| 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 _____ | 04/25/2019 |

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

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| F 000 | INITIAL COMMENTS<br><br>The standard Medicare/Medicaid recertification survey started on 04/22/19 and concluded 04/25/19. | F 000 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 10/18/18. | F 657 | The following care plans were reviewed and revised by the appropriate | 5/31/19 |

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

Electronically Signed | 05/16/2019

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| F 657 | Continued From page 1<br><br>Based on observation, record review, policy review, resident interview, and staff interview, the facility failed to review/revise the comprehensive care plans to reflect the current status for 6 of 35 sampled residents (Resident #73, #75, #93, #127, #162, and #183). Failure to revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident.<br><br>Findings include:<br><br>Review of the facility policy titled "Care Planning" occurred on 04/25/19. This policy, dated July 2016, stated, ". . . CARE PLAN REVIEW: a. On each shift the CNA's [certified nurse aides] and Nurse review care plans and care guides so that each resident's care plan is reviewed by the three shifts monthly adding or deleting problems, goals, and approaches as appropriate."<br><br>- Observation of Resident #93 throughout the survey showed the resident had several pressure ulcers, an air mattress, dermasaver [type of pressure-relieving] boots, continuous oxygen, and a urinary catheter.<br><br>Review of Resident #93's medical record occurred on all days of survey. The current care plan stated, ". . . At risk for developing a pressure ulcer/skin impairment r/t [related to] peripheral vascular disease [initiated 05/24/2018], . . . requires an indwelling urinary catheter related to hematuria. Resident currently receiving hospice care and requested to leave catheter for comfort [initiated 02/11/2019]. . . . receives hospice services r/t Cancer. . . . Hospice nurse and | F 657 | departments/nurse managers:<br><br>Care Plan for resident #93-Hospice Department Director was notified and care plan was update to remove "risk for" and add "pressure ulcer", also adding current interventions that were being used to treat pressure ulcer; oxygen and urinary catheter also added to care plan.<br><br>Care Plan for resident #162-Dermasavers added to care plan as an intervention.<br><br>Care Plan for resident #75-Oxygen was discontinued on March 20, 2019. All orders related to oxygen use removed from care plan.<br><br>Care Plan for resident #127-Oxygen discontinued March 31, 2019. All orders related to oxygen therapy removed from care plan.<br><br>Care Plan for resident #183-Antibiotic discontinued April 12, 2019. All active infection and antibiotic use removed from care plan.<br><br>Care Plan for resident #73-K-Pad added to resident care plan as non-medical intervention for pain relief.<br>All care plans changed and updated week of survey.<br><br>All residents have the potential to be affected if Care Plan is not reviewed/revised to reflect resident's current status, resident treatments, and | |

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| F 657 | Continued From page 2<br>hospice aide will provide cares as needed [initiated 02/28/2019]. . . ." The current hospice care plan stated, ". . . Skin integrity will remain intact [initiated 03/01/19] . . ."<br><br>Resident #93's care plan lacked information regarding the actual (versus risk for) pressure ulcers and lacked interventions of air mattress, dermasaver boots, and oxygen use. The hospice care plan lacked information related to the pressure ulcers and urinary catheter.<br><br>During an interview on 04/25/19 at 2:15 p.m., a nurse manager (#4) agreed the facility failed to update Resident #93's care plan with the above information.<br><br>- Observation of Resident #162 throughout the survey showed the resident wore dermasaver boots.<br><br>Review of Resident #162's medical record occurred on all days of survey. A physician's order, dated 02/05/19, stated, "Wound care to left posterior ankle above heel. Apply skin prep, then duoderm signal [type of dressing] once a day every 3 days." The current care plan stated, ". . . has a pressure ulcer Stage 3 left heel . . ."<br><br>Resident #162's care plan lacked the intervention of dermasaver boots.<br><br>During an interview on 04/24/19 at 12:45 p.m., a wound therapist (#7) stated she implemented the dermasaver boots on 02/19/19. When asked how staff would know to use the boots, the therapist stated, "They should be on his care plan." At 2:24 p.m., an administrative nurse (#1) agreed staff | F 657 | interventions used to take care of resident.<br><br>All Trinity Homes staff responsible for Care Plans received initial education April 26, 2019. Education for specific nursing departments scheduled in May. Education includes review and updates of care plans, responsibilities, and timeliness. Staff meetings are being held on May 15, 22, 19, 2019 for all nursing staff to address deficiencies, including this deficiency. Copies of the education for the POC have been placed in all appropriate departments as an inservice, and staff has been educated through the read and sign process.<br><br>QA audits started May 1, 2019. Nurse Managers will audit 5 charts per week on each unit. Audits will be completed weekly for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits.<br><br>All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken. | |

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| F 657 | Continued From page 3<br>should have added the dermasaver boots to Resident #162's care plan.<br><br>- Observation of Resident #75 throughout the survey showed no oxygen use or oxygen equipment in the resident's room.<br><br>Review of Resident #75's medical record occurred on all days of survey. A problem start date of 11/30/18 on the current care plan stated, ". . . requires oxygen therapy R/T [related to] shortness of breath and decreased oxygen saturations without supplemental oxygen . . . Oxygen per MAR [medication administration record]. O2 [oxygen] 2 liters nasal cannula as ordered . . ." The current physician orders failed to show orders related to oxygen use.<br><br>During an interview on 04/25/19 at 12:45 p.m., Resident #75 stated, "They took the oxygen off about 4 days after I came here." The medical record indicated an admission date of 11/30/18.<br><br>During an interview on 04/25/19 at 8:30 a.m., three administrative staff members (#1, #2, and #3) agreed Resident's #75 had not worn oxygen for a while and the care plan should have been updated.<br><br>The facility failed to review/revise the care plan to reflect Resident #75's current respiratory status.<br><br>- Observation of Resident #127 throughout the survey showed no oxygen use or oxygen equipment in the resident's room.<br><br>Review of Resident #127's medical record occurred on all days of survey. A problem start | F 657 | The Director of Nursing is responsible for this process. | |

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| F 657 | Continued From page 4<br>date of 03/03/19 on the current care plan stated, ". . . requires oxygen therapy R/T shortness of breath and decreased oxygen saturations without supplemental oxygen. . . . Oxygen per MAR. Oxygen via per nasal cannula as ordered. . . ." The current physician orders failed to show orders related to oxygen use.<br><br>During an interview on 04/25/19 at 8:30 a.m., three administrative staff members (#1, #2, and #3) agreed Resident's #127 had not worn oxygen for a while and the care plan should have been updated.<br><br>The facility failed to review/revise the care plan to reflect Resident #127's current respiratory status.<br><br>- Review of Resident #183's medical record occurred on all days of survey. A problem start date of 03/25/19 on the current care plan stated, ". . . receives antibiotic(s) r/t septic arthritis to right knee. . . . antibiotics as ordered. . . ." The current physician orders failed to show an order for antibiotics.<br><br>During an interview on 04/25/19 at 8:30 a.m., three administrative staff members (#1, #2, and #3) stated Resident #183 no longer received antibiotics for a septic arthritic knee and the care plan should have been updated.<br><br>The facility failed to review/revise the care plan to reflect Resident #183's discontinued antibiotic use.<br><br>- Observation of Resident #73 throughout the survey showed a K-pad [a form of heating pad] present in the resident's room. | F 657 | | |

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| F 657 | Continued From page 5<br><br>Review of Resident #73's medical record occurred on all days of survey. A problem start date of 06/04/18 on the current care plan stated, ". . . Pain . . . at risk for pain related to immobility and advanced age . . . Try non-medication interventions . . ." A physician order, dated 05/31/17, stated, "K-Pad for back pain . . ."<br><br>The facility failed to review/revise the care plan to reflect Resident #73's use of a K-pad as a non-medication intervention for pain. | F 657 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to provide dining assistance for 1 of 9 sampled resident's (Resident #73) who required assistance with eating. Failure to assist a resident who requires assistance may result in decreased intake and/or unwanted weight loss.<br><br>Findings include:<br><br>Review of Resident #73's medical record occurred on all days of survey. The annual Minimum Data Set, dated 02/23/19, indicated the resident required extensive assistance of one person for eating.<br><br>The current care plan stated the following: | F 677 | Resident #73 reassessed. Feeding assessment completed and Special Care unit screening completed by Nurse Manager and Social Worker. Resident moved to Alzheimer's unit for dementia specific care. 1:1 assistance with meals removed from care plan. Alzheimer's unit has higher staff: resident ratio to insure resident is getting assistance as needed with meals.<br><br>All residents have the potential to be affected if resident is not assisted with meals as needed and not following plan of care.<br><br>Facility staff responsible for care plans | 5/31/19 |

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| F 677 | Continued From page 6<br>* 04/20/17 - ". . . Potential for dehydration . . . 1:1 [one-on-one] assistance with meals. Staff should continue to offer small bite sizes of alternate solids/liquids while observing for pocketing on both right and left side of mouth . . . staff is to observe for appropriate posture, adjust her upright in chair if leaning during meals to prevent aspiration . . ."<br>* 06/04/18 - "[Resident's name] is not able to do own ADL's [activities of daily living] . . . due to Dementia and hemiplegia [paralysis to one side of the body] from a past CVA [cerebral vascular accident (stroke)]."<br><br>Observation during the noon meals on 04/22/19, 04/23/19, and 04/24/19, for 10 to 15 minutes on each day, showed staff failed to provide Resident #73 one to one assistance with eating. The resident made no attempts to feed self during these observations.<br><br>During an interview on 04/25/19 at 11:01 a.m., an administrative staff member (#1) stated she expected staff sit with a resident while they eat when a care plan indicated one to one assist with dining. When asked if that meant at all times throughout the meal, the administrative member (#1) stated, "Yes."<br><br>The facility failed to provide the necessary assistance Resident #73 required while eating. | F 677 | and staff responsible for assisting residents with meals initial education April 26, 2019 regarding following care plans and assisting residents as stated in plan of care. Education for nursing staff scheduled in May. Education includes review and updates of care plans, reassessment of residents for increased needs in cares, and timeliness. Staff meetings are being held on May 15, 22, 19, 2019 for all nursing staff to address deficiencies, including this deficiency. Copies of the education for the POC have been placed in all appropriate departments as an inservice, and staff has been educated through the read and sign process.<br><br>QA audits started May 1, 2019. Nurse Managers will audit 5 residents from their units during meals, focusing on residents that need assistance with feeding as stated on resident care plan. Audits will be completed weekly for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits.<br><br>All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of | |

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| F 677 | Continued From page 7 | F 677 | their employees. If non-compliance is noted, immediate corrective action will be taken.<br><br>The Director of Nursing is responsible for this process. | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, review of an investigation report, and staff interview, the facility failed to provide adequate supervision to prevent accidents for 1 of 1 closed record reviewed (Resident #188) who experienced a burn from a hot pack. Failure to ensure staff used a hot pack appropriately could have resulted in a more serious burn to Resident #188.<br><br>Findings include:<br><br>Review of the facility policy titled "Bath Bags" occurred on 04/25/19. This policy, revised 03/2018, stated, ". . . Bag baths may be used as an alternative to a basin of water and soap for partial baths . . . Mix bathing solution, in a large container not a sink, following the directions for dilution. Place moistened wash cloths in a plastic | F 689 | Past noncompliance: no plan of correction required. | 5/13/19 |

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| F 689 | Continued From page 8 | F 689 | | |

bag. . . . Heat bag in microwave to a comfortable temperature, approximately one minute. CAUTION: microwave ovens vary in their rate of heating. Do not put a premade bath bag directly on the resident's skin or body. . . ."

Review of Resident #188's medical record occurred on 04/25/19 and showed a hospital transfer on 02/13/19 due to shortness of breath and tachypnea (abnormal rapid breathing). The resident returned to the facility on 02/19/19. Medications included silver sulfadiazine cream (topical antibiotic to treat burns) 1% topical twice a day to neck until healed.

During an interview on the afternoon of 04/25/19, a wound care therapist (#7) stated she had not completed a wound assessment and wound measurements when Resident #188 returned to the facility on 02/19/19 because he went to the hospital again (unrelated to the burn) from 02/23/19 to 03/07/19.

The medical record showed wound care observation documentation and wound measurements as follows:
*03/11/19 - ". . . Location of area. L. [left] occipital [back of the head] protuberance . . . Measurement - Describe by Length x Width x Depth. 1 x 1.3 x 0.1 cm [centimeter]. . . . Character of Tissue - Necrotic Tissue (Eschar)-black, brown, or tan tissue that adheres firmly to the wound and surrounding skin. . . . no drainage, no odor . . ."
*03/18/19 - ". . . Location. L. occipital protuberance . . . Measurement - 0.6 x 1 x 0.1 cm. . . . Character of Tissue - Necrotic Tissue (Eschar) . . . no drainage, no odor . . ."

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| F 689 | Continued From page 9<br>*03/25/19 - ". . . Location. L. occipital protuberance . . . Measurement - 1 x 1.5 x 0.1 cm. . . . Character of Tissue - Necrotic Tissue (Eschar) . . . no drainage, no odor . . ."<br><br>During an interview on the afternoon of 04/25/19, an administrative nurse (#1) stated they were notified on 02/13/19 by the hospital staff of a burn to the back of Resident #188's neck and, following the report, completed an investigation to determine the cause. The administrative nurse (#1) reported Resident #188 continued to have a "scab" present on the back of his neck at the time he discharged home on 04/02/19.<br><br>Review of the "Abuse, Neglect, Misappropriation Investigation Worksheet" report completed by the investigating team occurred on 04/25/19. This report stated, ". . . During the evening him [Resident #188] and his wife requested a warm cloth on his neck. [certified nursing assistant #18] heated up a bag bath and put it inside a pillowcase and placed it on his neck . . . The next morning [name of Resident #188] was transferred back to the hospital. During his initial hospital assessment, they noticed a burn to his neck and his wife reported it must have been from the heating pad. . . ."<br><br>Based on the following information, non-compliance at F689 is considered past non-compliance:<br>The facility addressed the corrective action accomplished for Resident #188 affected by the deficient practice by:<br>*02/13/19, The administrative staff members (#1, #10, and #11) completed a thorough investigation. | F 689 | | |

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| F 689 | Continued From page 10<br>*02/13/19, The administrative staff member (#1) educated the involved staff member regarding the inappropriate use of a bag bath as a warm compress.<br><br>The facility identified all residents have the potential to be affected by the deficient practice and implemented the following:<br>*02/13/19, Administrative staff member (#10) reported the incident to the North Dakota Department of Health.<br>*02/20/19, The administrative nurse (#1) provided education on the use of the "bath bags" to all staff. The following expectation, "A nurse must be notified of any intervention prior to it occurring and documentation must accompany the intervention" was included in the staff education. The staff were required to provide their signature to indicate they completed and understood the education information. | F 689 | | |
| F 693 SS=D | Tube Feeding Mgmt/Restore Eating Skills<br>CFR(s): 483.25(g)(4)(5)<br><br>§483.25(g)(4)-(5) Enteral Nutrition<br>(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-<br><br>§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 | F 693 | | 5/31/19 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 693 | Continued From page 11<br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to prevent complications for 1 of 4 sampled residents (Resident #183) observed with a feeding tube. Failure to flush a gastrostomy (gastric) tube (tube surgically inserted into the stomach) as ordered before and after administration of feeding boluses and medications may result in adverse effects.<br><br>Findings include:<br><br>Review of Resident #183's medical record occurred on all days of survey.<br><br>WATER FLUSHES WITH FEEDINGS<br><br>The physician's orders included the following:<br>* 04/01/2019 - "Flush tube with 240 ml [milliliters] of H2O [water] Four Times A Day" (a scheduled flush independent of the feeding flush)<br>* 04/16/19 - "Jevity 1.5 Cal [enteral feeding] . . . 385 ml (4x/d) [four times a day]; gastric tube Special Instructions: Flush tube feed with 100 ml before and after each bolus."<br><br>Observations for Resident #183 included the following: | F 693 | Staff education done for nursing staff to follow all physician orders as written, including tube feedings for resident #183. Enteral Feeding policy reviewed and in process of being updated to have a standard water flush with medications. Nursing staff clarified all enteral feeding and water flushes with providers and updated all orders, including resident #183. All residents have the potential to be affected if nurses are not following policy and physician orders on enteral feedings.<br><br>Nursing staff and Dieticians received initial education April 26, 2019. Education for nursing and nutritional services will be provided when policy completed and approved, prior to May 31, 2019. Nursing staff educated on following enteral feeding orders as written by provider. Staff meetings are being held on May 15, 22, 19, 2019 for all nursing staff to address deficiencies, including this deficiency. Copies of the education for the POC have been placed in all appropriate departments as an inservice, and staff has been educated through the read and sign process. | |

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| F 693 | Continued From page 12<br>* On 04/22/19 at 11:57 a.m., a licensed nurse (#14) started the resident's Jevity feeding. Observation showed the nurse failed to flush the gastric tube with 100 ml of water prior to starting the Jevity feeding.<br>* On 04/24/19 at 5:14 p.m., observed the resident's tube feeding pump set at 390 ml/hr (milliliters per hour). When asked what constitutes the 390 ml/hr, the nurse (#13) looked at his "cheat sheet" and stated the 390 ml included 150 ml for the post feeding water flush and 240 ml for the scheduled water flush. When asked to confirm the order for the water flushes before and after the Jevity boluses, the nurse looked at his "cheat sheet" and at the medication administration record (MAR) and identified the order changed from 150 ml to 100 ml on 04/16/19. The nurse (#13) confirmed he administered 150 ml water flushes throughout his shift today.<br><br>The facility failed to follow the physician's orders regarding water flushes before and after the Jevity boluses for Resident #183's gastric tube.<br><br>WATER FLUSHES WITH MEDICATION PASS<br><br>The physician's orders for all of Resident #183's medications given per gastric tube included the following (with the exception of Banatrol Plus - to prevent diarrhea):<br>* 03/08/19 - "Special Instruction: Begin with 25 ml [water] flush before [and] end with 25 ml [water] flush after. Dilute meds [medications] with 25 ml/dose. Flush With 5 ml [water] between meds"<br>* 03/29/19 - "Banatrol Plus . . . amt [amount]: 1 pkt [packet]; gastric tube Special Instructions: Mix with 120 ml H2O and flush with 25 ml [water] | F 693 | QA audits started May 1, 2019. Nurse Managers will observe, weekly, all nurses who administer enteral feeding to insure that orders are followed. Audits will be completed weekly for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits.<br><br>All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken.<br><br>The Director of Nursing is responsible for this process. | |

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| F 693 | Continued From page 13<br>before and 25 ml [water] after med"<br><br>Observation on 04/25/19 at 9:33 a.m. showed a licensed nurse (#15) diluted eight medications in individual medications cups with 25 ml of water in each cup and one medication (Banatrol Plus) in 120 ml of water. The nurse then administered 25 ml of water prior to the first medication, between the administration of each medication, and after the last medication given to Resident #183. When asked why she used 25 ml to flush between medications, the nurse stated the order to flush with 5 ml did not make sense to her. "I ignored that [5 ml flush] since it says to flush 25 ml before and after medications. I decided to go with the 25 ml instead of the 5 ml."<br><br>The facility failed to follow the physician's orders regarding water flushes between medications for Resident #183's gastric tube. | F 693 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 10/18/18<br><br>Based on observation, record review, staff | F 695 | Upon notification of empty O2 tanks staff exchanged empty tanks with full O2 tanks for residents #116 and #142. Nurse managers made rounds on their units to | 5/31/19 |

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| F 695 | Continued From page 14<br>interview, and policy review, the facility failed to provide the necessary care and services for 1 of 6 sampled residents (Resident #116) and 1 supplemental resident (Resident #142) with orders for continuous oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate/excessive oxygen saturation levels.<br><br>Findings include:<br><br>Review of the facility policy titled "Oxygen Therapy And Titration Protocol-Oximetry Readings" occurred on 04/25/19. This policy, dated January 2016, stated, "L.P.N.'s [licensed practical nurse]/R.N.'s [registered nurse] is [are] responsible for putting oxygen on residents and charting oxygen saturations. . . . OXYGEN THERAPY BY NASAL CANNULA . . . PURPOSE: To administer in conditions in which insufficient oxygen is carried by the blood to tissues . . . Adjust liter flow as ordered . . . Monitoring of oxygen is done by the nursing staff. . . . "<br><br>- Review of Resident #116's medical record occurred on all days survey. Diagnoses included chronic obstructive pulmonary disorder (COPD) (difficulty in breathing). The current care plan stated, "Cardiac and respiratory function alteration r/t [related to] hypertension and obesity. . . . Oxygen per physician orders. O2 [oxygen] sats [saturations - level of oxygen in the blood] as ordered . . ."<br><br>A physician's order, dated 04/01/19, stated, "Oxygen @ 1 LPM [liter(s) per minute] /NC [nasal cannula] to keep sats >90% [keep oxygen level at 90% or higher] - if Spo2 <89% [if level is less | F 695 | insure no residents had empty O2 tanks.<br><br>All residents have the potential to be affected if O2 tanks are not changed as needed.<br><br>Trinity nursing staff on units received immediate education<br>All staff received initial education April 26, 2019. Education for specific nursing departments scheduled in May. Education includes importance of checking O2 tanks with every interaction, checking tanks for O2 level above 250 psi. Nursing staff will check all O2 tanks in use for O2 levels above 250 psi every 4 hours and maintenance staff will check O2 levels on tanks in use every shift. Staff meetings are being held on May 15 & 22, 2019 for all nursing staff to address deficiencies, including this deficiency. Copies of the education for the POC have been placed in all appropriate departments as an inservice, and staff has been educated through the read and sign process.<br><br>QA audits started May 1, 2019. Nurse Managers, charge nurse or designee will continue to monitor all O2 tanks in use for appropriate O2 settings and 250 psi or greater every 4 hours. Maintenance staff will assist with monitoring all O2 tanks in use for appropriate settings and 250 psi or greater each shift. QA audits will be done weekly to insure that oxygen is at the ordered flow and that O2 tanks have adequate oxygen for continuous use. | |

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| F 695 | Continued From page 15<br>than 89%] increase to 2L/NC Every Shift Night, Day, Evening."<br><br>Observations of Resident #116 included the following:<br>* On 04/22/19 at 5:11 p.m. - Showed the resident wearing a nasal cannula attached to an oxygen concentrator set at 3 LPM. Per the physician order, the concentrator should be set to 1 LPM.<br>* On 04/23/19 at 11:46 a.m. - Showed the resident wearing a nasal cannula attached to an oxygen tank on the back of the wheelchair. The oxygen tank meter is set at 2 LPM. Per the physician order, the meter should be set to 1 LPM.<br>* On 04/23/19 at 5:25 p.m. - Showed the resident wearing a nasal cannula attached to an oxygen concentrator set at 2 LPM. Per the physician order, the concentrator should be set to 1 LPM.<br>* On 04/24/19 at 11:57 a.m. - The resident seated at the dining room table in a wheelchair wearing a nasal cannula attached to an oxygen tank on the back of the wheelchair. The oxygen tank meter registered empty.<br>* On 04/24/19 at approximately 12:45 p.m. - The resident returned to her room per her power wheelchair. The oxygen tank meter on the back of the wheelchair continued to register empty.<br><br>During an interview on 04/24/19 at 12:35 p.m., when asked how it is determined if Resident #116 receives 1 liter or 2 liters of oxygen as ordered, a licensed nurse (#12) stated, "Oxygen saturation levels are taken three times a day or if the resident's respiratory status declines. The number received [oxygen saturation level] is documented and determines whether 1 or 2 liters will be used." | F 695 | Audits will be completed weekly for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits.<br><br>All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken.<br><br>The Director of Nursing is responsible for this process. | |

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| F 695 | Continued From page 16<br><br>During an interview on 04/25/19 at 8:30 a.m., three administrative staff members (#1, #2, and #3) agreed Resident #116's oxygen tank should not have been empty for almost an hour.<br><br>The facility failed to follow Resident #116's physician's orders for oxygen administration and provide full, portable oxygen tanks in a timely manner.<br><br>- Review of Resident #142's quarterly minimum data set (MDS), dated 04/18/19, showed intact cognition.<br><br>Observations for Resident #142 included the following:<br>* On 04/22/19 at 3:20 p.m. - The resident seated in wheelchair in his room wearing a nasal cannula attached to an oxygen tank on the back of the wheelchair. The oxygen tank meter registered empty. The resident stated he wears oxygen all the time and knows when his tank is empty. "I get sluggish."<br>* On 04/22/19 at 5:06 p.m. - The resident's oxygen tank meter continued to register empty as he passed in the hallway in his power wheelchair. The resident stopped at the nurses station and obtained a new oxygen tank.<br><br>During an interview on 04/25/19 at 8:30 a.m., three administrative staff members (#1, #2, and #3) stated Resident #142 should not have to obtain full oxygen tanks based on symptoms felt and staff should have assisted the resident with this task.<br><br>The facility failed to provide Resident #142 with a | F 695 | | |

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| F 695 | Continued From page 17<br>full, portable oxygen tank in a timely manner. | F 695 | | |
| F 740 SS=D | Behavioral Health Services<br>CFR(s): 483.40<br><br>§483.40 Behavioral health services.<br>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to provide the necessary behavioral health care services to ensure each resident attained/maintained their highest practicable emotional/mental well-being for 2 of 17 sampled residents (Resident #34 and #73) who exhibited behaviors. Failure to provide an environment conducive to each resident's emotional/mental well-being resulted in avoidable emotional/mental distress for Resident #34 and #73.<br><br>Findings include:<br><br>- Review of Resident #34's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and anxiety. The most recent quarterly Minimum Data Set (MDS), dated 02/06/19 identified Resident #34 as severe cognitive impairment. | F 740 | Residents #34 & #73 had special care unit pre-screening completed by Nurse Manager and Social Worker. Resident #73 transferred to special care unit with higher staff: resident ratio to insure needs are being met. All staff educated on meeting all residents behavioral needs immediately and following plan of care, including Resident's #34 & #73.<br><br>All residents have the potential to be affected if staff do not meet resident's behavioral needs.<br><br>All Trinity Homes staff received initial education April 26, 2019. Education for all nursing staff scheduled in May. Education includes observations and assessments of residents behavioral needs, importance of addressing resident needs in a timely manner, following | 5/31/19 |

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| F 740 | Continued From page 18<br>The care plan identified, ". . . [name of resident] is not able to do her own activities of daily living r/t [related to] Alzheimer's disease, weakness, and ambulatory dysfunction. . . . Staff assist of 1 to check and change every 2-4 hours and PRN [as needed]. . . . If she is making behavioral noises, talking with her and rubbing her hand can sometimes calm her. . . . Behavioral symptoms . . . She cries and hollers at times . . . Speak calmly with her, using simple terms. Decrease stimuli. When she is upset, place her in her bed in a quiet room. This seems to calm her. When she is crying, sometimes rubbing her hand will calm her. . . ."<br><br>Observations on 04/24/19 of Resident #34 showed the following:<br>* At 9:20 a.m., seated near the nurse's station.<br>* At 10:03 a.m., remained seated near the nurse's station and started to make intermittent verbal sounds like a moan or cry.<br>* From 10:44 a.m. to 12:08 p.m., seated to the left of the nurse's station, adjacent to the dining room, and continued to make louder intermittent, alternated with continuous, verbal sounds like a moan or cry. Nursing staff walked past Resident #34 as they took other residents into the dining room.<br>*At 12:12 p.m. the nursing staff assisted Resident #34 into the dining room while she continued to make intermittent verbal moaning/crying sounds.<br><br>The facility staff failed to meet the resident's behavioral health care needs and failed to implement the care planned approaches for her behavioral symptoms.<br><br>During an interview on 04/25/19 at 9:10 a.m., an | F 740 | interventions on resident care plans, and attending to all residents who are verbalizing/expressing a need. Staff meetings are being held on May 15, 22, 19, 2019 for all nursing staff to address deficiencies, including this deficiency. Copies of the education for the POC have been placed in all appropriate departments as an inservice, and staff has been educated through the read and sign process.<br><br>Nurse Managers started Quality audits May 1, 2019. Nurse Manager, Charge Nurse or Nurse Educator will do audits daily on each unit to insure that staff are providing timely care to residents who are displaying behavior which may indicate that they are not comfortable, in pain, tired, or have a need that is not being met. Audits will be done daily on each unit with nurses monitoring for residents that are displaying behavioral symptoms. These audits will be completed when behaviors are observed for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits.<br><br>All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for | |

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| F 740 | Continued From page 19<br>administrative nurse (#1) agreed the nursing staff should have followed the resident's care plan regarding behaviors.<br><br>- Review of Resident #73's medical record occurred on all days of survey. Diagnoses included vascular dementia with behavior disturbance. The most recent annual MDS, dated 02/23/19, identified moderately impaired cognition.<br><br>The current care plan stated, ". . . Behavioral Symptoms . . . Disruptive. Yells out during shift and states that she cannot help in [it] referring to her yelling . . . Goal . . . will not be disruptive and not yell out. . . . Approach [Resident's name] in a calm manner. Explain things to her in simple terms. Redirect if able. Offer snack. Allow [residents name] to ventilate her feelings. . . ."<br><br>Observations on 04/23/19 of Resident #73 showed the following:<br>* At 8:02 a.m., the resident repeatedly called out "Help me. Help me," while seated in a wheelchair at the dining room table. An unidentified certified nurse assistant (CNA) removed the resident from the dining room and placed the resident in her room.<br>* Between 8:02 a.m. and 9:03 a.m., multiple observations showed continued calls for help from the resident while seated in the room. Various staff walked by on 5 separate occasions and ignored the residents calls for help. The volume, intensity, and tone of the resident's voice changed/increased each time the staff passed by.<br>* At 9:03 a.m., an unidentified staff member walked by the resident's room and stated to | F 740 | the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken.<br><br>The Director of Nursing is responsible for this process. | |

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| F 740 | Continued From page 20<br>another staff member, "[Resident's name] needs to lay down."<br>* At 9:08 a.m., two CNAs (#5 and #6) entered the room, transferred the resident from the wheelchair to the bed, and checked and changed the resident's brief. After the resident cares where completed, the resident immediately fell asleep.<br><br>The facility failed to meet Resident #73's behavioral health care needs and to implement the care planned approaches for the behavioral symptoms displayed.<br><br>During an interview on 04/25/19 at 8:30 a.m., administrative staff (#1, #2, and #3) agreed staff should have addressed Resident #73's calls for help in a timely manner and implemented the care planned approaches. | F 740 | | |
| F 812 SS=D | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility. | F 812 | | 5/31/19 |

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| F 812 | Continued From page 21<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy/procedure, manufacturers' labeling, and staff interview, the facility failed to properly store beverages 2 of 2 days of survey (04/22/19 and 04/24/19). Failure to mark foods with a thaw and/or discard date when opened has the potential to result in altered consistency of beverages provided and/or foodborne illness.<br><br>Findings include:<br><br>Review of the facility policy and procedure titled "Viewing: Receiving and Food Storage" occurred on 04/25/19. This policy, dated March 2017, stated, ". . . 16. All food products opened or placed in another container must be labeled, dated, and covered. . . ."<br><br>Review of the facility policy and procedure titled "Viewing: Rotation/Storage of Foods/ Nutritional Services" occurred on 04/25/19. This policy, dated March 2019, stated, ". . . PURPOSE: To assure that foods served are wholesome and not out dated. . . . 4 Cold Storage . . . Supplements - Mighty shakes & frozen custard- 14 days from removal of freezer . . ."<br><br>Review of the manufacturers' labeling showed the following:<br>* Mighty Shake, a nutritional supplement: use within 14 days of thawing;<br>* Honey and nectar thickened milk beverage: use | F 812 | All nutrition services staff received education immediately on policy of dating all open food/beverages and marking foods with a thaw and/or discard date when opened.<br><br>All residents have the potential to be affected if thaw and open dates are not put on beverages and food; and if the items are not used within the specified time frame, per policy or manufactured discard date.<br><br>Trinity Homes staff received inservice education regarding new policy "Dating/Labeling Items Upon Opening/Thawing". Education was provided and completed April 30, 2019.<br><br>QA audits started May 1, 2019. Nutrition services Supervisors are responsible for ensuring the daily checks are completed and will update the GEMBA Board following the daily checks. As the goal on the GEMBA Board is now a safety goal, an action plan will be completed each time the products are not found with the thaw/open dates on the item. Weekly audits will be completed and give to the director of QAPI, this will be done until compliance is consistently achieved for four weeks, then QA audits will be | |

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| | 355074 | A. BUILDING _____ B. WING _____ | 04/25/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 812 | Continued From page 22<br>within four days of opening; and<br>* Honey and nectar thickened water and juice beverages: use within 10 days of opening.<br><br>- Observation during the initial kitchen tour on 04/22/19 at 10:55 a.m. with a dietary staff member (#8) showed the following opened and undated items:<br>* Four containers of honey thickened beverages, one water and three kinds of juice;<br>* One carton of honey thickened milk beverage;<br>* Four containers of nectar thickened beverage, one water and three kinds of juice; and<br>* One carton of nectar thickened milk beverage.<br><br>- Observation during the full kitchen tour on 04/24/19 at 2:00 p.m., with a dietary staff member (#9) showed the following:<br>* Special Care Unit: Four thawed Mighty Shakes not labeled with a thaw date.<br>* Three North: An opened and undated container of cranberry juice.<br><br>During an interview on the morning of 04/22/19, a dietary staff member (#8) identified the Mighty Shakes are dated by staff on the units and the thickened juice should have been dated when staff opened them. | F 812 | monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits.<br><br>The Dietary Director/Designee is responsible for this process. | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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. | F 880 | | 5/31/19 |

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| F 880 | Continued From page 23<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. | F 880 | | |

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| F 880 | Continued From page 24<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, review of the Food and Drug Administration (FDA) Food Code, and staff interview, the facility failed follow infection control standards on 2 of 4 days of survey (04/22/19 and 04/24/19). Failure to properly sanitize a glucometer and follow standard infection control practices during a water pass has the potential to spread illness/infection to residents in the facility.<br><br>Finding include:<br><br>Glucometer<br><br>Review of the facility policy, "Cleaning, Disinfection and Sterilization-Trinity Homes" | F 880 | Immediate education and review of policies were completed with all staff known to not follow policy. LPN educated on proper procedure and policy of cleaning accucheck equipment between each resident use. CNA educated on importance of making sure that all clean equipment does not come in contact with resident/dirty equipment All staff educated on cleaning of equipment between resident use, following infection control policies for appropriate handwashing, and policy updated for water pass.<br><br>All residents have the potential to be affected if staff do not follow infection | |

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| F 880 | Continued From page 25<br>occurred on 04/24/19. This policy, revised February 2018, stated, " . . . Any multi-use medical equipment needs to be cleaned if visibly soiled and disinfected after every resident use."<br><br>- Observation on the morning of 04/24/19 showed a licensed nurse (#16) checked Resident #125's and Resident #20's blood sugar with a glucometer. After lancing the resident's finger and performing the blood sugar test, the nurse placed the glucometer back onto a cart and failed to disinfect the glucometer before use between residents.<br><br>During an interview on 04/24/19 at 3:20 p.m., a nurse manager (#4) agreed staff should disinfect the glucometer after each resident use.<br><br>Water Pass<br><br>The 2013 FDA Food Code, page 72, stated, " . . . In-Use Utensils, Between-Use Storage . . . During pauses in food [ice] preparation or dispensing . . . Utensils shall be stored . . . (A) . . . in the food [ice] with their handles above the top of the food [ice] and the container . . . "<br><br>- Observation on 04/22/19 at 3:06 p.m. showed a certified nursing assistant (CNA) (#17) refilling water cups on Unit 2 South. The CNA brought each cup out into the hallway to a cart with an ice cooler and water pitcher. The CNA used a scoop to fill cups with ice from the cooler and placed the ice scoop back into the cooler and failed to position the handle above the top of the ice. The CNA entered the next four resident rooms performing the same task. | F 880 | control practices and policies.<br><br>Glucometers: Trinity Homes staff received education week of state survey and all education completed April 26, 2019. Education included review of cleaning and disinfection of the glucometers and infection control practices to prevent contamination from dirty to clean resident supplies. Staff meetings are being held on May 15, & 22, 2019 for all nursing staff to address deficiencies, including this deficiency. Copies of the education for the POC have been placed in all appropriate departments as an inservice, and staff has been educated through the read and sign process.<br><br>QA audits started May 1, 2019. 5 observations per week will be completed, demonstrating correct cleaning of the glucometer. Audits will continue until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits.<br><br>All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be | |

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| F 880 | Continued From page 26<br>The CNA failed to prevent contact between the contaminated scoop handle and ready to consume ice during the water pass. | F 880 | taken.<br><br>The Director of Nursing is responsible for this process.<br><br>Water Pass: The process of passing water has been reviewed and the policy has been updated. The use of an ice scoop has been eliminated effective 5/29/19 (extra cups have been ordered to meet the change in our policy). 5 observations of water passes per unit per week will be completed. Observations will be done weekly or until compliance has been achieved consistently for four week. At that time QA audit will be monthly for 4 months and them quarterly for 3 quarters. If compliance is not achieved staff will be reeducated and we will again complete weekly QA audits.<br><br>All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken.<br><br>The Director of Nursing is responsible for this process. | |