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 _____	C 04/21/2022

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 and complaint investigations started on 04/18/22 and concluded on 04/21/22	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 observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to complete Minimum Data Sets (MDSs) that accurately reflected the residents' status for 2 of 25 sampled residents (Resident #18 and #38). Failure to accurately code the MDS may negatively affect the development of a comprehensive care plan and the care provided to the residents. Findings include: Section H: Bladder and Bowel The Long-Term Care Facility RAI Manual, revised October 2019, pages H1-H2, and H-8 - H-11, stated, ". . . H100: Appliances . . . Coding Instructions . . . Check next to each appliance that was used at any time in the past 7 days. . . . H0100A, indwelling catheter . . . H0300: Urinary Continence . . . Steps for Assessment . . . Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical	F 641	F641 The MDS nurse was re-educated on the correct coding for section H of the MDS on 4/25/2022 for residents #38 and #18. The MDS nurse modified the MDS's for resident #38 April 22, 2022 and resident #18 May 18, 2022. Resident #38 is not listed in our resident sample, so the assumption was made that it was the resident that was identified by the surveyor at the time of the survey. Review of the RAI manual was done along with auditing the current open MDS□s. Auditing will continue as identified below to identify future residents that this may affect. All residents with an ostomy or urinary catheter have the potential to be affected by incorrect coding in section 8 of the MDS. All residents with an ostomy device or urinary catheter will be assessed for correct coding in the MDS.	5/18/22

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

Electronically Signed | 05/19/2022

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 _____	C 04/21/2022

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 641	Continued From page 1 examination. . . . Coding instructions . . . Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy . . . H0400: Bowel Continence . . . Steps for Assessment . . . Review the medical record for bowel records and incontinence flow sheets, nursing assessments and progress notes, physician history and physical examination. . . . Coding instructions . . . Code 9, not rated: if during the 7-day look-back period the resident had an ostomy. . . " - Review of Resident #18's medical record occurred on all days of survey. Current diagnoses included neuromuscular dysfunction of the bladder and colostomy. The care plan identified Resident #18 had an indwelling suprapubic urinary catheter and colostomy. A quarterly MDS, dated 01/19/22, identified the resident as always incontinent of urine and always incontinent of bowel. During an interview on 04/20/22 at 3:45 p.m., two administrative nurses (#6 and #7) confirmed the staff inaccurately coded the MDS. - Observation on 04/18/22 at 1:16 p.m., showed Resident #38 sitting in a wheelchair with a urinary catheter in a dignity bag. Review of Resident #38's medical record occurred on all days of survey. Diagnoses included bladder-neck obstruction and other retention of urine. A physician's order, dated 12/22/21, stated "Catheter change monthly along with drainage bag . . ." A quarterly MDS, dated 02/04/22, failed to include coding for a urinary catheter and identified Resident #38 as always	F 641	QA audits will be done on all MDS□s for Section H to have the correct coding. This will include coding of continence level and/or catheter and ostomy related devices. These audits will be completed by the DON/ADON. QA audits started on April 25th. Five MDS charts for section H will be reviewed weekly for 2 months, if compliance is achieved, 10 audits will be done monthly for 4 months until compliance is met for 4 consecutive months. The DON/ADON will be responsible for verifying the accuracy of section H on the MDS. If compliance is not achieved, the MDS nurse will be re-educated and the audit process will start over. QA audits will be sent to the QAA committee for review and at scheduled meetings. The DON/ADON is responsible for this process. Date of Correction is May 18, 2022.	

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 _____	C 04/21/2022

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 641	Continued From page 2 incontinent of urine. During an interview on 04/21/22 at 8:55 a.m., an administrative nurse (#2) agreed staff failed to include the urinary catheter on the 02/04/22 MDS and correctly code for the urinary continence.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		5/9/22

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 _____	C 04/21/2022

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 657	Continued From page 3 Based on observation, record review, and review of facility policy, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 2 of 25 sampled residents (Resident #93 and #109). Failure to revise the care plans may limit staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Planning" occurred on 04/21/22. This policy, revised January 2020, stated, "OBJECTIVES: . . . To assure optimum levels of care for each resident are being provided. . . . CARE PLAN REVIEW On each shift the CNAs [Certified Nursing Assistant] and Nurse review care plans and care guides so that each resident's care plan is reviewed monthly adding or deleting problems, goals, and approaches as appropriate." - Review of Resident #93's medical record occurred on all days of survey. Diagnoses included unspecified atrial fibrillation. Medications included Warfarin (an anticoagulant-blood thinner) daily. The most recent Minimum Data Set (MDS), dated 03/09/22, identified the use of an anticoagulant medication. Resident #93's care plan failed to address the use of an anticoagulant and the appropriate monitoring and interventions associated with the use of that medication. - Review of Resident #109's medical record occurred on all days of survey. Diagnosis included right posterior leg abscess post right	F 657	F657 All residents have the potential to be affected by incorrect care plans. Resident #93 and #109□s care plans were updated and corrected immediately. All IDT staff who are responsible for revision of the care plan were re-educated regarding the timing and revision/updating of the care plan for each resident. Changes in resident care, condition or treatments need to be added or modified on the care plan to meet each individual resident□s needs. QA audits started on May 9th. Audits will be completed on 10 residents a 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. Audits will be completed by the interdisciplinary team consisting of Nursing, Therapy and Social Work with the DON/ADON assigning audits. Results will be reported to the DON/ADON and any concerns identified will be have immediate action taken. All audits will be reported to the QA committee and at scheduled meetings. The DON/ADON/MDS Nurse will be responsible for this process. Date of correction is 5/09/2022.	

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 _____	C 04/21/2022

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 657	Continued From page 4 knee replacement with new incision and drainage. A progress note, dated 03/11/22 at 9:30 p.m., stated, "admitted resident . . . have surgical incision on her right leg assessed with wound care nurse. . . ." Observation on 04/19/22 at 2:22 p.m., showed a wound nurse (#5) completed a dressing change to Resident #109's right upper calf wound. Resident #109's care plan failed to identify a surgical wound to the resident's right upper calf area.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, record review and staff interview, the facility failed to provide assistance with activities of daily living (ADL's) for 1 of 15 sampled residents (Resident #52) dependent on staff for personal care. Failure to assist a resident who cannot perform the task independently may result in decreased self-esteem and poor hygiene. Findings include: Review of professional reference "Perry & Potter Clinical Nursing Skills and Techniques. PROCEDURAL GUIDELINE 18.1 Perineal Care.	F 677	F677 CNA #10 providing cares to resident #52 with surveyor present doing her observations. CNA failed to complete appropriate perineal cares for resident #52 before attempting to put on a clean brief. Surveyor appropriately told CNA that resident still had stool in gluteal folds; CNA completely cleaned resident and then applied clean brief. Immediate action was taken to verbally educate CNA #10 and CNA Educator and Nurse Managers re-educated all staff on correct	5/24/22

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 _____	C 04/21/2022

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 677	Continued From page 5 . . Perineal care for a female: . . . Clean from the perineum to the rectum [front to back] . . . ." Review of Resident #52's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and Overactive bladder. The current care plan stated, ". . .Category: ADL Functional / Rehabilitation Potential. [Resident #52] is not able complete her own ADLs due to dementia and weakness. Toileting: Frequently incontinent of bowel and bladder. . ." A current physician's order, dated 07/07/21 stated, ". . .PLEASE provide frequent and thorough peri-care per daughter's request. Every Shift; Night , Day, Evening." Observation on 04/19/22 at 11:06 a.m., showed a certified nursing assistant (CNA) (#10) toileted Resident #52. The CNA performed perineal care and started to place a new brief. The surveyor identified Resident #52 still had stool in her gluteal folds. The CNA (#10) then cleaned the gluteal folds and applied a clean brief. During an interview on 04/21/22 at 11:15 a.m., an administrative nurse (#2) stated her expectation is that staff clean residents properly after they had a bowel movement.	F 677	procedures for performing proper peri cares. All residents have the potential to be impacted by inadequate peri-care. Education provided at CNA meetings and written education placed on all units immediately with all direct care staff being educated the week of April 25th by the CNA/Nurse educator. QA audits will start on May 2nd following all direct care staff education. Audits will be completed on 5 residents, including resident #52, 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 10 audits quarterly until compliance is achieved for 3 consecutive months. Audits will be completed by nursing staff to include nurse managers, educator and charge nurses. Results will be reported back to the DON/ADON and any concerns identified will have immediate action taken. All audits will be reported to the QA committee and at scheduled meetings. The DON/ADON will be responsible for this process. Date of Correction: May 24, 2022	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		4/27/22

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 _____	C 04/21/2022

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 693	Continued From page 6 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, policy and procedure review, and staff interview, the facility failed to ensure care and services to prevent complications of enteral feeding for 1 of 2 sampled residents (Resident #95) observed with gastric tube (a tube inserted through the belly that brings nutrition directly to the stomach) feedings. Failure to ensure staff administer the correct formula by labeling it with name/concentration, administration rate, and the date and time opened may lead to weight loss, allergic reactions, and other complications.	F 693	F-693 □ The Nurse Manager immediately educated all nurses working with resident #95 on April 18-April 20, 2022 on the policy/procedure for hanging tube feedings; education included appropriate equipment and labeling per Trinity Homes policy/procedure. All residents with tube feedings have the potential to be impacted by improperly labeled tube feedings and bags. All nurses were educated on April 27th during unit meetings on the correct procedure to hang and label tube	

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 _____	C 04/21/2022

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 693	Continued From page 7 Findings include: Review of the facility policy titled "Gastric Tube: Insertion, verification, feeding and assessment of feeding tolerance" occurred on 04/21/22. This policy, revised January 2020, stated, ". . . Enteral Feeding . . . The primary indication for gastric tube feedings is the inability to eat or insufficient oral intake in a compromised patient . . . Procedure: 1. Observe provider's order . . . ready-to-hang formula: 1. Obtain ready-to-hang container and appropriate piercing pin feeding set . . . 3. Fill in information on label (i.e. patient name, room, date, start time, and rate) . . . 6. . . . Do not touch end of piercing pin or spike port . . . (to prevent contamination). . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process, and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, Page 1199, stated, ". . . Before administering a tube feeding, the nurse must determine any food allergies of the client and assess tolerance to previous feedings. . . . The nurse must also check the expiration date on a commercially prepared formula or the preparation date and time of agency-prepared solution, discarding any formula that has passed the expiration date or that was prepared more than 24 hours previously. . ." Review of Resident #95's medical record occurred on all days of survey. Diagnoses included dysphagia (difficulty swallowing) and pneumonitis due to inhalation of food (inflammation of the lungs). The quarterly Minimum Data Set, dated 03/18/22, indicated Resident #95 received greater than 51% of total	F 693	feedings according to policy and procedures. All residents with tube feeds will be monitored for correct labeling and procedures for tube feedings. QA audits will be completed by the nurse managers starting on May 10th. All residents with tube feedings will be audited weekly for 4 weeks or until compliance is achieved, followed by 6 audits monthly for 4 months or until compliance is achieved. Audits will continue at 15 audits quarterly until compliance is achieved for 3 consecutive months. If a resident tube feed is found out of compliance at any point, re-education will be provided to the nurse hanging the tube feeds and proper labeling and equipment will be used. All audits will be reported to the QA committee and at scheduled meetings. The DON/ADON will be responsible for this process. Date of Correction is April 27, 2022.	

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 _____	C 04/21/2022

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 693	Continued From page 8 calories and fluid intake through tube feeding. A physician's order, dated 11/19/21, stated, "Osmolite 1.5 Cal [calorie] (nutritional supplements) 0.06 gram-1.5 kcal/ml [kilocalorie/milliliter] 300 ml/1hr [milliliter/hour] Bolus Three Times A Day . . ." Observations of Resident #95 showed the following: * 04/18/22 at 1:31 p.m., a feeding bag containing approximately 900 ml of formula hanging on a pole. The bag identified Osmolite, but lacked the formula concentration, time of preparation, and rate of administration. * 04/19/22 at 8:28 a.m., a feeding bag hanging on a pole with a date and time of 04/19/22 at 4:30 a.m. The bag lacked the formula name, concentration, and rate. The tubing had no cover and drops of formula were visible on the tip of the tubing which may lead to contamination. The feeding was not running. * 04/19/22 at 4:30 p.m., the same feeding bag hanging from the morning. A staff nurse (#1) prepared to administer the scheduled feeding. When asked "How do you know what formula and strength was in the bag?" The staff nurse (#1) stated, "That's a good question. It's always hanging and I administer what is here." The nurse then administered the prepared formula that was not labeled. * 04/20/22 at 8:08 a.m., a feeding bag hanging containing approximately 800 ml of formula. The bag lacked the formula name, concentration, and rate. During an interview on 04/19/22 at 4:54 p.m., an administrative nurse (#2) stated her expectation	F 693		

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 _____	C 04/21/2022

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 693	Continued From page 9 is staff label all formulas with the correct name/strength, date and time, and the nurse does not administer a formula without proper labeling.	F 693		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure accurate labeling of multi-dose insulin pens for 3 of 3 sampled residents (#58, #87, and	F 761	F761 Immediate action on April 19th was taken to correct the insulin pens on all units that	5/2/22

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 _____	C 04/21/2022

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 761	Continued From page 10 #103) observed during medication administration and storage review. Failure to correctly label insulin pens increases the risk of residents receiving inaccurate doses of medications. Findings include: Review of the facility policy titled "Medication Administration" occurred on 04/20/22. This policy, revised October 2021 stated, ". . . Only the pharmacist changes labels . . . when administering medication . . . you must always follow the 6 Rights of Medication Administration, which includes . . . right medication-does the medication match the order . . . Does the medication match the name on the Medication Administration Record (MAR) . . . right dose-check the dose and strength . . . right time-make sure you are giving the medication at the right time . . ." Review of the facility policy titled "Medication-Returning to a Pharmacy for Relabeling and Destroying Unused Medications" occurred on 04/20/22. This policy, revised February 2019, stated, ". . . Nursing staff is not permitted to change any dosing information on a label . . . [name of pharmacy] will send a pharmacist to affix label changes . . ." - Observation during medication administration for Resident #58 on 04/19/22 at 8:51 a.m. with a staff nurse (#12) identified the following: * The Levemir insulin pen label stated 48 units subcutaneous (SQ) in the morning and 15 units at bedtime. The resident's MAR stated to administer 35 units of Levemir insulin in the morning and no insulin dosage at bedtime.	F 761	had the wrong dosage on the pharmacy label, including residents 58, 87, and 103. All residents receiving medications have the potential to be impacted by incorrect labels from pharmacy.All residents with insulin pens will have the pens inspected for correct labels. All nurses were immediately educated on the labels matching the order in the eMAR from the provider. The consultant pharmacist was re-educated immediately, and all pharmacy staff were re-educated on 5/12 by the director of pharmacy. Audits will be completed on 10 pens/medications weekly for 4 weeks or until compliance is achieved. Then 15 monthly audits for 2 consecutive months until compliance is achieved. We will then audit 15 insulin pens quarterly until compliance is achieved for 2 consecutive months. All audits will be completed by nursing department and consultant pharmacist with assignment of the audits by the DON/ADON to designated staff. Results will be reported to the DON/ADON and pharmacist and any concerns identified will have immediate action taken. All audits will be reported to the QAA committee. The DON/ADON/Pharmacist are responsible for this process. Date of Correction: 5/02/2022	

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 _____	C 04/21/2022

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 761	Continued From page 11 * The Novolog insulin pen label read, give 12 units SQ three times a day (TID) with meals, breakfast, lunch and supper. The resident's MAR stated to administer Novolog insulin per sliding scale (based on resident's blood glucose reading). - Observation during medication storage review on 04/19/22 at 8:55 a.m. with a staff nurse (#12) identified the following: * Resident #87's Levemir insulin pen label stated 35 units SQ in the morning and 5 units at bedtime. The resident's MAR stated to administer Levemir insulin 37 units in the morning and 5 units at bedtime. * Resident #87's Novolog insulin pen label stated 12 units SQ twice daily at 8:00 a.m. and 18:00 (6:00 p.m.) and 10 units daily at lunch. The resident's MAR stated to give Novolog 10 units three times a day with meals. * Resident #103's Lantus insulin pen stated 30 units SQ at bedtime. The resident's MAR stated to administer 32 units of Lantus insulin at bedtime. * Resident #103's Novolog insulin pen read 5 units SQ at bedtime. The resident's MAR stated to administer Novolog insulin 4 units with meals. During an interview on 04/19/22 at 3:13 p.m., an administrative nurse (#2) confirmed the insulin pens lacked the correct physician orders.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		4/21/22

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 _____	C 04/21/2022

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 812	Continued From page 12 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to properly store foods and/or consistently monitor/record refrigerator/freezer temperatures in 3 of 4 kitchens (Main, 2 East, and 3 East) and 1 of 2 nutrition rooms (2 West). Failure to discard food by the use-by dates and monitor/record refrigerator and freezer temperatures has the potential to affect food quality and may result in foodborne illness to residents, staff, and visitors. Findings include: FOOD STORAGE Review of the facility policy titled "Rotation/Storage of Foods/Nutritional Services" occurred on 04/18/22. This policy, approved March 2022, stated, ". . . PURPOSE: To assure that foods served are wholesome and not out	F 812	Plan of Correction: Outdate food items and temperature logs F483.60 Outdated food was immediately removed from refrigerators. All residents have the potential to be affected if outdated products are stored in dietary cabinets and refrigerators. A checklist for each kitchenette has been created for the day and evening shifts to monitor coolers in each area in the kitchen and for production to monitor the fridges in their area. This checklist has a verification statement on it and the Nutrition Assistant from each floor will sign their respective checklists and turn	

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 _____	C 04/21/2022

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 812	Continued From page 13 dated. POLICY: All foods rotated by date and stored properly. PROCEDURE: All foods are covered, dated, and labelled [sic]. . . . COLD STORAGE: Milk open or closed-Date of Manufacture . . . Mighty shakes (milk-based supplement) . . . 14 days from removal of freezer . . ." Observations during a dietary tour on 04/18/22 at 12:45 p.m. showed the following: * Main Kitchen - A snack cart located in the dessert cooler contained Mighty Shake supplements with a number "3" handwritten on the cartons. Further observation showed several more Mighty Shakes with "3" handwritten on them in an adjacent cooler. A dietary staff member (#13) stated the "3" indicated staff removed the shakes from the freezer on 04/03/22. The staff member (#13) stated facility staff were to deliver the shakes to the residents later that day and confirmed the kitchen staff should have discarded the shakes on 04/17/22, one day prior. * Main Kitchen - Cooks cooler, three cartons of liquid egg whites with "4/6" handwritten on the cartons and a manufacturer stamped use-by date of March 29, 2022. The dietary staff member (#13) stated "4/6" indicated the date staff received the eggs at the facility and stated, "We must have received these already expired." * Main Kitchen - Produce cooler, a large unopened package of cheese with a manufacturer stamped use-by date of 10/23/21 (177 days prior). * Three East Kitchenette - Silver fridge, an open carton of half and half cream with a manufacturer stamped use-by date of 04/13/22 and "Open 4/18" handwritten on the carton (opened five	F 812	them into the Nutrition Services Supervisor at the end of each shifts. The evening Nutrition Services supervisor will audit to ensure that the job is done, and will also sign off verifying fridges have been checked for outdated items and temperature logs are completed. The AM Nutrition Services Supervisor will audit the prior days checklists to ensure completeness and will then sign off the evening shifts work and sign off on their checklist. This will be completed daily, and results will be reported to the Nutrition Services Director. If concerns are identified immediate corrective action will be implemented. This process will be our daily Quality assurance and monitoring. This process will be daily, and will be a permanent ongoing process for the Nutrition Department. The Director of Nutrition Services will submit a report of the monitoring results to the QA committee for each scheduled meeting. These audits will be the responsibility of the Nutrition Services Supervisor and Department Director of Nutrition Services. Correction Date 4/21/2022	

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 _____	C 04/21/2022

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 812	Continued From page 14 days after the use-by date). REFRIGERATOR/FREEZER TEMPERATURES Review of the facility policy titled "Monitoring Of Cooler and Freezer Temperature Policy" occurred on 04/18/22. This policy, revised October 2021, stated, ". . . It is the policy of this facility to maintain temperatures of coolers and freezers at the appropriate temperature to promote food safety. . . Temperatures will be checked and logged twice a day per day by designated personnel. . . ." - Review of the April 2022 records titled "COOLER/FREEZER TEMPERATURE CHART" on 04/18/22 showed the records lacked the following entries: * Main Kitchen - No temperatures logged for 17 of 17 possible entries on the evening shifts for the reach-in cooler, unit freezer, and dessert cooler. * Two East Kitchenette - No temperatures logged on 04/11/22 evening shift for the silver fridge and the white fridge and freezer. * Two West Nutrition Room - No temperatures logged on 04/11/22 evening shift for the white fridge and freezer. * Three East Kitchenette - No temperatures logged on 04/05/22 and 04/11/22 evening shift and on 04/13/22 day shift for the silver fridge and the white fridge and freezer. During an interview on the afternoon of 04/18/22, the dietary staff member (#13) agreed the kitchen staff failed to consistently monitor/record refrigerator/freezer temperatures and confirmed the staff are to obtain/record the temperatures	F 812		

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 _____	C 04/21/2022

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 812	Continued From page 15 twice a day, once on the day shift and once on the evening shift.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		5/24/22

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 _____	C 04/21/2022

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 880	Continued From page 16 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow infection control practices for 3 of 15 sampled residents (Resident #25, #57, and #115)	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the	

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 _____	C 04/21/2022

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 880	Continued From page 17 observed during cares. Failure to practice infection control during catheter care, perineal care, and wound care has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: Review of facility policy titled "Catheter Bags-leg bag vs [versus] drainage bag and catheter cares" occurred on 04/21/22. This policy, dated March 2022, stated, ". . .2. Use an alcohol swab to clean drainage spigot after emptying. . . ." Review of the facility policies titled "Handwashing-Hand Hygiene" and "Dressing Change Guideline" occurred on 04/21/22. The Handwashing policy, revised February 2018, stated, ". . . Handwashing has long been considered the most important measure to prevent the transmission of disease causing [sic] microorganisms. . . . When is Hand Hygiene . . .necessary?: . . . When moving from a "contaminated" body site to a clean site during cares. (Peri-care and then oral care - even when gloves are worn) . . . After handling soiled equipment or utensils (e.g., used linens, dressings, bedpans, catheters, and urinals) . . ." The Dressing Change Guideline, April 2018, stated, ". . . Using gloved hands, remove soiled dressings. Place soiled dressings in garbage bag. Remove gloves and perform hand hygiene. . . . Cleansing or Irrigating wounds: . . . Put on new gloves. . . ." CATHETER CARE -Review of Resident #25's medical record	F 880	requirements of §483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff hand hygiene or handwashing after removing gloves and after performing perineal care, in accordance with CDC guidelines. (2) Ensuring staff provide catheter cares consistent with facility policy and in accordance with CDC guidelines for catheter maintenance. (3) Ensuring staff provide wound cares consistent with facility policy and in accordance with CDC guidelines. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff on correctly completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To verify this/these staff understands hand hygiene and handwashing, this/these staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand hygiene and handwashing. (2) Educate staff on correct emptying of urinary catheter bags and catheter cares.	

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 _____	C 04/21/2022

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 880	Continued From page 18 occurred on all days of survey. Diagnoses include Obstructive and reflux uropathy. The current care plan stated, ". . .[name of resident] requires an indwelling foley catheter. . . ." During an observation on the afternoon of 04/20/22, a certified nursing assistant (CNA) (#11) unhooked the drainage tube from Resident #25's catheter bag, drained the urine into the graduate, took a skin incontinence cleansing wipe out of the package and wiped the spigot before securing it to the leg bag. During an interview on 04/21/22 at 11:10 a.m., an administrative nurse (#2) stated she expected staff to use alcohol wipes to clean off the catheter tube as per policy. HAND HYGIENE - Observation on 04/19/22 at 8:27 a.m. showed a CNA (#8) performed hand hygiene, donned gloves, and provided perineal cares to Resident #115 after the resident had an incontinent bowel movement. Without removing her gloves, the CNA placed a new incontinence brief on the resident and a new under pad on the bed, straightened the bed linens, partially dressed the resident, and moved the overbed table. CNA (#8) failed to remove gloves and perform hand hygiene before completing other tasks. During an interview on 04/21/22 at 11:00 a.m., an administrative nurse (#2) stated she expected staff to remove gloves and perform hand hygiene after performing perineal cares. WOUND CARE	F 880	(3) Educate clinical staff on correctly completing hand hygiene before, during and after wound care/dressing application or changes. 2. Identification of Others The IP and DON, in conjunction with the applicable interdisciplinary team (IDT) members, will review current nursing facility guidelines for hand hygiene, wound and catheter care from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 05/24/2022 the facility shall complete the following actions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to complete handwashing or hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. All staff will receive education keeping hands clean between tasks, contacts with potentially contaminated surfaces and	

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 _____	C 04/21/2022

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 880	Continued From page 19 - Observation on 04/19/22 at 10:26 a.m. showed a staff nurse (#9) performed wound care and dressing changes to multiple sites on Resident #57. The nurse (#9) performed hand hygiene, donned gloves, and opened/arranged supplies. The nurse (#9) cleansed abrasions on the bridge of the resident's nose, discarded the 2x2, dried the area with a new 2x2, and applied antibiotic ointment with a cotton tipped applicator. The nurse failed to remove the gloves and perform hand hygiene. The nurse (#9) removed and discarded the soiled dressing from Resident #57's left arm. Without removing the gloves or performing hand hygiene, the nurse moistened additional 2x2's with normal saline, cleansed the wounds, applied a clean dressing, and wrapped the arm with a gauze wrap. The nurse (#9) removed the dressing on Resident #57's left thigh, and without removing gloves or performing hand hygiene cleansed the wound with a 2x2 moistened with normal saline, dried the wound with a clean 2x2, applied a new dressing, and placed three vials of unopened normal saline and a bandage scissors in her uniform pocket. The nurse then removed the gloves and performed hand hygiene. - Observation on 04/19/22 at 9:11 a.m. showed a staff nurse (#9) applied an absorbent dressing to Resident #115's right buttock as the previous dressing fell off. The nurse (#9) performed hand hygiene, donned gloves, and opened/arranged supplies. She moistened a 2x2 gauze with normal saline, cleansed the wound, then dried the wound with a new 2x2. Without removing the gloves and performing hand hygiene, the nurse	F 880	between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of all staff types to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. (2) Observations of staff types to ensure performance of proper catheter care, in the course of their duties. (3) Observations of staff types to ensure performance of proper wound care, in the course of their duties. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for	

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 _____	C 04/21/2022

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 880	Continued From page 20 (#9) applied the new dressing. The nurse (#9) then removed the gloves and performed hand hygiene before leaving the room. During an interview on 04/21/22 at 11:00 a.m., an administrative nurse (#2) stated she expected staff to follow the dressing change policy and remove gloves and perform hand hygiene after removing soiled dressings and applying new dressings and when moving between wound sites.	F 880	the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 05/24/2022	
F9999	FINAL OBSERVATIONS Based on observation, record review, policy review, and resident and staff interviews, the complaint investigations in conjunction with the Standard Medicare/Medicaid survey were not substantiated.	F9999		