

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 03/21/2013
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 02/27/2013
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 For the standard Medicare/Medicaid recertification survey started on February 24, 2013 and completed on February 27, 2013, 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 000			
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure residents of the special care unit were free from verbal, mental, or physical abuse from 2 of 2 sampled residents (Resident #1 and #2). Failure to ensure residents were free from abuse resulted in Resident #2 experiencing an arm fracture and Resident #1 and #2 continuing to verbally abuse, push, slap, and knock down unidentified residents of the special care unit. Findings include:	F 224	RECEIVED APR 16 2013 Division of Health Facilities All staff have been educated on the changes to the policy "Investigation and Reporting of Abuse, Abuse, including Injuries of Unknown Source, Neglect, and Misappropriation of Resident Property", under the "Catastrophic Events and Reactions" section. All residents have the potential to be affected. If a resident becomes abusive/aggressive towards another resident/staff/visitor, staff will follow the Catastrophic Events and Reactions in the Investigation and Reporting of Abuse Policy. Once the nurse has completed the		

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

TITLE *Original Sign*

(X6) DATE

*Khonda Janberg, Administrator**04/02/2013*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her 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.

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

PRINTED: 03/21/2013
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 02/27/2013
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 224 SS=G	For the standard Medicare/Medicaid recertification survey started on February 24, 2013 and completed on February 27, 2013, 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. 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure residents of the special care unit were free from verbal, mental, or physical abuse from 2 of 2 sampled residents (Resident #1 and #2). Failure to ensure residents were free from abuse resulted in Resident #2 experiencing an arm fracture and Resident #1 and #2 continuing to verbally abuse, push, slap, and knock down unidentified residents of the special care unit. Findings include:	F 224	All staff have been educated on the changes to the policy "Investigation and Reporting of Abuse, Abuse, including Injuries of Unknown Source, Neglect, and Misappropriation of Resident Property", under the "Catastrophic Events and Reactions" section. All residents have the potential to be affected. If a resident becomes abusive/aggressive towards another resident/staff/visitor, staff will follow the Catastrophic Events and Reactions in the Investigation and Reporting of Abuse Policy. Once the nurse has completed the		

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

TITLE

(X6) DATE

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.

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

PRINTED: 03/21/2013
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 02/27/2013
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 224	Continued From page 1 Review of the facility policy and procedure "Investigation and Reporting of Abuse" occurred on 02/27/13. This document, revised November 2012, stated "POLICY: All actual and alleged incidents of Abuse, Abuse including Injuries of Unknown Source . . . will be reported and investigated . . . and all staff will be provided initial and annual in-service training on prevention . . . of abuse . . . and prohibit verbal, mental . . . or physical abuse . . . *NOTE: . . . Residents who mistreat, abuse . . . other residents . . . must have a care plan in place that addresses the behavior(s) in question and those residents being abused, neglected . . . must be protected from further injury or mental anguish. Documentation must be in place to identify the steps taken to identify the problems, the corrective action taken, and follow-up monitoring. CATASTROPHIC EVENTS AND REACTIONS: In a situation where there is an aggressive resident or a catastrophic event such as pushing, hitting, throwing objects, etc. the following steps should be taken: a) Re-direct resident and take to a quiet area if possible. b) If resident cannot be re-directed call for Resident Assistance and/or call 911 for support staff. c) Contact resident MD [physician] if necessary and follow physician's orders. d) To ensure safety of all residents/staff, staff should remain with the resident until help arrives or situation subsides. e) Monitor closely for any further behaviors. f) Document in Care Plan: See Abuse Policy. . . ."	F 224	Abusive/Aggressive Behavior Incident, the social worker will be responsible to review the incident and identify, track, and trend information on resident's behavior, such as targeting a specific resident, time of day or area of the unit. If trends are identified the social worker will communicate this to the nursing staff and update the care plan and care guide. The social worker will review progress notes daily to monitor any potential abusive/aggressive behavior. The plan of care will address behavior and will be assessed to see if further interventions are appropriate. QA will be completed on any resident that demonstrates abusive/aggressive behavior and focus on any trends and to see if interventions on behavior are appropriate. The QA will be monitored weekly until the abusive/aggressive behavior has stopped.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 224	Continued From page 2 During the initial tour of the facility's special care unit, on 02/24/13 at 10:00 a.m., a supervisory nursing staff member (#41) reported Resident #2 experienced a fractured left shoulder approximately one month earlier after being pushed down by Resident #1. This staff member also reported Resident #1 demonstrated physical behaviors towards other residents and recently returned to the unit after an acute hospital stay following the incident of Resident #2's fracture. - Review of Resident #1's medical record occurred on February 24-27, 2013. The facility admitted the resident in August 2012. The facility transferred the resident to the acute care hospital for the period January 30, 2013 to February 07, 2013. Current diagnoses included dementia with behaviors, anxiety, and depression. The significant change Minimum Data Set (MDS), dated 11/29/12, identified the resident usually made himself understood, sometimes understood others, and for the seven day assessment period: demonstrated fluctuating inattention and disorganized thinking, physical behaviors occurred one to three days, other behaviors such as hitting, pacing, verbal or vocal symptoms occurred four to six days, wandering occurred four to six days, and walking in the corridor required limited assistance of two or more persons. Resident #1's Cognitive Care Area Assessment (CAA), dated 11/30/12, identified the resident demonstrated fluctuating inattention and disorganized thinking. The Mood and Behavior CAAs, dated 11/30/12, identified socially inappropriate behaviors, rummaging, pacing, and	F 224	Completion date is April 1st, 2013. The DON and Director of Social Services shall be responsible for the process.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 224	Continued From page 3 wandering with approaches of direction and re-direction. Resident #1's current care plan, dated 02/27/13, identified the following: "Problem, BEHAVIOR-Hallucinations-voids inappropriately, spits/wanders in and out of rooms/moves furniture about at times may upend tables-may be physically abusive to other residents/when hallucination [sic], monitor for lashing out at the hallucinations. [updated] (02/25/13), GOAL . . . will accept re-direction from staff and not be physically abusive to other residents. . . . APPROACH . . . Therapeutic Activities . . . enjoys playing ball (09/05/12) . . . Consult w/ [with] Psychiatry (09/13/12) . . . Refer Behavioral Issues to Behavioral Health (09/28/12) . . . Make referral to geropsych units for new placement (02/12/13) . . ." Resident #1's current Care Guide (used by facility direct care staff), dated 02/27/13, stated "Behavior Approaches . . . monitor interactions with female residents. Redirect from inappropriate behavior by removing resident from situation, Spend 1:1 time with resident, Distract from behavior w/snack/drink/walk, Leave alone and return later, Speak to resident calmly & [and] with simple terms, Decrease stimuli (calm supportive environment), Monitor wandering, Monitor physical aggression, Monitor agitation/restlessness, Monitor resistance/refusal of care, Monitor for inappropriate elimination . . . Protect from injury to self, Protect from injury to others, Tipping over furniture/moves w/c [wheelchair], etc." Resident #1's current physician orders included	F 224			

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

PRINTED: 03/21/2013
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 02/27/2013
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 224	Continued From page 4 the following medications: *Depakote Sprinkles (anticonvulsant which may be used to treat mania) 500 milligrams (mg), two times each day (BID), initiated 02/13/13. *Seroquel (antipsychotic) 200 mg, one time each day (QD), initiated 02/13/13. Prior to Resident #1's acute hospital admission on 01/30/13, his physician orders included the following medications: *Zyprexa (antipsychotic) 2.5 mg, QD, initiated 10/22/12. *Zoloft (antidepressant) 125 mg, QD, initiated 11/02/12. Resident #1's Nurse's Notes identified the resident's physically and verbally aggressive behaviors towards other residents, including the following examples: *09/18/12 - Female resident yelling at him in the hall. Resident #1 struck the female resident in the chest. Facility staff re-directed Resident #1. *09/30/12 - Female resident yelling at him, Resident #1 struck her with a magazine. Facility staff contacted the physician and administered Zyprexa 5 mg. *10/04/12 - Resident #1 was close to a female resident who yelled at him, he struck her in the arm. *10/13/12 - Resident #1 was pulling on the water fountain in the hall, a female resident yelled at him, and Resident #1 struck her. *10/16/12, 9:40 a.m. - While seated at the dining room table, Resident #1 struck a female resident in the mouth and the female resident threw coffee on Resident #1. Facility staff separated the residents. Facility staff monitored Resident #1 and did not observe any skin redness or burns.	F 224			

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

PRINTED: 03/21/2013
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 02/27/2013
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 224	Continued From page 5 *10/16/12, 8:47 p.m. - Resident #1 entered a female resident's room and pushed the resident against the door. Facility staff removed Resident #1 from the room. *12/18/12 - Resident #1 tugging on a female resident's clothes, she threw coffee on Resident #1, and he hit her in the face. Facility staff monitored Resident #1 and did not observe any skin redness or burns. *01/13/13 - Resident #1 was close to a female resident, she yelled at him, and he slapped her. Facility staff separated the residents. *01/29/13, 9:15 p.m. - Resident #1 was walking by another resident (identified as Resident #2) in the hall. Resident #2 told him to move and Resident #1 pushed Resident #2 to the floor. *01/30/13, 1:14 p.m. - Resident #1 admitted to the acute care facility emergency department for psychiatric evaluation. *02/12/13 - Resident #1 grabbed a female resident's walker and struck the resident in the chest. Facility staff re-directed the resident. Facility staff contacted Resident #1's family member and physician requesting return to the acute care facility for psychiatric evaluation, request denied. Facility staff began seeking placement of Resident #1 in geriatric psychiatric unit. Resident #1's Behavior Notes, dated, 01/25/13, identified a female resident yelled at Resident #1 and he struck her. During interview, on 02/27/13 at 8:15 a.m., a supervisory nursing staff member (#41) reported the facility did not identify the residents involved in the incidents with Resident #1. This staff member could identify Resident #2 in the incident on	F 224			

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

PRINTED: 03/21/2013
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 02/27/2013
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 224	Continued From page 6 01/29/13 because of the fractured shoulder experienced by Resident #2. The staff member (#41) reported it was unknown if any of the residents involved in the incidents previously identified experienced an injury, except as noted, since the facility did not identify the residents involved. Observation on February 24-27, 2013 showed Resident #1 in bed, in a wheelchair, or in a recliner. Resident #1 provided support with his lower extremities during stand and pivot transfers with a gait belt and assistance of two persons. Observation did not show Resident #1 ambulating with staff or attempting to rise independently from the wheelchair. During interview, on 02/27/13 at 8:15 a.m., a supervisory nursing staff member (#41) reported the facility's approaches to Resident #1's behaviors were limited to re-direction and medications. Medication adjustment occurred 10/22/12 and 11/02/12 as identified. This staff member reported Resident #1's family member and physician refused to have the resident returned to the acute care facility for psychiatric evaluation and medication adjustment after the incident on 02/12/13 and the facility began seeking geriatric psychiatric unit placement for the resident at that time. The staff member (#41) also reported Resident #1's physical status has declined since 02/12/13 which has resulted in reduced behaviors. The facility staff documented Resident #1's physically aggressive behaviors towards other residents as identified in the medical record. The facility staff responded to the behaviors with	F 224			

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

PRINTED: 03/21/2013
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 02/27/2013
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 224	Continued From page 7 re-direction and medications. Resident #1's physically aggressive behaviors continued. The resident's care plan and medical record lacked indications if Resident #1 targeted a particular resident or time of day or area of the unit. Failure to identify and track and trend this information limited the facility staff's ability to develop and implement a behavior monitoring plan for Resident #1. Resident #1 continued with physically aggressive behaviors which resulted in the fracture of Resident #2's left humerus. - Review of Resident #2's medical record occurred on February 24-27, 2013. The facility admitted the resident in August 2010. The resident's current diagnoses included dementia with behaviors, depression, and fracture of the left humerus. The quarterly MDS, dated 02/14/13, identified the resident made herself understood and understands others and during the seven day assessment period demonstrated: fluctuating disorganized thinking, physical and verbal behaviors one to three days, walked in corridor and locomotion on the unit with supervision only, and experienced one fall with a major injury since the prior assessment. Resident #2's Cognitive CAA, dated 08/16/12, identified disorganized thinking and dementia. The resident's Behavior CAA, dated 08/16/12, identified dementia and staff to provide re-direction. Resident #2's current care plan, effective date 02/01/13, stated "Problem, BEHAVIOR-Can be physically abusive to other residents and staff-verbally abusive and socially inappropriate and disruptive . . . GOAL . . . will interact	F 224			

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

PRINTED: 03/21/2013
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 02/27/2013
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 224	Continued From page 8 appropriately with staff and other residents, accept re-direction as needed . . . APPROACH . . . monitor behaviors-any aggression to other residents? . . . (01/17/13) . . ." and "Problem, Fracture to left shoulder (01/30/13) . . . Approach, Immobilizer on continuously q [every] shift. (01/30/13) . . ." Resident #2's current Care Guide, dated 02/27/13, used by facility direct care staff, stated "Behavior Approaches, Document mood and behaviors-responds well to TLC [tender loving care]-validate her concerns . . . Redirect from inappropriate behavior, Redirect from inappropriate behavior by removing resident from situation, Provide verbal reminders R/T [related to] behavior, Spend 1:1 time with the resident, Call family re: [regarding] behavior, Decrease stimuli (calm supportive environment), Monitor wandering, Monitor verbal aggression, Monitor physical aggression, Monitor agitation/restlessness, Monitor sadness/depression, Monitor anxiety, Maintain consistent environment & routine, Protect from injury to others." Resident #2's physician orders included: *Namenda (Alzheimer's dementia medication) 10 mg, BID, initiated 02/19/13. *Fentanyl Patch (Transdermal) (opioid pain medication) 12 micrograms, every 72 hours, initiated 02/09/13. Resident #2's Nurse's Notes identified physically and verbally aggressive behaviors towards other residents and included the following examples: *12/23/12 - Intentionally ran walker into two residents. No injuries noted to the other residents.	F 224			

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

PRINTED: 03/21/2013
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 02/27/2013
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. 224	Continued From page 9 *01/17/13 - Struck resident that wandered near her room. Pushed walker at another resident in a wheelchair. *01/18/13 - Pinched a female resident. *01/22/13 - Tells roommate to leave room. *01/23/13 - Aggressive towards roommate. Moved to a private room. *01/29/13 - Pushed to the floor by another resident (identified as Resident #1). Complains of arm pain. Taken by ambulance to the acute care facility. Returned to the facility that evening with left arm in an immobilizer, diagnosis of humerus fracture. During interview, on 02/27/13 at 8:15 a.m., a supervisory nursing staff member (#41) reported the facility did not identify the residents involved in the incidents with Resident #2. This staff member could identify Resident #1 in the incident on 01/29/13 because of the fractured shoulder experienced by Resident #2. The staff member (#41) reported it was unknown if any of the residents involved in the incidents previously identified experienced an injury, except as noted, since the facility did not identify the residents involved. Observation on February 24-27, 2013 identified Resident #2 ambulated independently on the special care unit with a four wheeled walker utilizing her right hand, and her left arm in a immobilizer at her side. The resident repeatedly called out "Help me." Facility staff approached the resident to offer assistance, returned the resident to her room for toileting, and the resident continued to call "Help me." Observation on 02/26/13 at 5:15 p.m., during the	F 224			

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

PRINTED: 03/21/2013
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 02/27/2013
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 224	Continued From page 10 evening meal, identified Resident #2 wandering in the unit with her walker as noted above. She repeatedly stated "Look at the mess." Staff attempted to re-direct her to the dining room for her evening meal. Facility staff assisted other residents with their meals and Resident #2 continued to wander in and out of the dining room and state "Look at the mess." Resident #2 approached other residents leaving the dining room in a threatening manner, telling them to "Shut up." Resident #2 approached the surveyor, repeatedly stated "Look at the mess", did not respond to verbal encouragement to return to her room or the dining room, and struck the surveyor's arm multiple times. Facility staff re-directed Resident #2 after they finished assisting other residents with the evening meal. During interview, on 02/27/13 at 8:15 a.m., a supervisory nursing staff member (#41) reported the facility's approaches to Resident #2's behaviors were limited to re-direction. Review of Resident #2's medical record and resident observations identified physically and verbally aggressive behaviors towards other residents, staff, and visitors. The facility's response to the behaviors was limited to re-direction. The resident's care plan and medical record lacked indications if Resident #2 targeted a particular resident or time of day or area of the unit. It is unknown if Resident #2 was the aggressor during the incident of 01/29/13. Failure to identify and track and trend this information limited the facility staff's ability to develop and implement a behavior monitoring plan for Resident #2. Failure to implement a behavior plan	F 224			

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

PRINTED: 03/21/2013
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 02/27/2013
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 224	Continued From page 11 for Resident #2 resulted in continued physically and verbally aggressive behaviors by Resident #2 towards other residents, staff, and visitors.	F 224			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide reasonable accommodations of individual needs and preferences for 2 of 22 sampled residents (Resident #21 and #24) and 1 supplemental resident (Resident #32) observed in wheelchairs during meals and for 1 of 1 sampled resident (Resident #5) observed in an incorrect wheelchair during 3 of 4 days of survey (February 25-27, 2013). Failure to ensure proper positioning for three residents (Resident #21, #24, and #32) during meals had the potential to cause fatigue for the residents and lead to a decrease in consumption of fluids and food. Failure of facility staff to use the correct chair (a Broda chair, a type of chair used to ensure correct upper body alignment and positioning) had the potential to cause Resident #5 discomfort. Findings include:	F 246	All staff has been in- serviced and re-educated on reasonable accommodation of resident needs/preferences ensuring resident equipment and cares are given in accordance with the care plan/care guide, which includes placing residents in appropriate wheelchairs and proper mealtime positioning. All residents have the potential to be affected. All residents cited have been assessed and appropriate changes have been implemented.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 246	Continued From page 12 - Review of Resident #24's record occurred on February 26-27, 2013. Medical diagnoses included cognitive impairment, malaise/fatigue, osteoarthritis, and anemia. A quarterly Minimum Data Set (MDS) dated 12/07/12 identified the resident with severe cognitive impairment, needed extensive assistance with transfers, and had limited range of motion in both upper and lower extremities. A physical therapy progress note dated 02/25/13 stated, "... I checked [resident's name]'s WC [wheelchair]; she states she is comfortable. Her feet don't quite reach the floor if removed from the footrests, but she does not try to use her feet to propel. Her armrests are high, but she prefers to sit with her arms at her sides and has the room to do so. I did write a work order to get her legrests shortened 1-2" [inches] so her feet are a bit flatter on the footrests. Her trunk is so short, that if we use a lower chair she may have trouble reaching even a lower table for dining. She again indicated she is comfortable in this chair." When requested, the physical therapist (#10) indicated the resident's last physical therapy evaluation was August of 2010. Observation on 02/25/13 at 3:00 p.m., showed a physical therapist (#10) approached Resident #24 who sat in her wheelchair by the elevators. The physical therapist removed the resident's feet from the foot pedals, the resident's feet dangled in the air, and physical therapist stated "might be a little short." The therapist asked the resident if she was comfortable in her wheelchair and the resident stated she was okay. Observation in the dining room on 02/26/14 at	F 246	Staff is to ensure that all residents will be seated in the most upright position, leg rests down or feet on the floor, feet supported, close enough to the table to reach items and have the ability to eat without need to hold dishes, table at comfortable height. Residents that are fed are to be positioned so a slight chin tuck is possible and are able to see the food in front of them. Any exceptions to this are to be documented on the care plan and care guide by the nurse. A wheelchair assessment screening tool for nursing staff was developed for guidance on proper wheelchair positioning and seating with the appropriate resource staff to contact when there are issues. PT developed a written wheelchair evaluation for residents		

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

PRINTED: 03/21/2013
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 02/27/2013
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 246	Continued From page 13 7:45 a.m., showed Resident #24 lean while sitting in her wheelchair with her lower back not touching the back of the wheelchair and her buttocks closer to the front edge of the seat than the back. The resident repeatedly stated "Lift me up," and two CNAs (#6 and #11) with a nurse (#12) assisted the resident to sit up straighter in the wheelchair. The resident continued to ask people who walked by her to "Lift me up," with her buttocks still not touching the back of the wheelchair. At 9:15 a.m. when the resident finished breakfast, a nurse (#12) again assisted the resident to sit up. While encouraging the resident to push her feet on the foot pedals, the nurse assisted the resident to slide back in the wheelchair so her back sat against the back of the wheelchair. Observation on 02/27/13 at 8:05 a.m., showed Resident #24 in the dining room with feet on foot pedals and the top of her left foot touching the tablemate's foot pedal across from her. The resident sat more than 12 inches from the table with the wheelchair arms touching the edge of the table and not allowing the chair to slide underneath. At 8:15 a.m., an unidentified staff member placed pureed food in separate containers on the table in front of the resident. While eating the individual foods, Resident #24 leaned forward, picked up food items, held the food items in her left hand over her lap, and ate them with her right hand. Once she consumed the food, the resident leaned forward and set the empty food containers back down on the table. The resident repeated the process for all her food items. During an interview on 02/27/13 at 8:40 a.m., a	F 246	QA is to be completed monthly by an Occupational Therapist that all residents are positioned properly unless there are exceptions. The Care Enhancement Team will be completing tracer studies on mealtime positioning for the time period of March 20th through April 15th, 2013. Nursing will be completing QA of mealtime positioning weekly and report to the QA committee until compliance is obtained. Completion date is 04/01/2013 OT/PT and the DON will be responsible for this process.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 246	Continued From page 14 physical therapist (#10) stated the facility did not have a formal wheelchair assessment form. The therapist stated she knew the resident's feet could not touch the ground if the foot pedals were removed. The therapist stated she was unaware if the resident had the ability to use her feet in addition to using her arms to help propel her own wheelchair. The physical therapist failed to evaluate if the wheelchair would be able to fit under the dining room table at meals. This therapist reported the Resident #24 had been in the same wheelchair for a long time. During an interview on 02/27/13 at 11:15 a.m., an occupational therapist (#27) stated she had not looked at Resident #24's wheelchair placement during meal times and indicated the arm rests of the wheelchair were high for the resident. This staff member stated the facility lacked foot rests in the dining room for resident's to rest their feet on if the foot pedals were removed at meals. - Review of Resident #32's current Care Guide (used by facility direct care staff) occurred 02/27/13 and identified staff push the resident in his wheelchair and provide set up assistance and staff assistance at meals, as needed. Observation on 02/27/13 at 8:15 a.m., showed Resident #32 self feeding french toast while sitting at a table in his wheelchair. The resident's wheelchair arms failed to fit under the table and showed the resident sat over 12 inches back from the table. The resident's feet remained on his foot pedals and his left foot pedal touched the leg of the table while the right foot pedal touched a neighboring wheelchair foot pedal. The resident reached with his right hand to dish food on a	F 246			

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

PRINTED: 03/21/2013
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 02/27/2013
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 246	Continued From page 15 utensil and when he brought food to his mouth, it dropped onto his clothing protector. When requested, the facility lacked policies related to assistance provided by staff or positioning of resident's during meal times and a form for wheelchair assessments. The occupational therapist provided a blank "Mealtime Positioning" form used by the facility but failed to provide completed forms regarding Resident #24's positioning. - Review of Resident #21's medical record occurred on February 26-27, 2013. Medical diagnoses for Resident #21 include depressive disorder, anxiety, and narcolepsy. Resident #21's quarterly Minimum Data Set (MDS), dated 12/03/12, identified the resident displayed short and long term memory problems, and required extensive one person physical assistance with eating. Observation on 02/26/13 at 8:05 a.m. showed Resident #21 seated in a Broda chair (a reclining wheelchair) about 18 inches from the dining room table. Observation showed Resident #21 attempted to eat a bowl of corn flakes which sat near the edge of the table. The majority of the corn flakes fell onto her lap. At 8:15 a.m., an unidentified staff member sat next to Resident #21, picked the corn flakes off her lap and clothing protector, and left. At 8:26 a.m., another unidentified staff member sat down next to the resident and assisted her with her meal. - Review of Resident #5's medical record occurred on February 24-27, 2013. Medical	F 246			

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

PRINTED: 03/21/2013
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 02/27/2013
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 246	Continued From page 16 diagnoses for Resident #5 include dementia with behavioral disturbance, depressive disorder, and osteoarthritis. Resident #5's annual MDS, dated 01/23/13, identified the resident displayed short and long term memory problems, required extensive two person physical assistance with transfers and bed mobility, and one person physical assistance with eating and locomotion on/off the unit. Review of Resident #5's current Care Guide identified the resident as non-ambulatory and "uses a Broda chair for mobility propelled by staff." Observation on 02/24/13 at 10:50 a.m., during the initial tour of the facility, showed Resident #5 seated in a Broda chair in the 2 West living/dining room. Observations on 02/25/13 showed: *8:00 a.m., Resident #5 seated in a regular wheelchair positioned at the table in the 2 West living/dining room. A CNA (#13) stated Resident #5 needs to go to the beauty shop after breakfast and this is the reason staff used a wheelchair this morning instead of her Broda chair. The CNA (#13) stated when Resident #5 returns from the beauty shop, staff members will transfer Resident #5 into her Broda chair. *11:38 a.m., two CNAs (#14 and #15) transferred Resident #5 out of bed into a regular wheelchair while a Broda chair remained in her bathroom. *4:10 p.m., two CNAs (#13 and #16) transferred Resident #5 out of bed into a regular wheelchair.	F 246			

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

PRINTED: 03/21/2013
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 02/27/2013
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 246	Continued From page 17 Observation on 02/26/13 at 7:45 a.m., 9:10 a.m., and 6:00 p.m. and on 02/27/13 at 9:00 a.m. showed Resident #5 seated in a regular wheelchair. During an interview on 02/26/13 at 10:50 a.m., an administrative nurse (#17) stated the facility's occupational therapists complete wheelchair assessments as ordered, recommend the type of chair for the resident to use based on the assessment, and then the type of chair is listed on the resident's care guide. This nurse stated she expected staff to use the type of chair listed on the care guide. Observations during the survey identified staff members failed to consistently utilize and place Resident #5 in the correct chair (Broda) as stated in the resident's current Care Guide. Failure to use the Broda chair for Resident #5 had the potential to cause the resident unnecessary pain and discomfort.	F 246			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide medically related social services to ensure 1 of 1 sampled resident (Resident #22) who recently experienced	F 250	All social workers will be educated on the Grief policy/procedure. All residents have the potential to be affected. The social worker is to identify any resident that has lost a significant other/family member and document in the progress notes and update the care plan and care guide. The social worker		

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

PRINTED: 03/21/2013
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 02/27/2013
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 250	Continued From page 18 a spouse's death. Failure to provide a supportive environment placed this residents at risk for unresolved grief issues and seclusion. Findings include: During the initial tour of the facility's special care unit, on 02/24/13 at 10:00 a.m., a supervisory nursing staff member (#41) reported Resident #22's wife passed away recently (12/31/12) and the facility staff were uncertain if the resident recalled her death. Observation identified Resident #22 seated at the edge of his bed looking through mail items. Review of Resident #22's medical record occurred on February 26-27, 2013. Current diagnoses included dementia and depression. The quarterly MDS, dated 02/13/13, identified the resident usually made himself understood and understood others. The Care Area Assessment (CAA) related to activities, dated 10/08/12, identified the Resident #22 visited his wife (who resided on another unit in the facility), attended activities with her, and spent time with her. Resident #22's current Care Guide, dated 02/27/13, failed to include approaches to assist staff regarding the resident's grieving process for his wife's death. The Care Guide also stated "Behavior Approaches . . . Spend 1:1 time with the resident . . . Monitor sadness/depression . . ." Observation of Resident #22 in his room identified the following: *02/26/13 at 11:20 a.m. - Dressed, laying on his bed with eyes closed, noon meal at his bedside, uneaten. Mail items on the bedside table next to	F 250	is to visit with the resident, offer pastoral care services and arrange as necessary. If the resident is unable to make their own decisions, the family/contact person will be contacted to determine if pastoral care services are needed. The social worker is to follow the resident weekly for one month and re-evaluate the resident quarterly for one year, for signs of depression and sadness. A progress note is to be entered in the chart after each visit. If the resident is showing continued depression and sadness that interferes with daily functioning (eating, bathing, dressing, etc) a psychiatric consult will be offered to the resident. QA is to be completed by the social worker for completion of the grief policy for each resident experiencing a loss of a significant other/family member. Completion date is March 27th, 2013. The Director of Social Services is responsible for the process.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 250	Continued From page 19 the meal tray. 11:40 a.m. - Continued as 11:20 a.m. No meal items eaten. Mail items remained next to the meal tray. 5:15 p.m. - Seated at edge of his bed, reading sympathy cards and an obituary. Evening meal of chicken, potato, squash, and ice cream at his bedside, no meal items eaten. When asked what he was reading, Resident #22 showed the sympathy cards and obituary of his recently deceased wife. The mail items appeared to be the same items present since the initial tour on 02/24/13. 5:35 p.m. - Remained seated on his bed looking at sympathy cards and an obituary. No meal items consumed. *02/27/13 at 7:50 a.m. - Dressed, laying on his bed with eyes closed, breakfast meal at his bedside, uneaten. Mail items on the bedside table next to the meal tray. 9:15 a.m. - Dressed with his boots off, laying on his bed with eyes closed. Mail items on the bedside table. During interview, on 02/27/13 at 8:15 a.m., a supervisory nursing staff member (#41) agreed the facility should have provided grief support for Resident #22. Observation showed the resident continued to keep and look at sympathy cards and his wife's obituary at his bedside, including during meal time. Observation showed facility staff failed to provide support and 1:1 contact regarding grief support and alternatives. The facility identified Resident #22 spent time and attended activities with his wife who passed away	F 250			

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

PRINTED: 03/21/2013
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 02/27/2013
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 250	Continued From page 20 on 12/31/12. The facility identified the resident prefers to spend time alone in his room. The resident's Care Guide lacked approaches to address Resident #22's grieving of his wife's death. The medical record lacked documentation facility staff provided any grief support for Resident #22.	F 250	All MDS nurses have been provided with education regarding accurately completing the Active Diagnosis on the MDS.		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	All residents have the potential to be affected. Each resident's MDS which reflects no longer active diagnosis that have a direct relationship to resident's care will have that MDS modified to reflect the accurate active diagnosis to support resident's POC. The following MDS's have been amended: Resident #14 Quarterly Resident #5 Annual- inactive diagnosis have been removed from section 12. Resident #4 Quarterly-inactive diagnosis have been removed from section 12. Resident #12 Annual Resident #11 Quarterly Resident #3 Quarterly- duplicate diagnosis removed from section 12.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 21 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/15/12. Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), professional reference review, and staff interview, the facility failed to ensure residents current Minimum Data Sets (MDSs) were accurately coded pertaining to Section I- Active Diagnosis for 7 of 25 sampled residents (Resident #3, #4, #5, #11, #12, #14, and #25); Section G- Range of Motion (ROM) for 3 of 25 sampled residents (Resident #10, #11 and #25); and for Section N- Medications for 1 of 25 sampled residents (Resident #3). Failure to accurately complete portions of the MDS for sampled residents does not allow each resident's assessment to reflect the resident's current status/needs. Findings include: The Long-Term Care Facility RAI User's Manual, page I-4, stated, "... Active diagnoses have a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the look-back period. ... Coding instructions: Code diseases that have a documented diagnosis in the last 60 days and have a relationship to the resident's functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period (except	F 278	QA will be done weekly on at least 10% of completed MDS assessments that the Active Diagnosis have a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the look-back period. The MDS nurse will complete the QA The date for completion was March 13th, 2013. The MDS Coordinator and _____ Administrator will be responsible for the process. Physical Therapy and MDS nurses have received education on completing section G ROM on all assessments. All residents have the potential to be affected.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 22 Item I2300 UTI [urinary tract infection], which does not use the active diagnosis 7-day look-back . . .) . . ." Review of the following resident's current MDSs for Section I- Active Diagnoses identified: * Resident #14's quarterly MDS, dated 01/15/13, identified the resident received physical and occupational therapy. Record review, on all days of survey, identified the resident's last physical and occupational therapies occurred in September of 2012. * Resident #5's annual MDS, dated 01/23/13, identified aftercare for traumatic lower arm fracture. Record review identified Resident #5 sustained an arm fracture in October 2009 with no current care or treatment ordered. * Resident #4's quarterly MDS, dated 02/02/13, identified aftercare for traumatic hip fracture. Record review identified Resident #4 sustained a hip fracture in August 2009 with no current care or treatment ordered. * Resident #25's significant change MDS, dated 02/04/13, identified physical therapy. An interview with therapy staff (#10 and #28) on 02/27/13 at 11:36 a.m. identified Resident #25 last received physical therapy 12/05/12. * Resident #12's annual MDS, dated 02/14/13, identified aftercare following a fracture. Record review identified Resident #12 sustained a fracture in October 2012 with no current care or treatment ordered. * Resident #11's quarterly MDS, dated 02/25/13, identified cellulitis of the toe. Review of Resident #11's medical record failed to show the facility treated the resident for cellulitis during the assessment period.	F 278	Each resident that has an MDS due will be assessed by Physical Therapy and have sections G0300, G0400 completed. The following MDS has been assessed by physical therapy and have been amended to accurately reflect the assessment: Resident # 10 Quarterly Resident # 11 Quarterly Resident # 25 Significant Change MDS. QA will be done weekly on at least 10% of completed MDS assessments that section G0300 and G0400 have been completed by Physical Therapy. The MDS nurse will complete the QA. The date for completion was March 13th, 2013. The MDS Coordinator and Administrator will be responsible for the process.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 23 During interview on 02/26/13 at 9:10 a.m., an administrative nurse (#17) stated the facility's computer system carries forward diagnoses from previously completed MDSs and expects the MDS nurse to review each diagnosis to ensure it is an active diagnosis. The Long-Term Care Facility RAI User's Manual, page G-29 stated, "... The intent of G0400 is to determine whether functional limitation in range of motion (ROM) interferes with the resident's activities of daily living or places him or her at risk of injury. When completing this item, staff should refer back to item G0110 and view the limitation in ROM taking into account activities that the resident is able to perform ... Coding Instructions ... Code 1, impairment on one side: if resident has an upper and/or lower extremity impairment on one side that interferes with daily functioning or places the resident at risk of injury; Code 2, impairment on both sides: if resident has an upper and/or lower extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury." Review of the following resident's current MDSs for Section G- Range of Motion identified: * Resident #10's quarterly MDS, dated 12/02/12, identified the resident had no limitations to her upper and lower extremity ROM. Observation of Resident #10 showed severe contractures of both hands which required that facility staff helped her eat. Observation showed the resident with limitations of the lower extremities. Observation showed the resident's knees would not bend and her feet came off the floor as she sat on the toilet. * Resident #11's quarterly MDS, dated	F 278	MDS nurses have received education on identifying the use of antipsychotic medication for completion of item N0410A. All residents have the potential to be affected. Resident #3's Quarterly MDS was amended to reflect the correct classification of drug. The MDS nurse will review the medication list on any MDS that is being completed and identify any antipsychotic medications that were received during the 7 day look-back period. Item N0410A is then to be completed. QA will be done weekly on at least 10% of completed MDS assessments that item N0410 has been completed by Physical Therapy. The MDS nurse will complete the QA. The date for completion was March 13th, 2013. The MDS Coordinator and Administrator are responsible for the process.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 24 02/25/13, identified the resident had no limitations to his lower extremity ROM. Observation of care, on 02/25/13 at 10:40 a.m., showed Resident #11 had an internal rotation of the right foot. As the CNAs (#34 and #35) assisted the resident they stated the resident's right foot would interfere with the resident's ability to walk again when his weight bearing restriction is lifted. * Resident #25's significant change MDS, dated 02/04/13, identified the resident had no limitation to her lower extremity ROM. Observation of Resident #25 showed the resident had an outward rotation of both ankles. An interview with physical therapy staff (#10 and #28), on 02/27/13 at 11:36 a.m. identified Resident #25 had a valgus (an outward turning from midline of a body part) affecting the ROM of both ankles. During an interview, on 02/27/13, at 1:00 p.m., an administrative nurse (#17) identified the facility failed to complete assessments of ROM for the MDS since the change to MDS 3.0. The Long-Term Care Facility RAI User's Manual, page N-5 stated, " . . . N0410A, Antipsychotic: Record the number of days an antipsychotic medication was received by the resident at any time during the 7-day look-back period" The Nursing 2013 Drug Handbook 33rd edition, page 1151, identified the drug classification for Seroquel as an antipsychotic. The record identified a physician order to decrease Resident #3's Seroquel dosage to 600 mg extended-release every 24 hours in October 2012.	F 278			

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

PRINTED: 03/21/2013
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 02/27/2013
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 25	F 278			
F 314 SS=D	Resident #3's quarterly MDS, dated, 02/14/13, failed to identify the use of an antipsychotic medication at Item N0410A. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 SURVEY COMPLETED ON 03/15/12. Based on observation, record review, policy and procedure review, and staff interview, the facility failed to provide the necessary treatment and services to aid in the prevention and promote the healing of pressure ulcers for 3 of 6 sampled residents identified by the facility with current pressure ulcers (Resident #3, #9, and #11) and 1 of 21 sampled residents identified at risk for pressure ulcer development (Resident #4). Failure to implement established treatment interventions (ensuring the floatation of residents heels off the bed mattress) may contribute to a delay in the healing of pressure ulcers for Resident #3, #9, and #11 or the development of a new pressure ulcer for Resident #4.	F 314	All staff has been provided with written education on how to float heels appropriately off the bed when positioning residents. All residents on the Pressure Ulcer Prevention Protocol have the potential to be affected. Resident # 3, 9, 11 have had their Care Guides updated to reflect changes in cares. This will ensure that staff will have a complete understanding of floating heels off the bed. A policy and procedure has been developed addressing and assessing the correct way to float heels off a bed. The C.N.A is to position residents on the Pressure Ulcer Prevention Protocol, so that a hand can be passed between the heel and the bed without touching. The nurse is responsible to check that heels are floated correctly every shift. The Every 2 hour Turning Schedule has been revised so the nurse can sign off that he/she has checked placement of the heels and it is correct. A new device called "Heels Off" has been ordered, some received and are currently in use on selected residents.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 314	Continued From page 26 Findings include: Review of the facility policy titled "Routine Care of Pressure Sores" occurred on 02/27/13. This policy, dated 08/2011, included a "Pressure Ulcer Prevention Protocol" which stated, ". . . Elevate/Float heels off bed using pillows or apply heel lifts" - Review of Resident #9's medical record occurred February 24-27, 2013. A quarterly/5 day Minimum Data Set (MDS), dated 12/09/12, identified the resident required extensive assist of two or more staff for bed mobility; dependent on two or more staff for transfers; at risk for the development of pressure ulcers; did not have a pressure ulcer; and the utilization of pressure reducing devices in the chair and bed. A 60 day MDS, dated 01/27/13, indicated the resident developed a Stage 2 pressure ulcer on 01/15/13 and received ulcer care. Record review showed a pressure ulcer to the resident's left heel. Resident #9's current care plan, dated 02/08/13, stated, "Problem: Skin integrity - Skin impairment r/t [related to] unstageable pressure ulcer to left heel: . . ." and included an approach of "Keep heels off bed q. [every] shift." The "Care Guide," (a part of the care plan located in each resident's room used by the certified nurse aide [CNAs]), included the heading of "Skin," and stated, ". . . Prevalon boot to left foot and dermasaver bootie (a covering that protects fragile skin and reduces shear and pressure) to right foot at all times . . . Float heels off mattress with use of pillows." Observations of Resident #9 showed the	F 314	QA is to be completed weekly by nursing that heels are floated correctly when a resident is in bed. The Care Enhancement Team will be completing tracer studies on floating heels for the time period of March 20th to April 15th, 2013. Completion date is March 20th, 2013. The DON is responsible for the process.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 314	Continued From page 27 following: * 02/25/13, at 10:58 a.m., two CNAs (#34 and #35) assisted the resident to lie down. A nurse (#40) and a CNA (#36) provided a dressing change to Resident #9's left heel. The nurse (#40) did not measure the wound, but the wound appeared to be approximately 2 centimeters (cm) in diameter surrounded by red and peeling skin. At the completion of care, the CNA (#36) place a pillow under the resident's lower legs. Despite placement of the pillow, Resident #9's heels rested directly on the mattress. * 02/25/13, at 12:11 p.m., two CNAs (#36 and #35) assisted the resident from bed to his wheelchair for the noon meal. When the CNAs (#36 and #35) removed the bedding Resident #9's heels were observed to rest directly on the mattress. * 02/25/13, at 3:50 p.m., observation showed Resident #9's heels rested directly on the bed prior to two CNAs (#34 and #37) assisting the resident from his bed to his wheelchair. * 02/26/13, at 9:26 a.m., a CNA (#36) and a nurse (#40) checked the dressing on Resident #9's left heel. The CNA (#36) and the nurse (#40) positioned the resident on his left side using a pillow behind his back, and attempted to float the resident's heels on a pillow. The CNA (#36) and the nurse (#40) could not position Resident #9's heels to prevent them from resting on the mattress. After trying to fold the pillow two different ways, the CNA (#36) and nurse (#40) covered the resident leaving his heels resting directly on the mattress. - Review of Resident #11's medical record occurred February 24-27, 2013. A quarterly MDS, dated 02/25/13, identified the resident required	F 314			

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

PRINTED: 03/21/2013
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 02/27/2013
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 314	Continued From page 28 extensive assistance of two or more staff for bed mobility and transfer; at risk for the development of pressure ulcers; developed a Stage 2 pressure ulcer on 06/27/12; and skin and ulcer treatments of: pressure reducing devices to the chair and bed; turning/repositioning program; nutrition or hydration intervention; ulcer care; surgical wound treatment; ointments/medications - other than feet; and dressings to feet. Record review showed a pressure ulcer to the resident's right heel and right lateral lower ankle. Resident #11's current care plan, dated 01/23/13, stated, "Problem: Skin integrity - Pressure ulcers to right heel and right lateral lower ankle region . . ." Approaches, dated 06/27/12, included " . . . Monitor skin - bilateral heels (deep tissue injuries) q. shift; Elevate lower extremities - Heels off mattress q. shift; Heel Lifts - keep heels off bed with pillow at all times. Keep heels open to air & dry. q.shift [sic] . . ." The "Care Guide" included the heading of "Skin" which stated, " . . . observe feet for evidence of problems, . . . Derma savers to bilateral feet at all times. . . . Heels off mattress at all times with a pillow, . . ." Observations of Resident #11 showed the following: * 02/25/13 at 10:40 a.m. the resident had kicked the derma savers off both heels. Upon completion of cares, the CNAs (#34 and #35) replaced the derma savers and placed a pillow under the resident's lower legs. Despite the pillow, Resident #11's heels rested directly on the mattress. * 02/25/13 at 11:32 a.m. the nurse (#40) provided treatments to Resident #11's lower legs and pressure sores. Upon completion of dressing	F 314			

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

PRINTED: 03/21/2013
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 02/27/2013
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 314	Continued From page 29 changes, the nurse (#40) placed the resident's lower legs on a pillow. Despite the pillow, Resident #11's heels rested directly on the mattress. - Review of Resident #3's medical record occurred on February 26-27, 2013. Medical diagnoses for Resident #3 included dementia without behavioral disturbances. The facility identified a facility-acquired pressure ulcer to his right heel in October 2012. Resident #3's current quarterly MDS, dated 02/14/13, identified the resident displayed short and long term memory impairment and required total assistance of two or more staff for bed mobility and transfers, the presence of a Stage 2 pressure ulcer and the use of a pressure reducing device on the chair and bed and the use of a turning/repositioning program. Review of Resident #3's current Care Guide identified "Skin" and stated, "Turn and reposition q [every 2 h [hour] and prn [as needed] . . . Resident on a turn schedule and Pressure Ulcer Prevention Protocol . . . Derasavers to both feet at all times . . . Float heels off mattress using pillows" Observation on 02/25/13 at 9:25 a.m. showed two CNAs (#13 and #18) transferred Resident #3 from his high-back wheelchair (w/c) to bed, applied Derasaver heel protectors to both feet, and placed a pillow under the resident's lower legs. Observation showed the position of the pillow failed to float the Resident #3's heels off of the bed.	F 314			

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

PRINTED: 03/21/2013
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 02/27/2013
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 314	Continued From page 30 Observation on 02/25/13 at 3:25 p.m. showed Resident #3 laying in bed positioned on his back. Two CNAs (#13 and #19) entered the resident's room to transfer the resident into his high-back w/c. Upon removal of Resident #3's blanket, observation showed a pillow in place under the resident's lower legs, bilateral Derasaver heel protectors on his feet, and the resident's feet resting directing on the mattress. Observation of Resident #3's right heel pressure ulcer occurred on 02/26/13 at 9:45 a.m. with the facility's wound care nurse (#33) and showed the wound measured 0.7 centimeters (cm) by 0.9 cm. and showed no drainage or redness. The wound care nurse (#33) stated Derasaver heel protectors provide extra padding and the placement of them does not ensure the floatation of heels. - Review of Resident #4's medical record occurred on February 25-26, 2013. Medical diagnoses for Resident #4 included dementia without behavioral disturbances, depressive disorder, and psychosis. Resident #4's quarterly MDS, dated 02/02/13, identified the resident displayed severe cognitive impairment, required extensive physical assistance with bed mobility. Review of Resident #4's current Care Guide included the heading of "Skin" and stated, "Turn and reposition resident q 2 h and prn . . . Turn schedule . . . Float heels off mattress with pillows . . . Pressure Ulcer Prevention Protocol." Observation on 02/25/13 at 3:42 p.m. showed Resident #4 laying in bed positioned on his right side. A CNA (#19) entered the resident's room to	F 314			

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

PRINTED: 03/21/2013
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 02/27/2013
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 314	Continued From page 31 transfer the resident into his w/c. Upon removal of Resident #4's blanket, observation showed a pillow in place between the resident's knees and lower legs, and the resident's right heel resting directly on the mattress.	F 314			
F 323 SS=G	Facility staff failed to float Resident #3, #4, #7, and #11's heels as identified by the resident's care guide. 483.25(h) FREE OF ACCIDENT 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: 1. Based on observation, record review, staff interview, and review of internal facility information (e-mails), the facility failed to ensure 2 of 2 sampled residents (Resident #3 and #20) received the care and services necessary to attain the highest degree of safety possible while drinking hot coffee. Failure to provide coffee at a safe temperature resulted in Resident #3 and #20 sustaining burns on their bodies and caused these residents unnecessary discomfort and pain. Failure of the facility to implement a system to monitor the temperature of the coffee dispensing machines used by residents has the potential to result in additional burns to residents who drink coffee.	F 323	All staff has received written education on assessing residents and using covered cups for hot beverages. Coffee and hot water temperatures inside the coffee dispensing machine are to be 160 degrees when brewed, according to manufacturer guidelines. This is to prevent germ growth inside the water holding tank. All residents have the potential to be affected.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 32 Findings include: - Review of Resident #3's medical record occurred on February 25-27, 2013. Medical diagnoses for Resident #3 include dementia without behavioral disturbances and depression. Resident #3's Progress Notes from September 2012 stated: 09/04/12 at 9:45 p.m. - "... Went out to dining room [adjacent to the 2 West Nursing Unit] to eat - able to feed self" 09/12/12 at 9:30 a.m. - "[resident's first name] spilled hot coffee on his right upper thigh he did obtain a water filled blister which is intact, ice applied to right upper thigh, leg is cool to touch denies any discomfort he stated 'It feels better then it did this morning.' Daughter . . . notified of incident, also reminded staff to put ice chips or cold water in his coffee." 09/13/12 at 12:47 a.m. - "Blister right thigh now open. It is 0.5 cm [centimeters] in diameter. No s/s [signs/symptoms] of infection present and resident does not c/o [complain of] pain to area." 09/13/12 at 5:47 a.m. - "Resident scratched at thigh blister early in the shift. Area cleaned and ointment applied then covered with non adherent dressing" Review of the Progress Notes from September 14-30, 2012 failed to provide any information regarding Resident #3's blister to his right thigh related to the coffee burn. Resident #3's September 2012 care plan, provided by the facility for review, failed to show evidence the facility implemented any interventions to prevent further burn incidents.	F 323	All current residents will be assessed by nursing staff through a QA process, to determine the need for covered cups when serving hot beverages. Dietary will be notified of any resident that will now require a covered cup. All new admissions will be assessed by nursing to determine if there is a need for a covered mug. This will be done on the admit assessment. Dietary will be notified of any resident that will require a covered cup and will update the care plan and care guide. New cups with covered lids have been ordered for hot beverages and staff was provided with written education on their use. A new position has been developed and filled, Clinical Excellence/Resident Safety Coordinator, that will be responsible to follow up on incident reports in a timely manner.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 33 During an interview on the morning of 02/27/13, the surveyor asked an administrative nurse (#26) to provide additional information regarding the coffee burn sustained by Resident #3 on 09/12/12 (specifically, what time of day did the incident occur, what type of eating assistance did the resident require at the time of the incident, did the resident have a cover/lid on the coffee cup prior to the incident, was the resident attended by staff at the time of the incident, and what correction action was implemented by the facility following the incident). On 02/27/13 at 2:00 p.m., an administrative nurse (#26) stated the facility did not have any incident report or additional information available for review regarding the coffee burn sustained by Resident #3. This administrative nurse (#26) stated she expected the nurse who knew of the burn to complete an incident report. When asked if any staff member in the facility initiated monitoring the temperature of the coffee dispensing machine used by residents following the September 2012 incident, an administrative nurse (#26) stated she did not know. - Review of Resident #20's medical record occurred on February 26-27, 2013. Resident #20's Progress Notes, dated February 02-18, 2013, stated, *02/02/13 at 2:15 p.m. - "resident was up in her wheelchair having coffee, coffee spilled on abdomen 11 cm wide X [by] 9 cm, left groin 6 x 4 cm, right groin 4 x 4 cm, all areas reddened. [name of doctor] taking call notified and residents [sic] daughter [name] updated: [regarding]	F 323	Data is to be completed weekly by dietary that identified residents will have a covered cup and that the care plan and care guide has been updated. QA will be completed by dietary weekly on serving temperatures of the coffee/hot water dispensing machines. The serving temperatures are to be below 160 degrees. QA will also be done by Unit Managers on new admissions that each resident has a completed assessment regarding use of covered cups. Completion date is April 1st, 2013 The Director of Dietary Services and the DON will be responsible for this process.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 34 incident." *02/03/13 at 3:25 a.m. - " . . . Resident did sustain burns from earlier coffee spill. Large area to abdomen, around umbilicus is red but free of blisters. Left inner thigh is red and has a large blister present. The right inner thigh has a smaller area of red with moderate sized blister. Triple antibiotic ointment applied as earlier ordered and resident settled in bed" *02/04/13 at 8:43 p.m. - "Resident up in chair per usual routine. Offers no complaints of pain or discomfort from coffee spill to her abdomen and leg/groin area. Cream applied to help with healing." *02/07/13 at 6:56 p.m.- "Residents [sic] adoment [sic] area is red and skin has peeled off in most areas. Resident combative when trying to apply cream to burn area." *02/11/13 at 1:34 p.m. - "Monitoring - Monitor Skin 3 open areas on abdomen are covered with yellow exudate. no drainage. cleansed areas with NS [normal saline] and covered with silvadene cream; covered with Telfa." *02/18/13 at 1:00 p.m. - "Monitoring - Monitor Skin abdomen is much improved some yellow eschar remains to three small open areas." The facility's wound care nurse assessed Resident #20's wounds on February 13, 19 and 25, 2013. A progress note dated, 02/13/13 stated, "Wound care note: Assessed burns to resident's abdomen and bilateral medial upper thighs. Right abdomen has two wounds: Superior: 0.5 X 1.5 cms with a wound bed that is 100% [percent] yellow; Inferior: 4 X 3 cms with a wound bed that is 80% yellow and 20% red. Left abdomen has a wound measuring 3.3 X 1.2 cms with a wound bed that is 90% yellow and 10% red. Left medial	F 323			

HEALTH AND HUMAN SERVICES
CARE & MEDICAID SERVICES

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2013
FOR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58702		
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 35 thigh has a wound that measures 4 X 1.5 cms with wound bed that is 80% red and 20% yellow. Also noted two long linear intact blisters to left medial upper thigh and 1 long linear blister that remains intact to right medial upper thigh. Resident became combative and would not allow any further measurements to be done Resident does express some discomfort during treatment and assessment. Current treatment is silvadene applied as per MD [medical doctor] orders." Resident #20's current quarterly MDS, dated 12/20/12, identified the resident displayed short and long term memory impairment and required extensive one person assistance with meals. Review of Resident #20's current Care Guide (a part of the care plan located in each resident's room used by certified nurse aides) identified "Eating" and stated, "Deliver [and] setup tray. Covered mugs. Colored plate. Provide cuing for eating. Starts to feed self. Staff assist as resident allows. Encourage intake of fluids." Review of a facility form titled "Bruises/Injuries of Unknown Origin" occurred on the morning of 02/27/13. This form, dated 02/02/13, stated Resident #20 sustained coffee burns to her abdomen which measured "11 cm wide [by] 9 cm" to her left groin which measured "6 [by] 4 cm" and to her right groin which measured "4 [by] 4 cm." The form stated a potential cause of the incident as "top came off coffee cup." Environmental changes implemented of "make sure top for cup is on securely" and a plan of action to "monitor [burn] areas affected."	F 323	F 323 Coffee Temperature Staff have been instructed on the following to meet the goal of approximately 140 degrees serving temperature for the coffee : • Add 1 cup of ice chips to a Carafate of coffee. (fill to the neck of the coffee Carafate with coffee). • Add 3 Tbs. of ice to 1 cup of coffee before serving the coffee to the resident. Cup lids will be added for the residents @ risk for spills. QA Random temps. of cooled coffee will be done weekly X 4, then monthly by Dietary. Completion date is April 12, 2013, The Director of Dietary Services will be responsible for this process.	

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

PRINTED: 03/21/2013
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 02/27/2013
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 35 thigh has a wound that measures 4 X 1.5 cms with wound bed that is 80% red and 20% yellow. Also noted two long linear intact blisters to left medial upper thigh and 1 long linear blister that remains intact to right medial upper thigh. Resident became combative and would not allow any further measurements to be done . . . Resident does express some discomfort during treatment and assessment. Current treatment is silvadene applied as per MD [medical doctor] orders." Resident #20's current quarterly MDS, dated 12/20/12, identified the resident displayed short and long term memory impairment and required extensive one person assistance with meals. Review of Resident #20's current Care Guide (a part of the care plan located in each resident's room used by certified nurse aides) identified "Eating" and stated, "Deliver [and] setup tray. Covered mugs. Colored plate. Provide cuing for eating. Starts to feed self. Staff assist as resident allows. Encourage intake of fluids." Review of a facility form titled "Bruises/Injuries of Unknown Origin" occurred on the morning of 02/27/13. This form, dated 02/02/13, stated Resident #20 sustained coffee burns to her abdomen which measured "11 cm wide [by] 9 cm" to her left groin which measured "6 [by] 4 cm" and to her right groin which measured "4 [by] 4 cm." The form stated a potential cause of the incident as "top came off coffee cup." Environmental changes implemented of "make sure top for cup is on securely" and a plan of action to "monitor [burn] areas affected."	F 323			

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

PRINTED: 03/21/2013
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 02/27/2013
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 36 On the morning of 02/27/13, a surveyor checked and obtained a temperature reading of 151.7 degrees Fahrenheit for the coffee dispensed directly from the machine located in the 4 East Dining Room. During interview on 02/27/13 at 11:00 a.m. an administrative nurse (#32) stated the facility could not determine if the coffee lid was incorrectly placed by staff when they provided Resident #20 the cup or if the resident loosened the lid herself. This administrative nurse stated the coffee involved in the incident came out of a dispensing machine located in the 4 East Dining Room and she did not know if any facility staff member checks/monitors the temperature of the coffee in the machines and stated "that would be done by dietary [referring to the dietary department]." During interview on 02/27/13 at 11:20 a.m. an administrative nurse (#26) stated the coffee burn incident involving Resident #20 was discussed by the facility's administrative team during the daily morning "standup meeting" (which occurred on Monday, February 04. The burn incident involving Resident #20 occurred on Saturday, February 02). When asked to provide evidence of monitoring the temperatures of the coffee machines following this incident, this nurse stated she recalled e-mail communication between herself and the dietician which stated the reading was 160 degrees. Review of these e-mails, provided by an administrative nurse (#26) identified the first e-mail communications took place on 02/15/13 (13 days after the incident).	F 323			

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

PRINTED: 03/21/2013
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 02/27/2013
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 37 An e-mail dated 02/15/13 at 11:28 from the dietician to the administrative nurse (#26) stated, "[employee name] went and temped all the floors [referring to checking the temperatures of the coffee machines. The first time the facility checked the temperatures occurred 13 days after Resident #20 sustained her burn]. She said all were at 160 degrees . . . [employee name] called . . . the guy who works with the coffee machines and he will be coming to check on them as well . . ." An e-mail dated 02/15/13 at 11:30 a.m. from an administrative nurse (#26) to the dietician stated, "So is 160 considered too high?" An e-mail dated 02/15/13 at 11:50 a.m. from the dietician to an administrative nurse (#26) stated, "I'm not too sure if there are specific nursing home guidelines, but from what I can find in research it says that hot beverages should be served between 160-185 degrees, and 140 degrees is preferred drinking temperature . . . I feel like 160 is reasonable because once it is poured into a cup it says the temp drops about 10 degrees . . ." Review of these e-mails failed to ensure the facility implemented a system to periodically monitor and check the temperatures of the coffee dispensing machines used for residents. 2. Based on observation, record review, review of manufacturer's operating instructions for a mechanical Hoyer lift, and review of facility policy, the facility failed to appropriately utilize assistance devices for 1 of 5 sampled residents observed transferred by staff using a mechanical Hoyer lift	F 323			

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

PRINTED: 03/21/2013
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 02/27/2013
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 38 (Resident #14), 4 of 12 sampled residents (Resident #4, #6, #8, #10) and 1 supplemental resident (Resident #33) observed transferred by staff with a gait belt, and 1 of 16 sampled residents (Resident #20) observed transported by staff in a wheelchair. Failure to ensure the correct placement of a mechanical Hoyer lift sling has the potential to cause injury to Resident #33. Failure to appropriately utilize gait belts resulted in Resident #4, #6, #8, #10 and #33 experiencing discomfort during transfers and placed them at risk for falls and/or injuries. Failure to utilize wheelchair foot rests may result in injury and pain to Resident #20. Findings include: Review of the facility policy titled "Gait Belts" occurred on 02/27/13. This policy, dated 03/2012, stated, "POLICY: Gait belts will be used on residents who require staff assistance with transfers or ambulations. Each resident . . . will have their own gait belt . . . PURPOSE: To provide support during transfers and ambulation without unnecessary strain on resident's upper extremities. PROCEDURE: . . . 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 . . . 5. Place one foot one [sic] either side of the resident's legs, with one of your feet about 8-10 inches ahead of the other. Bend hips and knees. 6. Ask the resident to use their arms if possible, to push themselves up from the bed, w/c [wheelchair] or commode. May support the resident's arms, but do not use their arms to pull the resident up. Grab the back of the gait belt	F 323	All staff will be provided with written education on the proper use of gait belts and transferring residents safely, using wheelchair pedals when moving residents, and the proper use of the hoier lift. The education will be provided by Jennifer Parks, DPT. Individual education will be provided to known employees that used equipment incorrectly. All residents have the potential to be affected. Physical Therapy staff will provide training twice a year on transferring residents safely, to include gait belt use, hoier lift transfers, and wheelchair safety. In-services will be coordinated through Nursing Service. Transferring techniques will continue to be taught through the C.N.A class at Trinity Nursing Home. All newly hired staff will complete an initial training with the Physical Therapy department on transferring techniques. Staff will be required to complete a return demonstration on correct transferring techniques.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 39 and on signal, ie [such as] on the count of three, lift the resident to a standing position. Hold onto the gait belt until resident is eased into the chair" Review of the operating instructions for the hoier lift occurred on 02/27/13. This manual, dated 2000, stated, ". . . Safety summary . . . Before transferring a patient from a stationary object (wheelchair, commode, or bed), slightly raise the patient off the stationary object and check that all sling attachments are secure. If any attachment is not correct, lower the patient and correct the problem, then raise the patient and check again. . . ." Review of Resident #14's medical record occurred on all days of survey. The resident's current Care Guide (used by the facility direct care staff) identified the resident at risk for falls, used a commode/shower chair for bathing, and needed total assistance of two persons and a mechanical lift for transfers. - Observation on 02/25/13 at 7:47 a.m., showed two certified nurse assistants (CNAs #6 and #7) assisted Resident #14 to transfer from a rolling commode/shower chair to her bed utilizing a manual Hoyer lift. A CNA (#6) raised the lift causing Resident #14 to be suspended in the air with the commode/shower chair still attached. Without lowering the resident back to the floor, the other CNA (#7) pulled down on the shower chair to detach it from the resident while she remained suspended in the air. When the chair and the resident separated, the resident stated, "I just about slid out." Observation showed the shower sling inappropriately placed under the	F 323	QA will be conducted weekly by the Physical Therapy Department on resident transfers, including wheelchair mobility, until compliance is achieved and then monthly. The Care Enhancement Team will conduct tracer studies on correct gait belt transfers for the time period of March 20th through April 15th, 2013. QA will be reported to the monthly QA committee. Completion date is April 1st, 2013. The DON and Physical Therapist are responsible for the process.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 40 resident. - Review of Resident #4's medical record occurred on February 24-26, 2013. Medical diagnoses for Resident #4 include dementia without behavioral disturbances, depressive disorder, and psychosis. Resident #4's quarterly MDS, dated 02/02/13, identified the resident displayed severe cognitive impairment, required extensive physical assistance with bed mobility, dressing and eating; and total physical assistance with transfers, locomotion on/off the unit, and toilet use. Review of Resident #4's current Care Guide included the heading of "Transfer" and stated, "Cue resident before [and] after transfers. Performs transfer slowly. 2 assist with gait belt." Observation on 02/25/13 at 9:00 a.m. showed two CNAs (#13 and #18) transferred Resident #4 from his wheelchair to his bed. A CNA (#13) locked the wheelchair brakes, placed the gait belt around Resident #4's waist loosely, and failed to snugly tighten the gait belt. The CNAs counted to three and instructed Resident #4 to stand up. Observation showed the resident failed to bear weight on his legs and the gait belt slid up around Resident #4's chest as the CNAs (#13 and #18) lifted the resident onto the edge of the bed. Observation on 02/25/13 at 11:10 a.m. showed two CNAs (#13 and #18) assisted Resident #4 to sit at the edge of his bed. A CNA (#13) placed the gait belt loosely around Resident #4's waist and failed to snugly tighten the gait belt. The CNAs (#13 and #18) grabbed the gait belt which caused the gait belt to slide up underneath Resident #4's	F 323			

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

PRINTED: 03/21/2013
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 02/27/2013
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 41 armpits. Observation showed Resident #4's feet did not touch the floor during the transfer and the CNAs (#13 and #18) lifted the resident into his wheelchair. Observation on 02/25/13 at 5:15 p.m. showed two CNAs (#13 and #19) assisted Resident #4 to sit at the edge of his bed. A CNA (#13) loosely placed the gait belt around Resident #4's waist. The CNAs grabbed the gait belt which caused the gait belt to slide up underneath Resident #4's armpits. Observation showed Resident #4 failed to bear weight on his legs when the CNAs assisted him to stand. A CNA (#19) grabbed the waistband of the resident's pants when transferring the resident to the wheelchair. Observation on 02/26/13 at 11:30 a.m. showed two CNAs (#13 and #19) assisted Resident #4 to sit at the edge of his bed. A CNA (#13) loosely placed the gait belt around Resident #4's waist. Observation showed a three to four inch gap between the gait belt and Resident #4's waist. The CNAs (#13 and #18) grabbed the gait belt which caused the gait belt to slide underneath Resident #4's armpits. Observation showed Resident #4 stood, beared weight on his legs, and assisted staff with the pivot transfer to his wheelchair. - Review of Resident #33's Care Guide, dated 02/06/13, indicated a transfer belt is needed with transfers and identified the resident as a fall risk. Observation on 02/26/13 at 5:10 p.m. showed Resident #33 stood from her wheelchair and walked down the hallway. A nurse (#8) observed Resident #33 walking and assisted/guided the	F 323			

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

PRINTED: 03/21/2013
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 02/27/2013
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 42 resident by holding underneath the resident's right arm. A CNA (#9) joined them and grabbed underneath Resident #33's left arm. Observation showed that neither of these staff members (#8 and #9) attempted to place a gait belt around Resident #33's waist while the resident was in the hallway. These staff members (#8 and #9) assisted Resident #33 into the bathroom and onto the toilet. The nurse (#8) remained in the bathroom while the CNA (#9) obtained the resident's wheelchair. When the resident indicated she had finished voiding, the nurse (#8) provided pericare and with the CNA (#9) placed a brief and pulled up the resident's pants. The CNA moved behind the wheelchair and the nurse placed his hand on the resident's back to guide Resident #33 into her wheelchair. - Review of Resident #10's current "Care Guide", stated, "Transfer belt [gait belt], Staff to physically pivot resident, Transfers with assist of 1, Performs transfer slowly . . ." Observation on 02/25/13 at 7:53 a.m. showed a CNA (#29) assisting Resident #10 in the bathroom. The CNA (#29) failed to place a transfer belt around Resident #10's waist and assisted her to stand up from the toilet by lifting under her left arm, pulling on her shoulder. As the resident stood, the CNA (#29) provided perineal care and finished dressing Resident #10. The resident became unsteady at times and the CNA (#29) steadied her by placing a hand on her torso or hip. The CNA (#29) then assisted Resident #10 to pivot and sit in her wheelchair without using a transfer belt.	F 323			

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

PRINTED: 03/21/2013
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 02/27/2013
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 43 Facility staff failed to place a transfer belt prior to transferring and caring for Resident #10 as identified by the resident's care guide. - Review of Resident #8's medical record occurred on February 25-26, 2013. Diagnoses included a left hip fracture on 02/05/13. The resident's "Care Guide," dated 02/24/13, stated, ". . . Transfer: Transfer belt, Transfer w/ [with] walker - two persons, . . ." Observation on 02/25/13 at 7:50 a.m. showed two CNAs (#20 and #21) assisted Resident #8 with morning cares. When they finished, one CNA (#20) positioned Resident #8 on the edge of the bed and placed her hands under the resident's armpits and the other CNA (#21) grasped the back of the resident's pants. In one motion, the CNAs pivot transferred Resident #8 into her wheelchair. The CNAs failed to utilize a gait belt during the transfer. - Review of Resident #6's medical record occurred on all days of survey. The "Care Guide," dated 02/03/13, stated, ". . . Transfer: Transfers with gait belt, assist of 1 and pivot board . . ." Observation on 02/25/13 at 5:45 a.m. showed Resident #6 seated on the edge of her bed. A CNA (#22) loosely applied a gait belt to the resident, lifted her under her armpits, and pivot transferred her into a wheelchair. The CNA failed to tighten or utilize the gait belt. Observation on 02/26/13 at 9:00 a.m. showed two CNAs (#23 and #24) transferred Resident #6 from her wheelchair to a recliner. The CNA (#24) grasped the gait belt and the other CNA (#23)	F 323			

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

PRINTED: 03/21/2013
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 02/27/2013
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 44 lifted underneath the resident's right armpit. - Observation on 02/26/13 at 8:35 a.m. showed Resident #20 asleep and seated in her wheelchair at the dining room table. A CNA (#25) attempted to assist and/or encourage her to eat her meal but the resident did not respond. The CNA removed Resident #20 from the table and transported her to her room. During the transport, the resident's feet bent backwards and her toes dragged on the carpet. Observation showed foot rests sitting on a chair in Resident #20's room. Failure to utilize the foot rests may result in pain and/or injury for Resident #20.	F 323			
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP 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, resident interview, review of resident council minutes, review of facility policy, and staff interview, the facility failed to serve foods at a proper temperature in 2 of 6 kitchen serving areas (2 South and 3 South which are both 15 bed units). Failing to ensure foods served to residents are held at appropriate serving temperatures may impact food consumption of residents related to palatability. Findings include:	F 364	All dietary staff has received written education on keeping food at the proper serving temperature. This may impact food consumption of residents related to palpability. All residents have the potential to be affected.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 45 Review of the facility dietary policy titled "Cooking of Food" occurred on 02/26/13. This policy, dated 2013, stated, "... Serving and holding temps [temperatures] for hot food is 135 [degrees Fahrenheit (F)] and above ..." Review of Resident's Council Minutes occurred on 02/25/13. The minutes dated 02/18/13, stated, "... Dietary: ... one resident complained that she did not get her food on time and another mentioned her eggs were cold at times. The heat of the steam table will be checked. ..." During a group interview on 02/25/13 at 10:00 a.m., Resident A and Resident B identified eggs served at breakfast as being cold. Both the residents reside on the 3 South Unit. Observation in the 2 South kitchenette on 02/26/13 at 7:55 a.m. showed a dietary staff member (#1) served fried eggs with a holding temperature of 138 degrees. This staff member stated the holding temperature needed to be between "150-160" degrees F as she continued to serve two fried eggs. At 8:05 a.m., a second temperature obtained from the nine remaining fried eggs was 124.5 degrees F. After this temperature the dietary aide, prompted by the surveyor, called the main kitchen. After the aide called, she covered the pan of nine eggs with plastic wrap, and stated the kitchen would send someone to check the eggs and she would stop serving them. The surveyor left and returned to the steam table at 8:20 a.m., and observed four fried eggs remained indicating five fried eggs had been	F 364	Food carts are only loaded when dietary aides come for the carts. Temperatures will be taken on hot foods before leaving the main kitchen, and will be retaken in resident kitchenettes before serving. Lids and aluminum will be rolled back on pans to help keep the heat inside the pans. Steam tables will be water bathed. All hot foods will be served to residents at a temperature above 135 degrees. A standing agenda item for all dietary meetings will include food temperatures and results of ongoing monitoring. Education was also provided to staff for reheating foods in the kitchenette. Data will be logged daily on food temperatures for each meal, and a monthly report will be presented at the QA monthly meeting. The data will be analyzed on a weekly basis. Completion date was 3/16/2013. The Director of Dietary Services is responsible for the process.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 46 served. The remaining fried eggs showed a temperature reading of 115 degrees F. The dietary aide stated she reported the 138 degree F to a kitchen manager (#4). The manager came to check the eggs and indicated the temperature was appropriate for the eggs. The eggs were served without staff reheating and the aide failed to notify the manager of the temperature reading of 124.5 degrees F. The dietary aide did not serve the remaining four fried eggs and served scrambled eggs in place of the fried eggs. Observation in the 3 South Kitchenette on 02/26/13 at 8:07 a.m., showed a dietary aide (#2) served fried eggs from an uncovered pan on a steam table. This aide stated eggs should be at least 140 degrees F, and temperature readings showed the fried eggs at 113.4 degrees F and scrambled eggs at 117.4 degrees F. The aide dished up scrambled eggs to be served to a resident and was stopped by the surveyor after stating the eggs would be less than the required temperature the aide just stated. The aide checked the steam table setting and turned it up higher. At 8:15 a.m., a cook (#3) came to the kitchenette, placed the fried eggs on a plate, covered the plate with plastic wrap, and reheated the eggs in the microwave. During interviews on 02/26/13 at 12:05 an administrative dietary staff member (#5) stated food items served on kitchenettes have temperatures taken prior to being served and not during food service, and the facility only uses pasteurized eggs. Also, a dietary manager (#4) stated this morning she had gone to the 2 South Kitchenette and the dietary staff member (#1) reported the temperature of the fried eggs was	F 364			

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

PRINTED: 03/21/2013
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 02/27/2013
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 47 138 degrees F (which was the first temperature obtained during the observation) and the manager did not retake a temperature or reheat the eggs.	F 364			
F 431 SS=E	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 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.	F 431	All RN's and LPN's have received written education on the appropriate storage of Flexpens once they have been opened. All residents utilizing Flexpens have the potential to be affected. Flexpens are to be stored in the refrigerator until ready to be opened and put into use. Once the Flexpen has been opened, it is to be kept at room temperature and stored in the medication cart. The Flexpen is to discarded 28 days once opened. The exception to this rule is 70/30 Flexpen which is to be discarded 10 days after use. QA will be done weekly to ensure Flexpens are being stored at the appropriate temperature. Once compliance is achieved, audits will be done monthly. All audits will be reported to the monthly QA Committee. Completion date is February 28 th , 2013. The DON is responsible for this process.		

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

PRINTED: 03/21/2013
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 02/27/2013
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 48 This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's guidelines, and staff interview, the facility failed to store in-use insulin pens as directed by the manufacturer in 6 of 7 medication refrigerators (Neighborhoods 2 East, 2 West, 2 South, 3 East, 3 South, and 4 East) (25 insulin pens). Failure to properly store opened in-use insulin pens has the potential to affect the potency and efficacy of the medication. Findings include: The manufacturer's insert for NovoLog insulin stated, "NovoLog in use: Vials, Keep in the refrigerator or at room temperature below 86 [degrees] F [Fahrenheit] for up to 28 days. . . . Throw away an opened vial after 28 days of use, even if there is insulin left in the vial. . . . NovoLog FlexPen, Keep at room temperature below 86 [degrees] F for up to 28 days. Do not store a . . . NovoLog FlexPen that you are using in the refrigerator. . . . Throw away a used . . . NovoLog FlexPen after 28 days, even if there is insulin left in the cartridge or syringe." The manufacturer's insert for Levemir insulin stated, ". . . FlexPen . . . After initial use, . . . a prefilled syringe (including FlexPen . . .) may be used for up to 42 days if it is kept at room temperature, below 30 [degrees] C [Celsius] (86 [degrees] F). In-use cartridges and prefilled syringes in-use must NOT be stored in a refrigerator . . ."	F 431			

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

PRINTED: 03/21/2013
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 02/27/2013
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 49 The manufacturer's guidance for Novolog Mix 70/30 FlexPen stated, "Do not refrigerate cartridges or pens that are currently in use." The manufacturer's guidance for Lantus insulin, stated, ". . . In-use (opened) cartridge system inserted in OptiClik insulin pen, 28 days Room temperature only (Do not refrigerate) . . ." Observation of the medication refrigerators occurred on 02/27/13 and identified the following in-use FlexPens: * 2 East Neighborhood - one Levemir pen, one Novolog pen, and two Novolog 70/30 pens * 2 West Neighborhood - one Levemir, one Novolog, and two Novolog 70/30 * 2 South Neighborhood - two Levemir pens and one Novolog pen * 3 East Neighborhood - two Novolog pens and four Levemir pens * 3 South Neighborhood - two Levemir pens, one Humalog pen, and one Lantus pen * 4 East Neighborhood - one Levemir pen, one Lantus pen, and two Novolog pens When asked, during the observation of the 3 East Neighborhood and 3 South Neighborhood, the nurses (#30 and #31) confirmed in-use insulin pens are stored in the refrigerator.	F 431			