

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

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 02/27/2014
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NAME OF PROVIDER OR SUPPLIER TRINITY HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702
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F 000 INITIAL COMMENTS

F 000

For the standard Medicare/Medicaid recertification survey started on February 24, 2014 and completed on February 27, 2014, the sampled included five (5) residents for complete review, 22 residents for focused review, and three (3) closed records for review. The sample included 3 additional residents to verify specific concerns during the survey.

F 252 483.15(h)(1)
SS=B SAFE/CLEAN/COMFORTABLE/HOMELIKE
ENVIRONMENT

F 252

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, review of facility policies, resident and group interviews, the facility failed to provide a clean, comfortable, and homelike environment during 2 of 4 days (February 24-25, 2014) of survey. Failure to make resident's beds in a timely manner does not provide a homelike environment.

Findings include:

Review of the facility policy titled "Making An Unoccupied Bed" occurred on 02/27/14. This policy, revised May 2005, stated, "POLICY: Beds will be made daily. . . ."

During initial tour on 02/24/14 at 11:10 a.m., Resident #39, #44, #45 and #46's beds were

All nursing staff has received written education on making all resident beds before lunch. Mandatory Inservice provided to staff on 3/13/14.

All residents have the potential to be affected.

All residents will have their beds made daily before lunch. Nurse staff & Nurse Managers will check each resident room after breakfast to ensure resident beds have been made by Env. Aides/CNA staff.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rhonda Lamborg Administrator</i>	TITLE <i>3/27/14</i>	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 252 Continued From page 1
unmade.

During the group interview, conducted on 02/25/14 at 10:00 a.m., two of eleven residents (#13 and #36) stated their beds often remain unmade. Resident #36 stated it has taken staff up to seven days before they make her bed.

Observation on 02/25/14 at 12:24 p.m., showed Resident #13, #14, #36, #37, #38, #39, #40, and #44's beds unmade.

During an interview on 02/25/14 at 2:30 p.m., Resident #13 stated, "Often times my bed never gets made, I ask and no one does it."

Observation on 02/25/14 at 2:50 p.m., showed Resident #14 and #36's beds unmade.

Observation on 02/25/14 at 5:42 p.m., showed Resident #36's bed unmade.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET
SS=D PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

F 252

QA (Beds made before noon) will be done weekly for 4 weeks or until compliance is achieved. Also to ensure compliance, "Beds made by Noon" calendar will be initialed by the day staff nurse. Once compliance is achieved, audits will be completed monthly times 4, then quarterly. Charge nurses and Nurse Managers are responsible for checking that beds are being made before lunch. All audits will be reported to the monthly QA Committee.

Completion date is March 28th, 2014. The DON is responsible for the process.

F 281

This REQUIREMENT is not met as evidenced by:
Based on record review and professional reference, the facility failed to coordinate care for 1 of 1 resident (Resident #11) prescribed a new antipsychotic medication following a hospitalization. Failure of facility staff to coordinate care between practitioners led to the discontinuation of an antipsychotic medication without tapering, then restarting the medication

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F 281	Continued From page 2 after nine days. Findings include: Kozier and Erb, "Fundamentals of Nursing, Concepts, Process, and Practice" 9th edition, Pearson Education, Inc., Upper Saddle River, New Jersey, page 73, stated " . . . Carrying Out a Physician's Orders: Nurses are expected to analyze . . . medications ordered by the physician . . . It is the nurse's responsibility to seek clarification . . . from the prescriber. . . ." Review of Resident #11's medical record occurred on all days of survey and diagnoses included dementia with behavioral disturbances and depression. Following a hospitalization for sexually inappropriate behaviors, Resident #11's primary physician ordered Seroquel (an antipsychotic medication) 12.5 milligrams (mg) three times a day (TID) for 30 days starting 12/09/13. A physician's discharge summary, dated 12/09/13, stated, " . . . DISCHARGE MEDICATIONS: . . . We did add Seroquel 12.5 three times a day . . . The patient will consult psych in the nursing home so they can continue following up with him. Otherwise, patient is to continue with his previous medication. For the next 2 to 3 months we will continue on this dose, and then we will continue reassessing. Will discuss with psychiatry when we can start cutting down on his Seroquel dose if he continues doing well." A physician's nursing home note, dated 12/26/13, stated, " . . . Medical Decision Making: . . . 2.	F 281	All nurses have received written education on the process of contacting a provider regarding clarification of antipsychotic prescriptions with end dates (ex. 30 day prescriptions) before discontinuing the medication. Mandatory Inservice was provided for staff 3/13/14. All residents taking antipsychotics have the potential to be affected. On resident #11, all antipsychotic medications have been clarified with the provider. Staff nurses will review all anti-psychotic med orders to look for end dates. No antipsychotic medication will be discontinued without a provider order. Night nurses will check new orders daily and monthly, and monthly orders before care provider makes rounds.	
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F 281 Continued From page 3

Impulsive sexualized behaviors. That seems to be much better controlled at this time with the addition of Seroquel 12.5 three times a day. Will continue with that dose. . . For now, we are going to continue with the same dose just to make sure that he is stable for a couple of months before we start talking with psychiatry about the possibility of starting to cut down on the medication dose. . . "

A nurse practitioner's nursing home note, dated 01/30/14, stated, ". . . He is seen today for a 1-month followup for his recent Seroquel initiation for his impulsive sexual behaviors. He was last seen by [primary care physician] on 12/26/13, and at that time his behavior seemed to be well controlled . . . Unfortunately for some reason, he did not receive his Seroquel for about 9 days [30 doses] at the beginning of January. Once that was identified, I did reinstate his Seroquel at 12.5 mg 3 times a day. [restarted on 01/17/14] Nursing staff reports that during the last time he was off, he has had some inappropriate comments . . . to the nurses . . . PLAN: At this time I will go ahead and increase his Seroquel to 25 mg b.i.d. [twice a day] since he is still having some inappropriate comments and sexualized behaviors . . . "

A physician's discharge summary (for a second hospitalization), dated 02/07/14, stated, ". . . COURSE IN HOSPITAL: . . . Of note, it was determined that somehow the patient had not been receiving his Seroquel for his full course back at Trinity Nursing Home but it had been restarted before admission . . . "

The facility failed to consult with the practitioners regarding the continued use of the antipsychotic medication ordered for Resident #11 on 12/09/13,

F 281

QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly times 4, then quarterly. All staff nurses are responsible for checking antipsychotic orders for end dates. All audits will be reported to the monthly QA Committee.

Completion date is March 28th, 2014. The DON is responsible for the process.

All nurses have received written education on the process of contacting the wound care nurse for assessment of suspected pressure ulcers, and notify provider. Mandatory Inservice provided to staff 3/13/14.

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F 281	Continued From page 4 after the original 30 day order expired on 01/08/14.	F 281		
F 314	483.25(c) TREATMENT/SVCS TO SS=D PREVENT/HEAL PRESSURE SORES	F 314		

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 02/27/13.

Based on record review, facility policy review, and staff interview, the facility failed to complete weekly assessments and provide the necessary treatment and services to prevent pressure ulcers from worsening for 1 of 1 sampled resident (Resident #13) who experienced a delay in treatment. Failure to immediately notify the physician, obtain orders for treatment, and routinely assess and monitor Resident #13's pressure ulcer resulted in a worsened pressure ulcer and prolonged the healing process.

Findings include:

Review of the facility policy titled "Routine Care Of Pressure Sores" occurred on 02/27/14. This

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F 314 Continued From page 5

policy, revised March 2013, stated, "POLICY, Consult Enterostomal Therapy nurse as needed. Notify physician of recommendations and obtain order for treatment of pressure sores . . . PROCEDURE: . . . 8. Measure the wound initially (length x width x depth) and document. Notify MD and wound care nurse. Measurements and assessment of the wound will then be done weekly by the wound care nurse. Staff nurse will do weekly measurements and assessment when wound care nurse is not available. . . ."

Review of Resident #13's medical record occurred on February 25-27, 2014. Diagnoses included diabetes, Parkinson disease, and a history of pressure ulcers. The quarterly Minimum Data Set (MDS), dated 02/20/14, identified the resident required extensive assistance with bed mobility and one Stage 2 pressure ulcer present.

Resident #13's current care plan, dated 02/06/14, stated, "Problem . . . SKIN INTEGRITY - Skin impairment r/t [related to] pressure ulcer to left heel. Potential for further skin impairment r/t history of ulcers to coccyx, occasional bladder incontinence, needing help with mobility . . . Approach . . . check feet daily . . . Monitor Skin - skin discoloration to left heel, quarter size . . . Ulcer. mgmt [management] - left heel Every week on Tu [Tuesday], Heels off bed - FLOAT heels when resident in bed, Elastogel - (L) [left] heel ulcer Every week on Tu [Tuesday], F [Friday], Elastogel - (L) heel PRN [as needed], Assess Dressing - to left heel- replace as per MD [medical doctor] if soiled/not intact . . ."

Resident #13's progress notes identified the following:
* 01/10/14 at 11:58 p.m. - "Resident complained

F 314

All residents have the potential to be affected.

Resident #13 has received treatment of the heel ulcer and it was resolved on 3/11/2014. Staff nurses, upon finding a pressure ulcer, will be required to contact the provider, receive orders and contact the wound care nurse. The wound care nurse is to be contacted by phone and by a written memo at the nurses' station.

QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly times 4, then quarterly. All staff nurses are responsible for the notification process and receiving orders. All audits will be reported at the monthly QA meeting.

Completion date is March 28th, 2014. The DON is responsible for this process.

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F 314 Continued From page 6

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of pain to the left heel. When assessed, a quarter-size dark red skin discoloration was noted. Tegaderm foam was applied temporarily to protect [sic] the affected area until assessed by wound care nurse. Left a message to [wound care nurse] to assess it. Heels floated."

* 02/04/14 at 2:45 p.m. - "Wound care note: Assessed Stage 2 pressure ulcer to left heel measuring 2 x 2.5 cms [centimeters]. Ulcer presents as an intact unroofed blister over a red wound bed. Some dark red blood is contained within the blister. Slight bogginess noted with palpation. Periskin is pink, intact and blanchable. Resident denies pain. Recommend Elastogel to cover left heel ulcer, change twice weekly and PRN if soiled or not intact. Will fax physician update . . ."

The progress notes identified the facility failed to assess and provide treatment to Resident #13's pressure ulcer from 01/10/14 to 02/04/14.

During an interview on 02/26/14 at 12:50 p.m., the wound care nurse (#23) stated, "Unfortunately I think the nurse left me a message and I forgot or did not get to it. The unit manager told me and then I looked at it on February 4, 2014."

Review of the ulcer management assessments identified the following measurements (length x width x depth) of Resident #13's stage two left heel pressure ulcer:

- * 02/04/14 - 2 cm x 2.5 cm x 0.2 cm
- * 02/11/14 - 2.5 cm x 1.8 cm x 0 cm
- * 02/18/14 - 3.7 cm x 2.7 cm x 0.2 cm
- * 02/25/14 - 2.7 cm x 2 cm x 0.2 cm

The facility staff failed to immediately notify the physician, assess, monitor and treat the pressure ulcer until 02/04/14 (25 days from when it first

All nurses have received written education on the process of contacting the wound care nurse for assessment of suspected pressure ulcers, and notify provider. Mandatory Inservice provided to staff 3/13/14.

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F 314	Continued From page 7 was identified) resulting in delayed treatment.	F 314	All nursing and social workers have received written education on completing and documenting an investigation following an injury of a resident. Mandatory Inservices provided for staff on 3/13/14. All residents have the potential to be affected. Resident #7 After investigating the incident, we were unable to conclude if transfer technique was a factor due to staff involved are no longer employed @ TNH, all staff will be educated on transfers & use of pivot disc for safety during transfers. Bruise/Injury of unknown origin V3 is completed when staff is unaware of how a resident injury occurred. If later a cause is identified, an investigation will be completed by the social worker and/or nurse manager and	
F 323	483.25(h) FREE OF ACCIDENT SS=E HAZARDS/SUPERVISION/DEVICES 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: THIS IS A REPEAT DEFICIENCY FROM THE COMPLAINT SURVEY COMPLETED ON 11/27/13 AND STANDARD SURVEY COMPLETED ON 02/27/13. 1. Based on observation, record review, review of facility facility policy/procedure, and staff interview the facility failed to ensure 1 of 1 sampled resident (Resident #7) previously transferred with a pivot disk and 5 of 7 sampled residents (Resident #4, #5, #6, #19, and #21) observed transferred using a gait belt were as free of accident hazards as possible. Failure to investigate the cause of Resident #7's injury during a transfer utilizing a pivot disk and ensure staff use these devices in a manner to prevent accidents places residents at risk of injury and/or pain. Failure to properly use gait belts placed the residents at risk of pain and/or injury. Findings include: Review of the facility's policy and procedure.	F 323		

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F 323 Continued From page 8

"Trinity Homes Policy and Procedure Gait Belts," occurred on 02/27/2014. This policy/procedure, dated December 2013, stated, "Policy: Gait belts will be used on residents who require staff assistance with transfers or ambulation. . . . Purpose: To provide support during transfers and ambulation without unnecessary strain on resident's upper extremities. . . . 4. Wrap the gait belt snugly around the resident's waist. The belt should neither bind the resident nor slip around the resident's waist. . . . 6. . . . May support the resident's arms, but do not use their arms to pull the resident up. . . ."

- Review of Resident #7's record occurred on February 24-27, 2014. Diagnoses included cerebral vascular accident, peripheral vascular disease, left side hemiplegia, osteoarthritis, and osteoporosis.

A nurse progress note, dated 10/20/13 at 1:40 p.m., stated, "When assessing resident for pain medication resident noted to have some swelling to her left ankle but no bruising, no redness, and no heat noted to lower left extremity. Asked the resident how often she gets this pain and if she may have injured it. Resident was not certain if it is an injury but feels spasms down the left leg accompanied by pain in the left ankle. Upon assessing the ankle and foot resident pinpoints the pain coming from below the ankle and into the bone from the upper foot . . ."

A nurse progress note, dated 10/20/13 at 6:00 p.m., stated, "Resident is complaining of severe pain to left ankle. Noted swelling to left ankle on assessment. Asked resident what happened to her ankle, and she stated, 'They were getting me ready this morning and my ankle got twisted up

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documentation will be made in the chart. If, during the course of the investigation, it is found that there was a break in technique or procedure, education will be given to the staff/persons involved to prevent repeat incidents and/or initiate other interventions and/or corrective actions. PT will continue to train CNA's/nursing staff proper transfer techniques along with pivot disc transfers q 6 months & with each CNA Class instruction.

QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly times 4, then quarterly. Social workers and nurse managers are responsible for completing the investigation. All audits will be reported at the monthly QA meeting.

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when they put me in my chair.' Resident did have prn [as needed] Tylox for pain at 1330 [1:30 p.m.]. Tylenol prn dose given now for pain to left ankle. Paged [physician's name]. New order received to keep ace wrap on left ankle. Continue to monitor."

A "Bruises / Injuries of Unknown Origin V3" report, dated 10/20/2013, began at 1:30 p.m. and completed at 10:50 p.m. by the nurse on duty, identified the following:

* Injury location "Left ankle swollen with no redness or bruising noted."

* Is Resident interviewable? "Yes" If yes, residents opinion of injury "Resident was not certain how/why her ankle was in pain but later stated that her left ankle got twisted when transferring in the morning."

* "This portion to be completed by Social Worker," dated 10/24/13, identified abuse/neglect had been ruled out and concluded "[Resident #7] reported her ankle twisted during a transfer - injury not unknown."

Results of a CT scan (computed tomography), dated 10/22/13, identified an avulsion off of the medial malleolus inferiorly (under the bony protrusion on the inner side of the ankle.) (An avulsion is a fracture with detachment of a bone fragment that results from the pulling away of a ligament, tendon, or joint capsule from its point of attachment on a bone.)

A quarterly Minimum Data Set (MDS), dated 08/13/13, identified the resident required extensive assistance of two or more staff members for transfer. The current "Care Guide" for Resident #7 identified, at transfer, "Total Mechanical Lift - two persons, . . ." Through

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Completion date is March 28th, 2014. The Director of Social Services and DON is responsible for this process.

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interview on the afternoon of 02/26/14, an administrative nurse (#20) identified Resident #7 transferred with a pivot disk at the time of her ankle injury in October.

During an interview on the afternoon of 02/26/14, an administrative nurse (#20) identified she had not completed an investigation with the certified nurse aides (CNAs) who transferred Resident #7 on the day her ankle was injured and deferred to the social worker who completed the "Bruises / Injuries of Unknown Origin V3" report.

During an interview on the morning of 02/27/14, a social service staff member (#21) identified she concluded there was no abuse. When questioned if she asked the CNAs what happened the morning of 10/20/13 to cause Resident #7 to say, "my ankle got twisted up", this staff member deferred back to nursing.

The facility failed to investigate the cause of Resident #7's injury during the transfer on the morning of 10/20/13. Failure to investigate did not allow the facility to identify if staff used the pivot transfer disk correctly, how the injury might have been prevented, and/or initiate other interventions and/or corrective actions to prevent the incident from happening to Resident #7 again, or to other residents.

- Review of Resident #19's medical record occurred on February 26-27, 2014. Diagnoses included malaise/fatigue and a history of falls. The resident's quarterly MDS, dated 12/05/13, identified severely impaired cognition and experienced two falls without injury.

Resident #19's current care guide stated.

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NAME OF PROVIDER OR SUPPLIER TRINITY HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 323 Continued From page 11

"Transfer: Cue resident before & [and] during transfers . . . Staff to physically pivot resident, Constant supervision for transfers, Staff assist x2 [two staff members] using gait belt . . ."

Observation on 02/26/14 at 3:40 p.m. showed Resident #19 seated on the toilet in her bathroom. The CNA (#3) entered the bathroom, applied a gait belt around the resident's waist, provided personal cares, and pivoted her to a wheelchair. The CNA (#3) failed to follow Resident #19's care plan and transfer the resident with two staff.

- Review of Resident #4's medical record occurred on all days of survey and identified diagnoses of dementia, osteoporosis, and chronic pain. The quarterly MDS, dated 02/14/14, identified the resident required limited assistance with transfers and extensive assistance with toileting. The current care guide stated, ". . . Independent for transfers, Utilizes [brand name] walker, Staff help as needed. . . ." A fall assessment, dated 02/09/14, identified the resident at risk for falls.

Observation on 02/25/14 at 11:30 a.m. identified Resident #4 walked from her bed to the bathroom with her walker while a CNA (#13) was present in the room. Observation showed the resident cautiously walked on the linoleum floor in her nylons. The CNA failed to assist the resident to put on her shoes. During this same observation, the CNA (#13) lifted under the resident's left arm to assist her to stand from the toilet.

- Review of Resident #5's medical record occurred on all days of survey and diagnoses included lumbago (low back pain), fibromyalgia

F 323

All nursing staff has received written education on use of gait belts & transfers per careplan/careguide. Mandatory Inservices provided for staff on 3/13/14.

All residents have the potential to be affected.

Nursing staff are to be observed performing transfers with residents to ensure the gait belts are used and residents are not lifted under their arms. The appropriate footwear is to be worn by residents during the transfers. Transfers are to be

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F 323

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(chronic, widespread pain), and arthropathy (inflammation of the joints). The annual MDS, dated 01/28/14, identified the resident required extensive assistance for transfers and toileting. The current care guide stated, "... Transfer belt, Cue resident before & [and] during transfers, Encourage resident to bear full wt. [weight] when standing, transfers with assist of 1 or 2 depending on how awake she is. ..."

Observation on 02/25/14 at 5:30 p.m. identified two CNAs (#8 and #9) transferred Resident #5 from bed to her wheelchair, to the toilet, and then back to her wheelchair using a gait belt. Both CNAs held on to the gait belt with one hand and lifted under the resident's arms with their other hand.

- Review of Resident #6's medical record occurred on all days of survey and diagnoses included Alzheimer's dementia and osteoarthritis. The quarterly MDS, dated 02/16/14, identified the resident required extensive assistance for transfers and toileting and experienced a fall since the prior assessment. The current care guide stated, "... Transfers with assist of 1 or 2 ... and use gaitbelt ..."

Observation on 02/25/14 at 10:00 a.m. identified two CNAs (#12 and #14) transferred Resident #6 from her wheelchair to the toilet and back to her wheelchair using a gait belt. Both CNAs held on to the gait belt with one hand and lifted under the resident's arms with their other hand.

- Review of Resident #21's medical record occurred on February 26-27, 2014 and diagnoses included orthostatic hypotension, osteoporosis, and chronic pain. The annual MDS, dated

F 323

performed as per the care guide and policy.

QA (Nursing staff will observe transfers using a gait belt and not lifting under resident arms. Appropriate footwear is to be worn by the resident) will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly times 4, then quarterly. All audits will be reported at the monthly QA meeting.

Completion date is March 28th, 2014. The DON is responsible for this process.

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F 323	Continued From page 13 12/21/13, identified the resident required extensive assistance for transfers and toileting and experienced a fall since the prior assessment. The current care guide stated, "... Transfers with a gaitbelt & assist of 1. . . ." Observation on 02/27/14 at 8:15 a.m. showed two CNAs (#13 and #15) transferred Resident #21 from her wheelchair to her bed using a gait belt. One CNA (#15) held on to the gait belt with one hand and lifted under the resident's arm with her other hand. 2. Based on observation, record review, facility policy review, and staff interview, the facility failed to ensure the resident environment remained as free of accident hazards as possible regarding assessing and implementing fall prevention strategies for 1 of 12 sampled residents (Resident #22) who experienced falls during self-transfers. Failure to accurately assess and review each fall and implement established interventions placed Resident #22 and other residents at risk for injury. Findings include: Review of the facility policy titled "Falls Prevention Protocol" occurred on 02/27/14. This policy, revised October 2013, stated, "... 3. Implement the plan of action to be used to reduce the risk of further falls. . . ." Review of Resident #22's medical record occurred on February 26-27, 2014 and diagnoses included dementia, osteoarthritis, osteoporosis, and history of a fall and hip fracture prior to admission. The quarterly MDS, dated 01/28/14, identified severely impaired cognition, extensive	F 323		
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assistance for transfers and bed mobility. and multiple falls with injury since the prior assessment.

The current care guide stated, "... Transfer, Transfer belt, Transfer [with] walker - one person ... Constant supervision for transfers ... Safety, Resident assessed at risk for falls, Call light within reach, Bed alarm, Chair alarm, Hi-Lo Bed, confused, attempts to ambulate per self, swim buddies, hourly fall rounding, falls prevention. ..."

Observation on 02/27/14 from 7:55 a.m. until 11:00 a.m. identified Resident #22 in her wheelchair without her chair (tab) alarm in place. Observation showed the resident was restless and agitated as she wanted to "go home" and "find her family."

Review of Resident #22's progress notes identified the following:

*11/01/13 - "at 0515 [5:15 a.m.] resident attempted to get up and slid down with right knee onto floor; CNA [certified nursing assistant] with resident and assisted her back to bed; small abrasion to right knee, no other signs of injury; see falls documentation and vitals." The progress note and Falls Documentation Form related to this fall failed to identify if the CNA was transferring the resident at the time of the fall.

*11/11/13 - At 11:20 p.m. Found sitting on floor next to bed. Unwitnessed. No injury. Post Fall Intervention: will continue bed alarm - will leave door open so staff can look in at resident. The progress note and Falls Documentation Form related to this fall failed to identify if the bed alarm was in place and sounding at the time of the resident's fall.

*01/12/14 - "Resident was seen by treatment

F 323

All nursing staff has been educated on completion of the Falls Documentation form and detailed progress notes following a fall. Mandatory Inservice provided for staff on 3/13/14.

All residents have the potential to be affected.

Resident # 22 - No pattern was identified for her falls by the time of day, day of week or activity. 11/1/13 new careplan/guide noted. Updates were made to the careplan and care guides. Interventions were reviewed and updated (See attached handout). Staff educated that documentation must include time of fall and if established interventions are in place, eg chair alarm in place and sounding, witnesses, etc. Nurse managers will check that documentation is complete before presenting to the weekly Falls Committee meeting.

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nurse sitting on the floor in front of her wheelchair at the dining room. Assessed for injuries, not [sic] noted. Assisted back to wheelchair. Denied hitting her head. No complaints of pain. Vital signs taken and recorded. Family was notified. Resident had good appetite at supper. Assisted to her room before 1900H [7:00 p.m.] to watch Lawrence Welk Musical show but she refused. Was wheeled back near the Nurses Station. Went to bed at 2030H [8:30 p.m.]. The resident's medical record lacked a completed Falls Documentation Form for this fall. The progress note failed to identify the exact time of the fall and if the resident's chair alarm was in place and sounding at the time of the fall. (A Falls Documentation Form from a previous fall, dated 01/03/14, identified staff "will obtain a chair alarm.")

*02/05/14 - 7:30 a.m. - Resident sitting in wheelchair in TV room. Staff heard "I'm on the floor." Found resident scooting into the hallway. States she slid out of her wheel chair onto her bottom and was trying to get out of that room. Happened in visitor's lounge. Not witnessed. Resident anxious. The Falls Documentation Form related to this fall failed to identify if the resident's chair alarm was in place and sounding at the time of the fall.

During an interview on 02/27/14 at 12:50 p.m., an administrative nurse (#11) confirmed Resident #22's medical record lacked specific details for the falls which occurred on 11/01/13, 11/11/13, 01/12/14, and 02/05/14. The staff member stated she reviewed residents' falls after the fact, however was unable to confirm if the alarms were in place and functional.

Failure to ensure Resident #22's chair alarm was

F 323

QA (Falls doc. & progress notes are completed i.e. alarms inplace & functional, date/time documented, staff interviewed for the investigation of incident & intervention inplace with patterns of falls & trends identified.) will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly times 4, then quarterly. All audits will be reported at the monthly QA meeting.

Completion date is March 28th, 2014. The DON is responsible for this process.

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in place when the resident sat in her wheelchair and failure to complete thorough assessments after the resident fell (such as the exact time of the fall, whether established interventions were in place, and the details surrounding a witnessed fall) does not allow the facility to track and trend and look for patterns in the resident's falls to possibly prevent further falls from occurring.

3. Based on observation and staff interview, the facility failed to ensure safety measures were followed for 2 of 2 sampled residents (Resident #6 and #22) and 5 supplemental residents (Resident #31, #32, #33, #34, and #35). Failure to ensure beds are equipped with proper fitting mattresses and side-rails may increase the risk of entrapment and injury to residents.

Findings include:

- Random observations occurred on February 24-27, 2014 and revealed:
- * Resident #31 and Resident #32 had two side-rails in use on the same side of the bed. Each bed was equipped with a side-rail on the lower and upper portion of the bed. A space of four to five inches existed in the middle of the bed between the two side-rails.
- * Resident #6, and #22 had a space of at least five inches between the mattress and the bed's head board.
- * Resident #33, #34 and #35 had a space of five to six inches between the mattress and the bed's foot board.

During an interview, on 02/26/14 at 9:00 a.m., a supervisory staff member (#26) indicated the beds with spaces between the mattress and head board required longer than standard mattresses.

F 323

All Plant Operations and nursing staff have received written education on properly fitting mattresses and using only upper side rails unless otherwise indicated through resident assessment/needs.

Mandatory Inservices provided for staff 3/13/14.

All residents have the potential to be affected.

Resident #31 and #32 had lower side rails removed from bed. Residents' # 6, 22, 33, 34, 35 had properly fitting mattresses put on their beds.

Director of Plant Operations and Clinical Excellence Coordinator performed an initial check on all mattresses and side rails for compliance. Nurse Managers will then check mattress/side rails anytime a change to a bed or mattress is made.

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and the beds with spaces between the mattress and the foot board required the adjustable footboards to be placed closer to the mattress.

During an interview, on 02/26/14 at 3:30 p.m. a nursing manager (#27) indicated the two beds with side-rails were older beds, and plant operations should have removed the lower half of the beds' side-rails.

F 327 483.25(j) SUFFICIENT FLUID TO MAINTAIN
SS=D HYDRATION

F 327

The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and staff interview, facility staff failed to offer fluids to 2 of 2 sampled residents (Resident #5 and #20) with a history of urinary tract infections (UTIs) and dependent on staff for fluid intake. Failure to offer fluids during cares increased the residents' risk of dehydration, constipation, and additional UTIs.

Findings include:

- Review of Resident #5's medical record occurred on all days of survey and diagnoses included Alzheimer's dementia and a history of UTIs. The annual Minimum Data Set (MDS), dated 01/28/14, identified short and long term memory problems, extensive assistance for eating, and weight loss. A nutrition assessment, dated 01/24/14, identified severely impaired cognition, required 1500-1800 milliliters of fluids

QA (all mattresses & side rails meet FDA requirements – siderails & mattresses are safe for the resident, without gaps where the resident could get head, arms or legs stuck.) will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly times 4, then quarterly. All audits will be reported at the monthly QA meeting.

Completion date is March 28th, 2014. The DON and Director of Plant Operations are responsible for this process.

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daily, was prone to UTIs, and staff should encourage fluids.

The current care plan stated, "... Nutrition/Feeding - starts to feed self, staff assist with most ... Potential for dehydration - r/t [related to] occasionally leaves 25% or more of fluids at meals ... monitor for S&S [signs and symptoms] dehydration every week ... night snack - PRN [as needed]. ..."

Observations of Resident #5's cares identified the following:

* 02/25/14 at 10:10 a.m. - Two certified nursing assistants (CNAs) (#6 and #7) toileted the resident and transferred her back to her wheelchair. The CNAs failed to offer Resident #5 fluids during cares.

* 02/25/14 at 5:30 p.m. - Two CNAs (#8 and #9) transferred the resident from bed to her wheelchair, toileted the resident, and then transferred her back to her wheelchair. The CNAs did not offer fluids at this time.

* 02/26/14 at 10:25 a.m. - Two CNAs (#7 and #10) toileted the resident and transferred her back to her wheelchair. The CNAs failed to offer Resident #5 fluids during cares. During this observation, the resident licked her dry lips.

During an interview on 02/27/14 at 8:20 a.m., a nurse (#2) stated staff should "try to" offer fluids with cares.

- Review of Resident #20's medical record occurred on February 26-27, 2014. Diagnoses included dementia, depression, and malaise/fatigue. The quarterly MDS, dated 02/20/14, identified the resident required extensive assistance for eating. The current care

All nursing staff has received written education on offering residents fluids after performing cares.

Mandatory Inservices
offered for staff 3/13/14.

All residents that are able to take oral fluids have the potential to be affected.

Staff is to be offering fluids to residents after performing cares.

QA (Residents are hydrated & offered fluids after cares) will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly times 4, then quarterly. All audits will be reported at the monthly QA meeting.

Completion date is March 28th, 2014. The DON is responsible for this process.

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guide stated, "Eating: . . . Provide cueing for
eating, Starts to feed self, Staff finish feeding. . . .
Encourage intake of fluids . . ."

Review of Resident #20's progress notes and
urine cultures from March 2013 to February 2014
identified a UTI on nine occasions.

Observation on 02/26/14 at 4:00 p.m. showed a
CNA (#3) provided personal cares for Resident
#20. After cares, the CNA transferred the resident
into her wheelchair and transported her to the
lounge area. The CNA (#3) failed to offer fluids
with cares and failed to provide a beverage in the
lounge.

Observation on 02/27/14 at 8:45 a.m. showed two
CNAs (#4 and #5) provided personal cares for
Resident #20. After cares, the CNAs transferred
the resident to her bed and left the room. The
CNAs failed to offer fluids with cares.

F 332 483.25(m)(1) FREE OF MEDICATION ERROR F 332
SS=D RATES OF 5% OR MORE

The facility must ensure that it is free of
medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced
by:

Based on observation and review of
manufacturer's instructions, the facility failed to
ensure a medication error rate of less than five
percent during observation of medication
administration for 3 of 3 supplemental residents
(Resident #41, #42, and #48) who received
insulin incorrectly. Failure to prime insulin pens

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according to manufacturer's instructions resulted in residents receiving inaccurate doses of medication. Three errors occurred during staff administration of 33 medications, which resulted in a 9 percent error rate.

Findings include:

Review of the manufacturer's instructions for NovoLog FlexPen occurred on 02/27/14. This insert stated, "... Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: ... E. Turn the dose selector to select 2 units. F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of cartridge. G. Keep the needle pointing up, press the button all the way. The dose selector turns to zero. A drop of insulin should appear at the needle tip. If not, change the needle, and repeat the procedure ..."

- Observation of medication pass on 02/25/14 at 11:50 a.m. showed a nurse (#1) administered insulin to Resident #41. During the observation, the nurse (#1) dialed the dose selector on the resident's NovoLog FlexPen to the number of units prescribed by the provider. Prior to administering the ordered dose of insulin to Resident #41, the nurse failed to "prime" or expel the air from the attached needle with two units of insulin.

- Observation of medication pass on 02/25/14 at 12:15 p.m. showed a nurse (#1) administered insulin to Resident #42. During the observation, the nurse (#1) dialed the dose selector on the resident's NovoLog FlexPen to the number of

F 332

All staff nurses have received written education on priming insulin pens. Mandatory Inservices provided for staff 3/13/14.

All residents receiving insulin have the potential to be affected.

Staff nurses will prime all insulin syringes following manufacturer's instructions. Observations will be made of priming the insulin pens. (The Quick Reference Guide on Priming insulin pens was posted on the med fridges).

QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly times 4, then quarterly. All audits will be reported at the monthly QA meeting.

Completion date is March 28th, 2014. The DON is responsible for this process.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 02/27/2014
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NAME OF PROVIDER OR SUPPLIER TRINITY HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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units prescribed by the provider. Prior to
administering the ordered dose of insulin to
Resident #42, the nurse failed to "prime" or expel
the air from the attached needle with two units of
insulin.

- Observation of medication pass on 02/25/14 at
5:30 p.m. showed a nurse (#25) administered
insulin to Resident #43. During the observation,
the nurse (#25) dialed the dose selector on the
resident's Humalog FlexPen to one unit, held the
pen sideways to prime the needle, and then
proceeded to administer the ordered dose of
insulin to Resident #48. The nurse failed to
"prime" or expel the air from the attached needle
with two units of insulin.

F 441 483.65 INFECTION CONTROL. PREVENT
SS=E 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

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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 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:
THIS IS A REPEAT DEFICIENCY FROM THE COMPLAINT SURVEY COMPLETED ON 11/27/13.

1. Based on observation, record review, and review of facility policy, the facility failed to follow standard infection control practices for 4 of 15 sampled residents (Resident #5, #13, #15, and #20) observed during personal cares and for 3 of 3 supplemental residents (Resident #41, #43 and #47) randomly observed during medication administration. Failure to follow infection control practices related to hand hygiene has the potential to cause or spread infection within the facility.

Findings include:

Review of the facility policy titled "Female

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Perineal Care" occurred on 02/27/14. This policy, revised January 2010, stated, "... PROCEDURE:
... 5. Perform hand hygiene with soap and water
... 8. Put on gloves ... 13. ... Bring soaped
washcloth in one downward stroke, being sure
not to bring the washcloth back upwards on the
skin ... 20. Remove gloves and discard ... 29.
Perform hand hygiene with soap and water. ... "

Review of the facility policy titled
"Handwashing/Hand Hygiene" occurred on
02/27/14. This policy, reviewed February 2012,
stated, "... When is Hand Hygiene (Alcohol Hand
Sanitizers) necessary? ... Before and After
having direct contact with resident ... Before and
After performing any invasive procedure (e.g.,
finger stick blood sampling) ... Before and After
entering isolation precautions ... After contact
with resident's mucous membranes and body
fluids, or excretions ... After removing gloves or
gowns ... When is Handwashing (Soap and
Water) necessary? ... Before and After assisting
a resident with toileting. ... "

Review of the facility policy titled "Isolation
Precautions" occurred on 02/27/14. This policy,
revised February 2012, stated, "...
PROCEDURE: ... Standard Precautions: ...
Standard precautions will apply to all residents at
all times and are designed to prevent
transmission of antibiotic resistant organisms
from unrecognized sources ... Gloves: ...
Change gloves between tasks and procedures on
the same resident ... *Remove gloves promptly
after use, before touching non-contaminated
items and environmental surfaces, ... " Contact
Precautions: In addition to Standard Precautions,
use Contact Precautions for specified resident
known or suspected to be infected or colonized

All nursing staff has
received written education
on appropriate hand
hygiene. Mandatory
Inservice provided for staff
on 3/13/14.

All residents have the
potential to be affected.

All nursing staff have been
instructed to perform hand
hygiene before leaving a
resident's room, after
removing soiled gloves,
before touching the
environment, before
handling pills (clean
gloves may be applied
prior to handling pills), and
after administering insulin.

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with epidemiologically important microorganisms that can be transmitted by direct contact with the resident . . . Gloves and hand Hygiene: . . .

*During the course of providing care for a resident, change gloves after having contact with infective material that may contain a high concentration of microorganisms (fecal material and wound drainage) . . ."

- Observation on 02/25/14 at 8:40 a.m. showed a certified nursing assistant (CNA) (#16) assisted Resident #13 to the bathroom. The resident was incontinent of urine. The CNA removed the resident's brief then removed her gloves, and left the resident's room to dispose of the garbage without performing hand hygiene.

- Observation on 02/25/14 at 11:41 a.m. showed two CNAs (#16 and #17) assisted Resident #15 onto the bed pan. The CNA (#16) provided perineal care prior to placing the resident on the bedpan. The CNA (#16) then removed her gloves, covered the resident with a blanket, and clipped the call light to the blanket. Both CNAs left the room without performing hand hygiene.

- Observation on 02/25/14 at 12:06 p.m. showed two CNAs (#16 and #18) assisted Resident #15 off of the bed pan. The CNA (#16) donned gloves, performed perineal care, and placed a clean brief on the resident. The CNA (#16) then removed her soiled gloves, donned clean gloves, pulled up the resident's pants, repositioned resident, and placed call light on the resident's lap. Both CNAs left the room without performing hand hygiene.

- Observation on 02/25/14 at 5:30 p.m. identified two CNAs (#8 and #9) assisted Resident #5 with

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QA (Performing hand hygiene before leaving a resident's room, after removing soiled gloves, before touching the environment, before handling pills (clean gloves maybe applied prior to handling pills), and after administering insulin.) will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly times 4, then quarterly. Observations will be done to ensure compliance on performing hand hygiene before leaving a resident's room, after removing soiled gloves, before touching the environment, before handling pills (clean gloves maybe applied prior to handling pills), and after administering insulin. All audits will be reported at the monthly QA meeting.

Completion date is March 28th, 2014. The DON is responsible for this process.

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toileting. One CNA (#9) performed perineal cares after the resident voided, left her gloves on, and assisted the resident to transfer to her wheelchair. The CNA (#9) combed the resident's hair, removed her gloves, and then assisted the resident to the dining room. The CNA (#9) failed to perform hand hygiene after completing perineal cares.

- Review of Resident #20's medical record occurred on February 26-27, 2014. Diagnoses included colonized vancomycin-resistant enterococci (VRE) and contact isolation. The quarterly Minimum Data Set (MDS), dated 02/20/14, identified the resident required extensive assistance of one person for transfers, toilet use, and personal hygiene. The current care guide stated, "Safety: . . . Contact Precautions."

Observation on 02/27/14 at 8:45 a.m. showed two CNAs (#4 and #5) donned gowns and gloves, entered Resident #20's room, and assisted her onto the toilet. One CNA (#4) pulled down the resident's brief and touched a visibly soiled area on the brief with her gloved hand. The other CNA (#5) removed the brief and also touched the soiled area with her gloved hand. The CNAs reapplied a gait belt and assisted Resident #20 to stand and the CNA (#5) provided perineal cares. The CNAs applied a clean brief, and pulled up her pants, and transferred her into the wheelchair. Resident #20 stated, "I'm all wet, I'm all wet." The CNA (#5) touched the residents pants and confirmed they were wet. The CNA (#5) then opened the resident's closet and obtained a clean pair of pants. Both CNAs removed their soiled gloves, donned clean gloves, and changed Resident #20's wet pants. Both CNAs removed their gloves and washed

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their hands. The CNAs (#4 and #5) failed to remove their soiled gloves after assisting Resident #20 in the bathroom and before touching other surfaces in the resident's room.

During an interview on the morning of 02/27/14, an administrative nurse (#22) agreed the CNAs (#4 and #5) failed to follow infection control practices and stated the CNAs have been instructed when to remove and change gloves while providing cares for residents.

- Observation on 02/25/14 at 12:05 p.m. identified a nurse (#1) administered insulin to Resident #41. After administering the insulin, the nurse removed his gloves and without performing hand hygiene went to the dining room to obtain a pain pill for Resident #43. Observation identified the nurse picked up the pain pill with his bare hands and placed it in the medication cup. The nurse failed to perform hand hygiene after administering insulin to Resident #41 and prior to touching Resident #43's pain pill.

- A random observation on 02/27/14 at 7:55 a.m. showed a nurse (#24) prepared the morning medications for Resident #47. The medication cup tipped and three of the pills fell onto the medication cart. The nurse picked up the pills with his bare hand and placed them back in the medication cup. The nurse failed to perform hand hygiene or apply a glove before touching Resident #47's medication.

2. Based on observation, review of professional literature, and staff interview, facility staff failed to properly disinfect the glucometer for 2 of 4 supplemental residents (Resident #41 and #42)

All staff nurses have received written education on disinfecting the Accucheck machines in-between resident use. Mandatory Inservice provided for staff on 3/13/14.

All residents that require their glucose levels to be checked have the potential to be affected.

Staff nurses will disinfect the Accucheck machine with a germicidal wipe each time the Accucheck machine is used.

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observed during blood glucose testing. Failure to correctly disinfect glucometers may result in the transmission of organisms and pathogens to other residents, staff, and visitors.

Findings include:

A Centers for Disease Control and Prevention publication titled "Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration," dated 03/08/11, stated, "... General: ... Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use per manufacturer's instructions. ..."

Observation on 02/25/14 at 11:50 a.m. showed a nurse (#1) tested Resident #41's blood glucose with a glucometer. After testing the resident's blood glucose, the nurse (#1) failed to disinfect the glucometer with a germicidal wipe (used to disinfect shared equipment), which were located on the blood glucose testing cart.

Observation on 02/25/14 at 12:10 p.m. showed a nurse (#1) tested Resident #42's blood glucose with a glucometer. After testing the resident's blood glucose, the nurse (#1) failed to disinfect the glucometer with a germicidal wipe.

During an interview on the morning of 02/26/14, a nurse (#2) stated staff should disinfect the glucometer after each use with the "purple top" germicidal wipes.

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QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly times 4, then quarterly. Observations will be done to ensure compliance (staff nurses will disinfect the Accucheck machine with a germicidal wipe each time the Accucheck machine is used). All audits will be reported at the monthly QA meeting.

Completion date is March 28th, 2014. The DON is responsible for this process.