15 - Dulcolax suppository administered on day four of no BM. No PRN laxative administered on day three * 01/13/15 - Dulcolax suppository administered on day four of no BM. No PRN laxative administered on day three Staff failed to follow the facility's bowel protocol and failed to administer/offer Resident #18 an oral laxative prior to administering a suppository on four occasions. - Review of Resident #23's medical record occurred on February 11-12, 2015. Diagnoses	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 24 included dementia and failure to thrive. The current care plan stated, "... ELIMINATION ... self care deficit for toileting ... Goal: Resident will have normal BM's q 2-3 days ... Approach ... MiraLax 17 g Oral Powder ... every 2 days (Started October 23, 2013 - continuing). Senna Plus 1 Tablets Oral Tablet daily PRN (Started October 23, 2013 - continuing). ..." Physician's orders stated, "MiraLax 17 g Oral Powder Every 2 days continuous Hold if having loose stools Start Date Oct 23, 2013; Senna Plus 1 Tablets Oral Tablet daily continuous prn repeating Start Date October 23, 2013; FentaNYL 12 mcg/hr [micrograms per hour] Transdermal Patch Start Date May 04, 2013 [for osteoporosis pain]." Review of Resident #23's BM reports and MARs from October 2014 through February 12, 2015 identified: * 10/03/14 - Senna Plus 1 Tablet administered on day five of no BM. No PRN laxative administered on day three or four Staff failed to follow the facility's bowel protocol and failed to administer/offer Resident #23 a laxative before day five. - Review of Resident #25's medical record occurred on February 11-12, 2015. The current care plan stated, "... ELIMINATION - self care deficit for toileting ... Goal: Resident will have normal BM's q 2-3 days ... Approach ... MiraLax 1 Scoop Oral Powder daily (Started April 16, 2011 - continuing). ..." Physician's orders stated, "MiraLax 1 Scoop Oral Powder daily continuous Start Date Apr 16, 2011."	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 25 Review of Resident #25's BM reports and MARs from October 2014 through February 12, 2015 identified: * 10/17/14 - MOM administered on day three and on day four of no BM * 11/04/14 - Dulcolax suppository administered on day five of no BM. No PRN laxative administered on day three or four * 11/20/14 - MOM administered on day two of no BM * January 2015 - three occasions of three days with no BM and no PRN laxative administered Staff failed to follow the facility's bowel protocol and failed to administer/offer Resident #25 an oral laxative prior to administering a suppository on one occasion. - Review of Resident #1's medical record occurred on February 09-11, 2015. The current care plan stated, "Problem: ELIMINATION - prone to constipation, self care deficit for toileting, incontinent of bowel & [and] bladder . . . Approach . . . Milk of Magnesia 30 ml Oral Suspension daily PRN x1 (Started February 8, 2008 - continuing), Dulcolax 10 mg Rectal Suppository daily PRN x1 (Started February 8, 2008 - continuing) . . . Senna 8.6 mg Oral Tablet Two times daily (Started October 27, 2014 - continuing), MiraLax 17 GM Oral Powder daily (Started January 7, 2015 - continuing) . . ." Physician's orders stated the following: * 02/08/08: "Dulcolax 10 mg Rectal Suppository daily continuous prn one time" * 02/08/08: "Milk of Magnesia 30 ml Oral Suspension daily continuous prn one time" * 10/27/14: "Senna 8.6 mg Oral Tablet Two times daily continuous"	F 309			

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 309	Continued From page 26 * 01/07/15: "MiraLax 17 GM Oral Powder daily continuous" Bowel records identified a bowel movement on 01/14/15 and not again until 01/20/15 (six days later). Nurses' notes identified the following: * 01/20/15 at 5:00 a.m.: "Reason for medication: to promote BM, Bowel Movement Results: Large BM, Medications - Dulcolax 10 mg Rectal Suppository" * 01/20/15 at 8:32 a.m.: "BM consult: Res [resident] on day 6 of no BM. Res had 2 BM charted last 7 days. Last BM noted 1-20 today. Res refuses bowel aides from dietary and eats meals in cafe downstairs. Encourage fluids. Senna bid on board and MOM as needed." Staff failed to administer prn constipation medication until 01/20/15 (six days after the resident's last bowel movement). During an interview on 02/11/15 at 4:17 p.m., a supervisory nurse (#2) stated staff should follow the facility's bowel protocol for constipation if residents do not have specific physician's orders.	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 315	Continued From page 27 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview the facility failed to ensure care in a manner to prevent urinary tract infections (UTIs) for 1 of 2 sampled residents (Resident #2) with a Foley catheter, and for 2 of 7 sampled residents (Resident #8 and #14) observed provided incontinence cares. Failure to transfer/transport catheter drainage bags in an aseptic manner and perform incontinence cares from front to back may contribute to the development of UTIs. Findings include: Review of the facility policy and procedure for "CATHETER CARE" occurred on 02/12/15. The policy, dated 02/10, stated, "PURPOSE: Prevent infection. . . . Position drainage bag below the bladder level. Do not allow drainage bag or tubing to touch the floor. . . ." Review of the facility policy and procedure for "FEMALE PERINEAL CARE" occurred on 02/12/15. The procedure, dated January 2010, stated, ". . . Clean the supra pubic area first then use one gloved hand to stabilize and separate the vulva. With the other gloved hand, proceed as follows. Bring soaped washcloth in one downward stroke, being sure not to bring the washcloth back upwards . . . Turn resident away from you. . . . Make a mitt, wet, and apply soap lightly, wash buttocks, turning cloth with each wipe. 16. Expose anal area. Wash area, stroking from	F 315	F315 Pericare All nursing staff has been educated on following the policies "Peri Care-Female" and "Peri Care- Male". All residents have the potential to be affected Resident #14 and # 8 will have peri cares performed as per policy. All nursing staff has reviewed the policies titled "Peri Care -Female" and "Peri Care-Male". Observations of nursing staff will be performed to ensure the policy is being completed as written. QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. All nursing is responsible to make sure the policies are being completed as written. All audits will be reported to the monthly QA Committee. Completion date is March 12, 2015 The Director of Nursing is responsible for the process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 315	Continued From page 28 perineum to coccyx." Review of the facility policy and procedure for "MALE PERINEAL CARE" occurred on 02/15/15. The policy/procedure, dated January 2010, stated, "... PERINEAL CARE IN STANDING POSITION ... 4. With resident standing - wash the penis and scrotal area, then wash the rectal area wiping front to back." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included urinary retention treated with the placement of a Foley catheter. The record identified the treatment of a urinary tract infection in January 2015. Observations showed: * 02/09/15 at 5:10 p.m., an unidentified certified nursing assistant (CNA) transported Resident #2 down the hall in a wheelchair. The catheter drainage bag cover skimmed the surface of the carpeted floor. * 02/10/15 at 7:50 a.m., two CNAs (#12 and #16) transferred Resident #2 from the bed using a full body lift to a wheelchair and tied the Foley drainage bag to the sling strap on the resident's right side, which placed the drainage bag at the resident's upper chest level. Following the transfer, the CNAs placed the drainage bag under the seat of the wheelchair. Following the transfer, during transport, the covered drainage bag skimmed the surface of the carpeted floor. * 02/10/15 at 9:00 a.m., a CNA (#16) and a nurse (#13) transferred Resident #2 from the wheelchair to bed with a full body lift. During the transfer, the staff attached the Foley drainage bag to one of the two sling straps which placed the drainage bag at the resident's chest level	F 315	F315 Positioning Catheter Bags All nursing have received education on correct positioning of urinary catheter bags. All residents with catheters have the potential to be affected. Resident #2's urinary drainage bag will be positioned below bladder level but not touching the ground when in wheelchair. Resident #2's urinary drainage bag will be positioned below the level of the bladder during transfers. All nursing staff has reviewed the policy titled "Catheter Care", with special attention to number 8, "Position drainage bag below the bladder level". Do not allow drainage bag or tubing to touch the floor. Put drainage bag cover on drainage bag when outside the room." Nursing staff will be observed to make sure the catheter bag remains below the level of the bladder and is not touching the floor. Trinity Homes only uses catheters that have anti reflux valves.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 315	Continued From page 29 during the transfer. During interview on 02/11/15 at 4:50 p.m., an administrative nurse (#10) stated Foley catheter drainage bags should not be at chest level. - Review of Resident #14's medical record occurred on all days of survey. Diagnoses from a hospitalization in early January 2015 included a UTI and five days of an intravenous antibiotic. During observation of personal cares on 02/10/15 at 8:45 a.m., a CNA (#12) provided perineal cares for an incontinent bowel movement. The CNA provided cleansing of the rectal area with gloved hands, and followed with providing frontal pericare with the same gloved hands. - Review of Resident #8's medical record occurred on February 9-12, 2015. Diagnoses included history of urinary tract infection (identified when hospitalized with behaviors August 2014), and chronic kidney disease. The resident's quarterly MDS, dated 02/04/15, identified short and long-term memory problems, and extensive assist of two person for toileting and personal hygiene. Observation of care for Resident #8 occurred on 02/10/15. The CNA (#6) assisted the resident with toileting. When Resident #8 indicated, the CNA (#6) assisted him to stand up from the toilet and provided rectal perineal cares for stool. The CNA (#6) changed gloves and provided frontal perineal cares. The CNA (#6) failed to provide perineal care from front to back as identified by policy.	F 315	QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. All nursing is responsible for following the policy "Catheter Care". All audits will be reported to the monthly QA Committee. Completion date is March 12, 2015. The Director of Nursing is responsible for the process.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 323	Continued From page 30 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the necessary supervision to prevent accidents for 1 of 13 sampled residents (Resident #5) with a history of falls. Failure to consistently implement fall prevention measures (i.e. leaving a resident's room door open) may result in avoidable falls and injuries. Findings include: Review of Resident #5's medical record occurred on February 9-11, 2015. Diagnoses included dementia and a history of falls. Observation during the initial tour, on the morning of 02/09/15, showed a sign on Resident #5's room door which stated, "Only close door during cares! Please check on me when you walk past my room!" During an interview on the morning of 02/09/15, a supervisory nurse (#2) identified Resident #5 as a "frequent faller." The resident's current Care Guide (used by certified nursing assistants [CNAs]) stated, "... Transfers with gaitbelt and assist of 1 ... Ambulatory, refuses to use a walker - gaitbelt &	F 323	F 323 Door not left open as per care plan/care guide All nursing staff have been educated on compliance on the falls prevention measure; leaving resident room door open when staff not in room All residents have the potential to be affected. Resident #5 has been reviewed for falls, with the last fall for this resident on 1/06/2015. The last time this resident had behaviors that involved putting herself on the floor was 2/07/2015. Based on this, the intervention to keep the door open when staff not in the Resident #5's room has been removed from the care plan and care guide. Nursing staff need to be aware of any resident that has "leave door open when staff not in room" on their care plan/guide, as a falls prevention measure, and follow through with compliance. Nursing staff will be monitored for compliance through observations by the Nurse Manager.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 323	Continued From page 31 assist of 1 in room . . . uses manual wheelchair" The Care Guide and the Care Plan failed to identify the fall intervention of leaving Resident #5's room door open except when staff completed personal cares. A "Falls Documentation" form, dated 12/16/14, identified a fall which occurred in Resident #5's room. The form stated, ". . . What adjustments are being made? . . . will leave door open so staff can see resident as staff walks past her room . . ." A "Falls Documentation" form, dated 12/22/14, identified another fall which occurred in Resident #5's room. The form stated, ". . . What adjustments are being made? . . . Educated staff on importance of leaving door open at all times. . ." Observations throughout the afternoons of 02/09/15 and 02/10/15 showed the door to Resident #5's room remained closed, even when staff were not present in the room. An observation on 02/10/15 at 3:05 p.m. showed an unidentified staff nurse entered Resident #5's room to offer the resident a supplement. The nurse then left the resident's room and pulled the door shut behind her. During an interview on 02/11/15 at 3:50 p.m., a staff nurse (#3) stated the door to Resident #5's room is supposed to be left open. During an interview on 02/11/15 at 4:17 p.m., a supervisory nurse (#2) identified leaving the door open as one of Resident #5's fall prevention measures and staff are expected to implement it.	F 323	QA's will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. All nursing are responsible to make sure falls prevention measures are completed. All audits will be reported to the monthly QA Committee. Completion date is March 12, 2015. The Director of Nursing is responsible for the process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 328 F 328 SS=D	Continued From page 32 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide the necessary care and services for 1 of 6 sampled residents (Resident #14) who required oxygen. Failure to provide oxygen as ordered/as necessary to maintain appropriate oxygen levels has the potential for Resident #14 to experience complications and/or hospitalization related to low oxygen saturation levels. Findings include: Review of the facility policy and procedure titled "Oxygen Therapy & Titration Protocol" occurred on 02/12/15. This policy, dated 02/14, stated, "... L.P.N's [licensed practical nurses]/R.N.'s [registered nurses] is [sic] responsible for putting oxygen on residents ..." Review of Resident #14's medical record occurred on all days of survey. Diagnoses	F 328 F 328	F328 Oxygen All nursing staff has been educated on the policy "Oxygen therapy & titration protocol-oximetry readings". All residents have the potential to be affected. Resident # 14 will only have oxygen shut off /on or tubing changed from tank to a concentrator by an R.N or L.P.N All nursing staff has received has received education on the policy "Oxygen therapy and titration protocol-oximetry readings." Oxygen is considered a medication and requires an assessment for its use, therefore only R.N's/L.P.N's will be permitted to shut oxygen on and off and switch oxygen between a concentrator and an oxygen tank. C.N.A's must not shut off oxygen on residents. CNA's will be educated to contact the nurse to switch the oxygen before transferring the residents. Nursing staff will be observed to make sure the process is being completed correctly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 328	Continued From page 33 included chronic obstructive pulmonary disease (COPD). Resident #14 experienced a hospitalization January 02-06, 2015 for respiratory failure, pneumonia, and exacerbation of COPD. Current physician's orders included oxygen at three liters per minute continuous. Observation on 02/10/15, showed a certified nursing assistant (CNA) (#12) removed Resident #14 removed Resident #14's oxygen tubing attached to a portable oxygen tank at 8:55 a.m. The CNA provided cares to the resident and at 9:20 a.m. informed the nurse who then turned on/adjusted the flow rate of the oxygen from the concentrator. Observation on 02/10/15, a CNA (#12) showed a CNA (#12) provided cares to Resident #14. At 11:11 a.m., the CNA turned off the oxygen flow from Resident #14's oxygen concentrator and connected the oxygen tubing to the portable tank on the back of the wheelchair. The CNA transported Resident #14 to the dining room by wheelchair. At 12:00 noon, a random staff member passed through the dining area checking the level of portable oxygen tanks and noticed Resident #14's portable oxygen off. The unidentified staff member notified the nurse on duty who turned on the oxygen and adjusted the flow rate of the oxygen from the portable oxygen tank. During the observation on the morning of 02/10/15, a staff member (#12) stated only the nurse can turn resident's oxygen tanks/concentrators on.	F 328	QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. All nursing is responsible to make sure only R.N's or L.P.N's shut off oxygen and switch between a tank and a concentrator. All audits will be reported to the monthly QA Committee The completion date is March 12, 2015. The Director of Nursing is responsible for the process.		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 364	Continued From page 34 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, group interview, and review of facility policy, the facility failed to serve foods at a palatable temperature in 1 of 2 serving kitchens tested (4 East). Failure to ensure foods served to residents are held at appropriate serving temperatures may impact their food consumption related to palatability. Findings include: Review of the facility policy titled "TEMPERATURE GUIDELINES FOR CAFETERIA AND RESIDENT HOT FOOD ITEMS" occurred on 02/12/15. This policy, revised May 2014, stated, "... STATE HEALTH REQUIREMENTS ARE 135 [degrees Fahrenheit] MINIMUM FOR HOT HOLDING IN STEAMTABLE. ROOM TRAYS SERVED TO RESIDENTS IS EVALUATED BY FOOD PALATABILITY." During a group interview on 02/10/15 at 10:00 a.m., Resident A, B, and C who reside on the 4 East Unit and Resident D who resides on the 3 East Unit identified food served at meals as cold. Observation of tray line occurred on the 4th floor on 02/11/15 at 12:12 p.m. At 12:28 p.m., the survey team requested a test tray. Temperature	F 364	F364 All dietary staff has received education on keeping foods at a minimum of 135 degrees Fahrenheit for hot holding on the steam table and correct procedures for preparing room service trays. All residents have the potential to be affected. Dietary cooks will take the temperature of hot foods and log them before leaving the main kitchen. The minimum temperature will be 135 degrees Fahrenheit. All data will be logged for each meal, and checked weekly by dietary supervisor. Diet aides will log hot food temperatures before serving. Aluminum foil will be rolled back on all hot foods just prior to serving to retain heat. Diet aides will check and log the temperature on all hot foods after serving to ensure that a temperature of 135 degrees Fahrenheit is maintained. Two new steam tables have been purchased for use in serving kitchens.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED * C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 364	Continued From page 35 readings obtained are as follows: *Soup - 121 degrees Fahrenheit (F) *Mashed potatoes - 128 degrees F *Cooked carrots - 114 degrees F *Chopped steak - 108 degrees F The survey team sampled the above food items and identified the food tasted cool, not hot.	F 364	QA will be done weekly X 4 or until compliance is achieved. Once compliance is achieved, audits will be completed monthly and reported to QA quarterly. All dietary staff is responsible for checking and logging temperatures. Dietary		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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	F 431	supervisors are responsible for checking the process is completed correctly. Completion date is 2/18/2015. The Director of Dietary Services is responsible for the process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 431	Continued From page 36 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 observation, facility policy review, and staff interview, the facility failed to properly store medications in 2 of 7 nurses stations (4 West and 2 East). Failure to date insulin when first opened (4 West) and discard expired medications (2 East) increases the risk of residents receiving outdated medications with reduced efficacy. Findings include: Review of the facility policy titled "Insulin Labeling/Discard Dates & Disposal of Insulin Vials" occurred on 02/12/15. This policy, revised March 2013, stated, "1. Insulin vials are to be dated upon opening and shall be discarded 28 days after opening. . . . 5. . . . Discard insulin pens after 28 days . . ." On 02/11/15 at 3:05 p.m., observation of the medication storage areas on 4 West showed two open NovoLog FlexPens, one open Lantus SoloSTAR pen, and one open vial of Lantus insulin. Staff failed to write the date on the pens and vial upon opening them. During an interview on 02/11/15 at 3:15 p.m., a licensed nurse (#15) stated the above insulin pens and vial should have been labeled with the date when they were opened.	F 431	F 431 Dating insulin and removing expired medications All R.N's and L.P.N's have been educated on the policy "Insulin labeling/Discard Dates and Disposal of Insulin Vials". R.N's, L.P.N's, and med aides have been educated on the use of the routine cleaning sheet for cleaning med carts and removing expired medications. All residents have the potential to be affected. Insulin vials and pens are to be dated upon opening and discarded 28 days after use. The exception to this rule is insulin flex pen 70/30 which is to be discarded 10 days after opening. Nursing staff (excluding C.N.A's) are to follow the routine cleaning sheet for cleaning medication carts/medication cabinets and removing expired medications. Nurse Managers will monitor for completion of the routine cleaning sheet including removal of expired medications, and dating insulin vials and pen upon opening.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 431	Continued From page 37 - On the afternoon of 02/11/15 observation of the treatment cart and medication cabinet on 2 East with a staff nurse (#3) identified expired dates on four over-the-counter medications. * Acetaminophen 325 mg (milligrams), expired in December 2013 * Acetaminophen 500 mg, expired in July 2014 * Vitamin B-12 100 mcg (micrograms), two bottles expired in November 2014 * Magnesium 250 mg, expired in January 2015	F 431	QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. R.N's and L.P.N's are responsible for dating insulin vials and pens upon opening. R.N's, L.P.N's and medication aides are responsible for cleaning medications carts and removing expired medications. All audits will be reported to the monthly QA Committee.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	The completion date is March 12, 2015. The Director of Nursing is responsible for this process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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	
F 441	Continued From page 38 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to ensure staff performed proper hand hygiene and glove usage for 3 of 3 residents (Resident #14, Resident #32, and one unidentified resident) observed administered eye drops. Failure to follow infection control practices including proper hand hygiene and glove usage during administration of eye drops has the potential to spread infection to other residents, family, visitors, and staff. Findings include: Review of the facility policy and procedure for "EYEDROP AND EYE OINTMENT ADMINISTRATION" occurred 02/12/15. The policy, dated 02/12, stated, "... PROCEDURE: ... Perform hand hygiene with soap and water. Apply examination gloves. ... instill medication as follows: place hand against resident's forehead to steady, and instill required number of drops inside lower eyelid close to out corner of eye. ... Remove gloves and perform hand	F 441	F441 Instilling eye drops R.N's, L.P.N's and medication aides have received education on the policy "Eye drop and Eye Ointment Administration". All residents that receive eye drops have the potential to be affected. Resident #14 and #32 will have eye drops/eye ointment administered as per policy. Eye drops and eye ointments are to be instilled in resident's eyes as per policy. Hand hygiene is to be completed before and after the administration of eye drops/ointment. Gloves are to be worn during the procedure followed by proper hand hygiene. Staff observations will be completed to ensure compliance with the policy. QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. R.N's, L.P.N's and medication aides are responsible for following the procedure as stated. All audits will be reported to the monthly QA Committee.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
(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
F 441	Continued From page 39 hygiene with soap and water. . . ."	F 441	Completion date is March 12, 2015.		
	During observation on 02/10/15 at 11:25 a.m., a medication assistant (#9) administered Refresh (artificial tears) eye drops, one to each eye, to Resident #32 with gloves on. The assistant failed to perform hand hygiene including washing with soap and water prior to applying gloves and after the removal of the gloves.		The Director of Nursing is responsible for the process.		
	During observation on 02/10/15 at 11:40 a.m., a medication assistant (#9) administered Refresh eye drops, one to each eye, to Resident #14. The assistant wore gloves for the procedure, removed the gloves, and failed to perform hand hygiene including washing with soap and water. The assistant returned Resident #14's eye drops to the medication cart, obtained an unidentified resident's eye drops, applied gloves, instilled the eye drops, removed the gloves and failed to perform hand hygiene including washing with soap and water. The assistant returned the eye drops to the medication cart and proceeded to prepare other medication for the medication pass.				
F9999	FINAL OBSERVATIONS	F9999			
	Based on observation, record review, and resident and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.				