STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58703

(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 The Standard Medicare/Medicaid recertification survey started on 02/22/21 and concluded on 02/25/21.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17), the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 23 sampled residents (Resident #60). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION K: SWALLOWING/NUTRITIONAL STATUS The Long-Term Care Facility RAI User's Manual, revised October 2019, pages K-5-6 stated, ". . . Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available . . . Code 2, yes, not on physician prescribed weight-loss regimen: if the resident	F 641	Section K for the MDS dated 2/15/21 for Resident #60 was updated to reflect the most current weight prior to the Assessment Review Date of 84lbs. This weight was taken on 2/10/21. Updating this MDS has now shown that this resident does not have a significant weight loss. All residents have the potential to be affected by not using the weight taken closest to the ARD date. The weight taken closest to the ARD date is the one that must be entered on the MDS. Failure to use the most current weight may lead to inaccurate assessment and treatment of residents with regard to weight gain or weight loss. The Dietitian was re-educated on using the weight closest to the ARD date for documentation in the MDS. A spreadsheet for tracking of MDS□'s completed will be kept by the Dietitian. QA audits will be done on all MDS's□	3/5/21

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

Electronically Signed | 03/12/2021

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F 641	Continued From page 1 has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days and the weight loss was not planned and prescribed by a physician . . ." Review of Resident #60's medical record occurred on all days of survey. The resident's current MDS, dated 02/15/21, showed a weight of 82 pounds (lbs) and identified a weight loss. The facility failed to use the most current weight prior to the Assessment Reference Date (ARD) of 84 lbs on 02/10/21. One month prior, on 01/18/21, Resident #60's weight was 84 lbs (no weight loss). Six months prior, on 08/10/20, Resident #26's weight was 88 lbs (a loss of 4.6%, i.e., not significant).	F 641	completed. These audits will be completed by the Nutrition Services Director. Two audits will be done weekly for 2 months, and if compliance is achieved 10 audits will be done monthly for 4 months, until compliance is met for 4 consecutive months. The Director of Nutritional Services or designee will be responsible for verifying the correct weight is used on the MDS. If compliance is not achieved, Dietician will be re-educated and the audit process will start over. QA audits will be sent to the QAA Committee monthly for review. The Director of Nutritional Services is responsible for this process.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of manufacturer instructions, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 2 of 2 observations of insulin pen administration (Resident #89). Failure to inject insulin for the appropriate duration may result in the resident receiving an inaccurate dose of insulin and failure to provide food within 5 to10 minutes after the administration of a rapid acting insulin may result in hypoglycemia (low blood	F 658	Nursing staff promptly educated regarding the importance of following policy of insulin preparation; disinfection of tip of pen, securing needle, priming pen and administration to include following recommended time of injection. Nursing staff also promptly educated on importance of providing food timely to meet needs of residents requiring rapid acting insulin. Education to these nurses will prevent all	3/15/21

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F 658	Continued From page 2 sugar). Findings include: Review of the facility policy titled "Medications-Administration of Sub-Q" occurred on 02/24/21. This policy reviewed, November 2019, stated, ". . . For insulin pen administration - continue to push the button, leaving the needle under the skin for at least 10 seconds after injecting. . . ." The manufacturer's instructions for the NovoLog FlexPen, found at www.novomedlink.com, stated, ". . . Give your injection: Insert the needle. Press and hold the dose button. After the dose counter reaches 0, slowly count to 6. . . ." Prescribing information for NovoLog insulin, found at www.novo-pi.com/NovoLog., stated, ". . . NOVOLOG® is rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus . . . Inject subcutaneously within 5-10 minutes before a meal . . ." Observation on 02/23/21 at 4:51 p.m. showed a licensed nurse (#1) prepared the Novolog insulin pen and administered the ordered units of insulin to Resident #89. The licensed nurse (#1) provided no food or snack for Resident #89 prior to the evening meal scheduled to begin at 5:30 p.m., more than 39 minutes after rapid acting insulin administered. Observation on 02/24/21 at 11:39 a.m. showed a licensed nurse (#2) prepared the insulin pen, without disinfecting the tip of the pen, secured	F 658	residents of being affected by deficient practices. All residents on insulin have the potential to be affected by improper insulin pen prep and/or administration and not being offered a snack/meal/juice within 10-15 minutes if being given short acting insulin. All nurses were given an in-service on the correct preparation of the insulin pen by cleaning the hub with alcohol prior to securing the needle, priming the insulin pen vertically with the needle end up to visualize the insulin, and holding the pen and needle in place for 10 seconds after pushing the plunger prior to withdrawing it from the resident. The in-service also covered short acting insulin guidelines. All nurses were given education on offering a snack/meal/juice within 10-15 minutes of administering short acting insulin. QA audits started on March 9th and will be done on 5 residents (including Resident #89) per week for 4 weeks or until compliance is achieved, followed by 10 audits monthly for 4 months until compliance is achieved. Audits will then continue at 15 audits quarterly until compliance is achieved for 3 consecutive months. All audits will be completed by Nursing and CERS department with DON/ADON assigning audits to designated staff. Results will be reported to the	

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F 658	Continued From page 3 the needle, primed the pen, administered the ordered units of insulin, and immediately removed the insulin pen after injection into Resident #89's arm. The licensed nurse (#2) provided no food or snack for Resident #89. Observation at 12:11 p.m. showed facility staff delivered a meal tray to Resident #89, 32 minutes after rapid acting insulin administered. The facility staff failed to disinfect the tip of the pen, wait the recommended time during insulin pen injection, and failed to provide food within 10 to15 minutes after rapid acting insulin administered. During an interview on 02/25/21 at 8:35 a.m., an administrative nurse (#3) confirmed staff did not follow the facility policy for insulin pen injection duration and agreed the facility failed to include in the policy to provide food within 5-10 minutes after rapid acting insulin administration.	F 658	DON/ADON and any concerns identified will have immediate action taken. All audits will be reported to the QAA committee monthly. The DON/ADON are responsible for this process.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of a professional reference, and staff interview, the facility failed to provide adequate supervision necessary to prevent accidents for 1 of 8 sampled residents	F 689	Staff involved with transfers of Resident #35 and Resident #60 educated on assessment of resident needs and appropriate use of equipment, including	3/19/21

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F 689	Continued From page 4 (Residents #60) and one supplemental resident (Resident #35) observed transferred without a mechanical lift. Failure to properly use a gait belt during transfers placed the residents at risk of an accident and/or injury. Findings include: Berman, Snyder, and Frandsen, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th edition, Pearson Education, Inc., New Jersey, page 1054, stated, "Assisting a Client to Ambulate . . . If the client is a low safety risk . . . use a gait/transfer belt for standby assist as needed and assistive devices as needed . . . and 1-2 caregivers. Make sure the belt is pulled snugly around the client's waist and fastened securely. Grasp the belt at the client's back . . ." - Review of Resident #35's medical record occurred on 02/22/21. The current care plan stated, ". . . Transfer with assist of 1 . . ." Observation on 02/22/21 at 2:22 p.m. showed a Certified Nurse Assistant (CNA) (#5) supervised Resident #35 while transferring to the toilet and bed. The CNA (#5) failed to assist the resident and use a gait belt. - Review of Resident #60's medical record occurred on 02/22/21. The current care plan stated, ". . . Transferring: Staff assist of 2 with gait belt donned and use of slideboard [sic]. . ." Observation on 02/23/21 at 5:32 p.m. showed two CNAs (#6 and #7) assist Resident #60 to the wheelchair. During the transfer, the CNAs (#6 and #7) lifted under the resident's axilla area and	F 689	gait belts, slide board, and Hoyer lifts for proper safe transfers of residents, as well as following plan of care. All residents who utilize gait belts for transfers have the potential to be affected by this. All nursing staff were re-educated on reviewing the care plan and care guide for transfer information and proper use of gait belts for transfers. Our annual CNA Education program Falls Education has been changed to include return demonstrations for proper use of gait belts. QA audits will be completed on proper use of gait belts (Residents #35 and #60 included) with observations of 5 resident transfers per week for 4 weeks, or until compliance is achieved for 2 consecutive weeks, and then 10 audits monthly audits until 2 consecutive months of compliance is achieved. We will then audit 15 transfers quarterly until compliance is achieved for 2 consecutive quarters. All audits will be completed by the nursing department with DON/ADON assigning audits to designated staff. Results will be reported to the DON/ADON and any concerns identified will have immediate action taken. All audits will be reported to the QAA committee monthly. The DON/ADON are responsible for this process.	

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F 689	Continued From page 5 failed to use the gait belt around Resident #60's waist. During an interview on 02/25/21 at 1:30 p.m., an administrative nurse (#4) stated she would expect staff to use a gait belt during transfers.	F 689		