

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 279                                                    | <p>Continued From page 41</p> <p>identified the facility admitted the resident in 11/03. The resident's current diagnoses included dementia, esophageal stricture, and constipation. Resident #16's current Minimum Data Set (MDS), dated 04/18/10, identified short and long term memory problems, moderately impaired daily decision making, insufficient fluids, and a stage II pressure ulcer (healed on 04/27/10). The resident's RAP, dated 08/01/09, identified insufficient fluids intake.</p> <p>The resident's Nutrition Assessment, dated 04/14/10, stated "... Fluids averaging 61% in past 3 days. Potential for dehydration related to occasionally leaves 25% or more at meals and diuretic use. Offer and encourage fluids at and between meals. . . . Monitor for s/s [signs/symptoms] of dehydration. . . ."</p> <p>Resident #16's current care plan, dated 09/01/09, stated "Problem, NUTRITION/FEEDING . . . Potential for weight loss related to occasionally leaves 25% or more at meals. . . . (04/19/10) . . . Approach . . . Food/Fluid Intake Da [Days] [dated 01/15/07], Food/Fluid PM [Evenings] [dated 01/15/07] . . . Problem, POTENTIAL FOR DEHYDRATION - Occasionally leaves 25% or more of fluids offered (04/19/10) . . . Approach, Edema Checks - Weekly edema checks Every [sic] W [Wednesday] [dated 04/11/07], Monitor for S&amp;S dehydration Every [sic] week on W [Wednesday] [dated 11/14/07] . . ."</p> <p>Resident #16's Care Guide, dated 05/04/10, failed to identify any approaches for facility staff regarding encouragement of fluids.</p> <p>- Review of Resident #21's medical record, on May 05-06, 2010, identified the facility admitted</p> | F 279                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 279                                                    | <p>Continued From page 42</p> <p>the resident in 01/01. Current diagnoses included dementia, chronic pain, myalgia, and renal disease. The resident's current MDS, dated 04/05/10, identified short and long term memory problems and insufficient fluids.</p> <p>Resident #21's RAP, dated 07/04/09, identified the resident consumed insufficient fluids.</p> <p>Resident #21's current care plan, dated 04/01/09, stated "Problem, NUTRITION/FEEDING . . . Potential for weigh [sic] loss r/t [related to] occasionally leaves 25% or more @ [at] meals (07/02/09) . . . Approach . . . Food/Fluid Intake Da [Days] [dated 01/15/07], Food/Fluid PM [Evenings] [01/15/07] . . . Problem, POTENTIAL FOR DEHYDRATION - r/t diuretic use order and occasionally leaves 25% or more fluids @ meals (07/11/08) . . . Approach . . . Monitor for S&amp;S dehydration Every[sic] week on W [Wednesday] [dated 03/07/07] . . ."</p> <p>Resident #21's Care Guide, dated 05/05/10, stated ". . . Eating . . . Provide cueing for eating, Encourage intake of fluids, starts to feed self, but needs prompting and staff assist."</p> <p>The facility identified on the MDSs Resident #16 and #21 consumed insufficient fluids and identified the residents are at risk of dehydration. The facility failed to fully assess the residents' nutritional and dehydration risks in the RAPs (Refer to F272) and failed to develop, review, and revise the residents' care plans to provide facility staff with approaches for these potential risks. These failures placed the residents at risk of complications/decline related to fluid and nutritional status, including recurrent pressure ulcers.</p> | F 279                                                                      |                                                                                                                          |                            |                                                        |

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

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 279                                                    | Continued From page 43<br><br>- Observation on 05/05/10 at 2:50 p.m. showed two CNAs (#39 and #41) transferred Resident #20 from her bed and placed her into a wheelchair. Upon completion of care, these CNAs failed to offer fluids to Resident #20. Observation showed a water glass on the bedside table out of Resident #20's reach. During interview at 4:05 p.m., a CNA (#41) stated she did not know if Resident #20 consumed her afternoon snack, which staff provided earlier, as she assisted a different resident. At 4:10 p.m., Resident #20 stated staff failed to offer or provide her with an afternoon snack and stated "I have water, but I can't reach it," referring to the water glass on her bedside table.<br><br>Review of Resident #20's medical record occurred on May 04-06, 2010 and identified diagnoses of failure to thrive, anemia, depressive disorder, and chronic pain.<br><br>Review of Resident #20's current plan of care, dated 08/07/09, stated "Problem: Potential for Dehydration- diuretic use and occasionally leaves 25% or more of fluids offered (04/29/09) . . . Approach: Monitor for S/S dehydration every week on Sa [Saturday] (started 11/15/08)."<br><br>Review of Resident #20's Care Guide failed to identify Resident #20 as at risk for dehydration and failed to include interventions to promote this resident's fluid intake. | F 279                                                                      |                                                                                                                          |  |                                                        |
| F 312<br>SS=D                                            | 483.25(a)(3) ADL CARE PROVIDED FOR<br>DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | F 312                                                                      |                                                                                                                          |  | 6/1/10                                                 |

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

|                                                     |                                                                            |                                                                  |                                                        |
|-----------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
|-----------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------|

|                                                          |                                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b> |
|----------------------------------------------------------|------------------------------------------------------------------------------------|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X5)<br>COMPLETION<br>DATE |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| F 312                    | <p>Continued From page 44<br/>and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide proper perineal care for 4 of 23 sampled residents (Resident #5, #8, #14, and #16) who required assistance with toileting or incontinence cares. Failure to provide appropriate perineal care placed the residents at risk for skin irritation, skin breakdown, and urinary tract infections.</p> <p>Findings include:</p> <p>Review of the facility policy and procedure titled, "FEMALE PERINEAL CARE" occurred on 05/06/10. This policy and procedure, revised 01/2010, stated:<br/>"POLICY: Perineal care will be done bid [twice a day] and prn [as needed] (May use pre-moistened wipes &amp; or Periwash prn)<br/>OBJECTIVES: To decrease the growth of bacteria</p> <ul style="list-style-type: none"> <li>To remove excessive secretions</li> <li>To promote healing</li> <li>To prevent the spread of microorganisms . . .</li> <li>To increase resident comfort</li> </ul> <p>PROCEDURE: . . . PERINEAL CARE IN STANDING POSITION . . . 4. Wipe across supra pubic area in front. 5. With resident standing - reach between legs - being careful not to expose the cloth. Reach from front to back with one wipe. Repeat - make sure a clean part of the cloth is used with each wipe. . . ." The policy failed to</p> | F 312               | <p>Education provided to individuals involved with improper hand hygiene and peri-cares.</p> <p>All residents have the potential to be affected. Inservices have been given to all nursing staff May 25th &amp; 26th, 2010. Areas of focus will include infection control practices to ensure that all residents receive the care needed when they are unable to perform their own ADL's. Will continue to follow toileting schedules for all residents and educate staff to offer toileting to all residents after naps.</p> <p>Random weekly observations/audits will be completed. The Nurse Managers and DON will be responsible for monitoring and reporting monthly to the Quality Department. to insure compliance with this regulation. Once compliance is obtained, audits will be done quarterly.</p> <p>The Director of Nursing will be responsible for this process.</p> |                            |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 312                                                    | <p>Continued From page 45</p> <p>identify how to wipe across the frontal perineal area for female residents who receive perineal care in a standing position.</p> <p>Review of the facility policy and procedure titled, "MALE PERINEAL CARE" occurred on 05/06/10. This policy and procedure, revised 01/2010, stated:</p> <p>"POLICY: Perineal and genital care will be done bid and prn (May use pre-moistened wipes &amp; or Periwash prn)</p> <p>OBJECTIVES: To decrease the growth of bacteria</p> <ul style="list-style-type: none"> <li>To remove excessive secretions</li> <li>To promote healing</li> <li>To prevent the spread of microorganisms . . .</li> <li>To increase resident comfort.</li> </ul> <p>PROCEDURE: . . . PERINEAL CARE IN STANDING POSITION . . . 4. With resident standing - wash the penis and scrotal area, then wash the rectal area wiping front to back. . . "</p> <p>- Review of Resident #5's medical record occurred on all days of survey. A significant change Minimum Data Set (MDS), dated 03/11/10, identified this resident required extensive assistance with toileting and personal hygiene and frequently incontinent of bowel and bladder. The current care plan stated, "Elimination - incontinent of both bladder and bowel, prone to diarrhea, self care deficit for toileting." A Resident Assessment Protocol (RAP), dated 04/02/10, identified Resident #5's urinary incontinence and gives a description which stated, "Resident #5 had 3 incontinent episodes this assessment period. . . . Staff provide good pericare after incontinent episodes."</p> | F 312                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 312                                                    | <p>Continued From page 46</p> <p>Observation on 05/05/10 at 8:20 a.m., showed a CNA (#4) donned gloves and assisted Resident #5 (a female resident) to the toilet. A CNA (#4) removed the resident's visibly soiled brief. Observation showed a CNA (#5) wiped the frontal perineal area from front to back on one side, across the bottom of the perineum, and up the other side going from the back to the front.</p> <p>During an interview on 05/06/10 at 11:30 a.m., an administrative nurse (#4) confirmed facility staff failed to follow the policy and procedure for proper perineal care.</p> <p>- Review of Resident #8's medical record occurred on all days of survey. A quarterly MDS, dated 03/09/10, identified this resident as requiring extensive assistance with toileting and personal hygiene and frequently incontinent of bowel and bladder. The current care plan/care guide stated, "Bathing . . . Completely dependent for peri-care. . . . Toileting . . . Peri-care w/ [with] each incontinent episode . . ." Review of Urinary Incontinence, Dehydration, and Pressure Ulcer Resident Assessment Protocol Summary (RAPS), dated 09/08/09, identified Resident #8 "Triggers with frequent urine incontinence and wearing a brief. Staff provide good peri care after each incontinent episode . . . Staff monitor for signs and symptoms of UTI [urinary tract infection] . . . encourage fluids . . . Dehydration [RAP] . . . Triggers for being at risk for dehydration due to having a UTI in the last month. Refer to INCONTINENCE RAP. . . . Pressure Ulcers [RAP]. . . Triggers for being at risk for skin breakdown due to being . . . incontinent of bowel. Staff provide good peri care after each incontinent episode. . . ."</p> | F 312                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                     |                                                                                                                          |                            |                                                 |
|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>355074 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br>05/06/2010 |
| NAME OF PROVIDER OR SUPPLIER<br><br>TRINITY HOMES   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>305 8TH AVE NE<br>MINOT, ND 58701                                               |                            |                                                 |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                 |
| F 312                                               | <p>Continued From page 47</p> <p>Observation of cares provided by a CNA (#26) for Resident #8 on 05/04/10 identified the following:</p> <p>* At 8:40 a.m., the resident requested assistance toileting and prior to sitting on the toilet, stated she was incontinent. Observation showed the resident incontinent of a large amount of bowel movement (BM). The CNA removed the excess BM on the resident's buttocks (with wipes) prior to the resident sitting down onto the toilet seat. Upon completion of toileting, the CNA provided pericare over the resident's rectal/buttocks area only, failing to ensure proper cleansing of the resident's frontal peri area.</p> <p>* At 11:50 a.m., the CNA assisted Resident #8 to the toilet. The CNA removed the resident's brief and reported to the surveyor, the brief was "saturated [with urine]." Upon completion of toileting, the CNA provided pericares from the resident's rectal/buttock area only, failing to ensure proper cleansing of the resident's frontal peri area.</p> <p>- Review of Resident #14's medical record occurred on all days of survey. The admission MDS, dated 02/24/10, identified this resident as requiring extensive assistance with toileting and personal hygiene and occasionally incontinent of bladder and usually continent of bowel. The current care plan stated, "Elimination - occas. [occasionally] inct. [incontinent] of urine, self care deficit for toileting . . . ." A RAP summary, dated 02/24/10, identified Resident #14 as "Triggers with wearing a pull-up and occasionally incontinent of bladder. . . ."</p> <p>Observation on 05/04/10 at 10:30 a.m., showed two CNAs (#28 and #29) donned gloves and assisted Resident #14 to the toilet. The CNA (#28) removed Resident #14's visibly soiled brief.</p> | F 312                                                               |                                                                                                                          |                            |                                                 |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 312                                                    | <p>Continued From page 48</p> <p>Observation showed the CNA (#28) wiped the rectal perineal area from front to back using two disposable wipes and failed to cleanse or wipe Resident #14's frontal perineal area.</p> <p>- Resident #16's medical record, reviewed on all days of survey, identified the facility admitted the resident in 11/03. The resident's current diagnoses included dementia, urinary retention, and a stage II coccyx pressure ulcer (healed on 04/27/10).</p> <p>The resident's current MDS, dated 04/18/10, identified short and long term memory problems, moderately impaired daily decision making, required extensive assistance of two or more persons for toilet use, was frequently incontinent, and a stage II pressure ulcer.</p> <p>The resident's Activities of Daily Living (ADL) Functional Rehabilitation Potential RAP Summary, dated 08/03/09, stated "... Staff toilet her every 2-3 hours to encourage [sic] continence of bladders [sic]. She wears a pullup and staff do pericare for her after incontinent episodes. Staff should monitor her for any signs of breakdown and apply barrier cream to promote good skin integrity [sic]. ... Staff give her extensive assist of one for personal hygiene. ..."</p> <p>Resident #16's current care plan, dated 09/01/09, stated "Problem, ELIMINATION - incontinent of both bladder and bowel, self care deficit - requires extensive assistance, chronic itching to periaarea [sic] (10/22/09) ... Problem, GROOMING/PERSONAL HYGIENE - extensive assistance required (01/01/08) ...". The resident's Care Guide, dated 05/04/10, stated "Bathing ... Completely dependent for peri-care ... Toileting, Peri-care w/ [with] each incontinent episode,</p> | F 312                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 312                                                    | <p>Continued From page 49</p> <p>wears a pullup. Staff toilets every 2-3 hrs [hours]."</p> <p>The resident's medical record identified the stage II coccyx pressure ulcer healed on 04/27/10.</p> <p>Observation, on 05/05/10 at 7:53 a.m., showed Resident #16 receiving morning cares from CNAs (#7) and (#13). The staff members applied a gait belt around the resident's waist and assisted the resident to stand at the side of her bed.</p> <p>CNA (#13) assisted the resident to maintain the standing position with the gait belt, while a CNA (#7) removed the resident's brief, wiped the resident's frontal and posterior areas with the wet wash cloth, dried the areas, pulled up the pullup and slacks, and Resident #16 returned to sitting at the edge of the bed. The staff members transferred the resident to a wheelchair, completed the resident's oral and hair care, and took the resident to the dining room.</p> <p>During interview, at the completion of this episode of care, CNA (#7) reported the only care provided to the resident before the above observation was washing, drying, and applying the stockings to the lower legs. The CNA (#7) reported the resident had voided in the brief which she removed. This staff member reported she only used the wet wash cloth and no other additive for the resident's morning cares.</p> <p>The facility staff identified Resident #16 is frequently incontinent, dependent on staff for toileting and personal hygiene, has potential for skin irritation in the perineal area, and has a recently healed stage II coccyx pressure ulcer. The CNA staff members failed to provide Resident #16 the opportunity to use the toilet</p> | F 312                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                            |                                                        |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 312                                                    | Continued From page 50<br>before being dressed and going to breakfast,<br>failed to provide perineal care after incontinence,<br>and failed to provide perineal care to reduce the<br>risk of skin irritation and recurrent skin<br>breakdown.<br><br>During interview, on 05/06/10 at 8:30 a.m., a<br>nursing management staff member (#2) agreed<br>nursing staff should have toileted, and performed<br>more extensive perineal care for Resident #16.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F 312                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                            |                                                        |
| F 327<br>SS=E                                            | 483.25(j) SUFFICIENT FLUID TO MAINTAIN<br>HYDRATION<br><br>The facility must provide each resident with<br>sufficient fluid intake to maintain proper hydration<br>and health.<br><br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on observation, record review, review of<br>policy and procedure, and resident and staff<br>interview, the facility staff failed to provide fluids to<br>ensure sufficient intake for 4 of 16 sampled<br>residents (Residents #9, #16, #20, and #25)<br>requiring assistance with fluids, observed not<br>offered fluids during cares, and identified by the<br>facility with insufficient fluid intake. Failure to offer<br>fluids placed these residents at risk of<br>dehydration and recurrence of pressure ulcers.<br><br>Findings include:<br><br>Review of the facility's policy and procedure titled<br>"Fluids" occurred on 05/06/10. This policy, revised<br>04/07, stated "Residents will be offered fluids at<br>meal times according to meal plan determined by<br>dietary and at the request of the individual<br>resident. . . . Those residents who have been | F 327                                                                      | Facility denies this allegation of non-<br>compliance. F327 states "The facility must<br>provide each resident with sufficient fluid<br>intake to maintain proper hydration and<br>health."<br><br>Addressing specific residents and deficiencies<br>listed:<br><br>F327 is very specific (485.25) "Do sampled<br>residents show signs of possible insufficient<br>fluid intake (e.g. dry skin and mucous<br>membranes, cracked lips, poor skin turgor,<br>thirst, fever), abnormal laboratory values (e.g.<br>elevated hemoglobin and hematocrit,<br>potassium, chloride, sodium, albumin,<br>transferring blood urea nitrogen (BUN) or<br>urine specific gravity?"<br><br>Each resident will be addressed individually:<br><br>Resident #9: Skin Status Questionnaire done<br>quarterly and Hydration checks completed<br>weekly. No symptoms of dehydration noted.<br>Basic Metabolic Panel done 11/06/2009<br>WNL. Resident is independently able to drink<br>fluids and request fluids. Fluids also given<br>with medication . | 6/1/10                     |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                        |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | (X5)<br>COMPLETION<br>DATE                             |
| F 327                                                    | <p>Continued From page 51</p> <p>identified by nursing to be at risk for insufficient fluid intake will be monitored for clinical signs of dehydration. Residents should be checked at least weekly and documented in the medical chart. If clinical symptoms of dehydration are noted, this information will be communicated to attending physician." The facility's policy failed to ensure provision of fluids to residents requiring assistance and those that are unable to request fluids.</p> <p>- Review of Resident #9's medical record occurred on all days of survey. Resident #9's current diagnoses included constipation, cerebral vascular accident, history of pressure ulcer, and depression. The resident's Minimum Data Set (MDS), dated 04/21/10, identified total assistance with transfer, locomotion and toileting, extensive assist with bed mobility, dressing, eating, and personal hygiene. The Resident Assessment Protocol Summary (RAPS), dated 04/19/10, stated "... insufficient fluid ... diuretic ... monitor for s/s [signs and symptoms] of dehydration weekly ... " The resident's medication administration record included Lasix (diuretic) daily, KCL (potassium) daily and multivitamin with iron.</p> <p>Resident #9's nutrition questionnaire, dated 04/15/10, indicated overall fluid intake is 50-75% at meals. A dietary progress note, dated 04/19/10, stated, "... does continue to sit at a feeder table ... Staff should continue to offer and encourage fluids at and between meals. ... "</p> <p>Resident #9's current care plan, dated 09/01/09, stated "Problem: Potential for Dehydration ... Approach: Monitor for S&amp;S dehydration every week on W [Wednesday], Lasix 40 mg</p> | F 327                                                                      | <p><b>Resident #25:</b> Skin Status Questionnaire and Hydration checks completed weekly. No symptoms of dehydration noted. Physical Exam done May 13, 2010 completed by physician-no dehydration noted. Basic Metabolic Panel done 3/28, 3/30, and 5/12/2010 WNL. Resident also receives 100 cc water flushes per G-tube every 4 hours. Fluids also given with medication .</p> <p><b>Resident #16:</b> Skin Status Questionnaire completed quarterly-done 4/13/2010 and hydration checks completed weekly-No symptoms of dehydration. Resource Breeze 8 ounces offered three times daily, resident normally takes all supplements. Medications administered four times daily with 100-180 cc's water. Labs done 1/18/2010 are WNL.</p> <p><b>Resident #20:</b> (Resident is 103 years old) Skin Status Questionnaire completed quarterly and hydration checks completed weekly. These show no symptoms of dehydration. Resident offered thickened liquids with medications (100-180cc) three times daily. Resident also offered ensure or health shakes (4-6 ounces) TID.</p> <p>In the spirit of cooperation, please find the following:</p> <p>Staff instructed to remember to always have water within reach of the resident, offer fluids often, and cue residents to drink. All residents involved were assessed and have no hydration deficits.</p> |  |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                        |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | (X5)<br>COMPLETION<br>DATE                             |
| F 327                                                    | <p>Continued From page 52</p> <p>[milligrams] daily. . ." The resident's record indicated a stage I left heel pressure ulcer healed on 11/23/09.</p> <p>Observation of Resident #9 included the following:</p> <ul style="list-style-type: none"> <li>* 05/04/10 at 8:33 a.m. - Resident #9 independently eating breakfast. Facility staff did not cue resident to finish drinking the fluids offered with the meal.</li> <li>* 05/04/10 at 9:12 a.m. - Two CNAs (#22 and #23) toileted Resident #9 in her room using a commode. These staff members failed to offer Resident #9 fluids and left the room with the resident's fluids on her bedside stand, out of her reach.</li> <li>* 05/04/10 at 1:30 p.m. - Resident #9 in bed with fluids out of her reach.</li> <li>* 05/04/10 at 3:40 p.m. - CMA (#24) entered Resident #9's room and discussed the resident's medication regimen for constipation complaints. The CMA (#24) did not offer Resident #9 fluids and the water glass remained out of the resident's reach.</li> <li>* 05/05/10 at 9:30 a.m. - Resident #9 lying in bed, the bedside stand and fluids out of her reach.</li> <li>* 05/05/10 at 2:00 p.m. - Resident #9 lying in bed with fluids out of reach.</li> </ul> <p>The facility staff failed to offer fluids and ensure fluids within reach of Resident #9 to maintain hydration.</p> <p>- Resident #25's medical record, reviewed on May 05-06, 2010, identified the resident's current diagnoses included cancer of the head/face/neck (radiation and chemotherapy), tracheostomy with suctioning every shift and as needed, Peg feeding tube (feedings currently on hold), catatonic schizophrenia, congestive heart failure, high</p> | F 327                                                                      | <p>All residents have the potential to be affected.</p> <p>Ongoing education provided to all staff, and will continue with addressing the importance of adequate hydration with current employees, as well as in new C.N.A. orientation.</p> <p>Monthly random review of medical records will be done and nurse managers will compare chart audits with communication notes. Audits will be submitted to Quality Assurance Committee monthly, and once compliance is obtained will do quarterly audits.</p> <p>The Director of Nursing will be responsible for this process</p> |  |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 327                                                    | <p>Continued From page 53</p> <p>blood pressure, and renal disease. The resident has history of a stage II coccyx pressure ulcer healed on 02/25/10 and urinary tract infections. The resident's MDS, dated 04/12/10, indicated short term and long term memory problems, moderate impairment with daily decisions, difficulty making self understood, total assist with transfer and locomotion, and extensive assist with dressing, eating, toileting, and personal hygiene. Resident #25's Resident Assessment Protocol Summary (RAPS), dated 02/22/10, stated ". . . insufficient fluid intake, . . . swallowing problem, . . ."</p> <p>Resident #25's care plan, dated 02/11/10, indicated ". . . swallowing problems . . . tube feeding on hold (03/29/10), eating orally, independent with set-up, pureed diet with honey thickened liquids . . ." The resident's care plan did not address the potential for dehydration or interventions to provide adequate fluids to maintain hydration.</p> <p>Observation of facility staff providing Resident #25's care included the following:</p> <ul style="list-style-type: none"> <li>* 05/05/10 at 1:00 p.m. - Resident #25 seated in wheelchair near nursing station with no fluids available.</li> <li>* 05/05/10 at 2:55 p.m. - Resident #25 remained seated in wheelchair near nursing station without accessible fluids. Three other residents in the area were offered fluids by nursing staff.</li> <li>* 05/05/10 at 3:30 p.m. - Resident #25 toileted in the resident's bathroom by a CNA (#27). The CNA (#27) failed to offer Resident #25 fluids following care, pushed him back to the nursing station area, and again failed to offer fluids.</li> <li>* 05/05/10 at 4:10 p.m. - Resident #25 remains seated in wheelchair at the nurses station without</li> </ul> | F 327                                                                      |                                                                                                                          |  |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 327                                                    | <p>Continued From page 54</p> <p>fluids available.</p> <p>* 05/05/10 at 5:00 p.m. - Resident #25 continued to remain at nurses station without fluids.</p> <p>Observation showed Resident #25 received no fluid intake for four hours.</p> <p>An interview with an administrative nursing staff member (#19) occurred the afternoon of 05/05/10. The staff member (#19) agreed nursing staff should offer fluids with cares and ensure their availability, i.e. within reach of the resident (unless otherwise indicated).</p> <p>The facility identified Residents #9 and #25 as dependent on staff for assist with fluid intake. Failure to offer Residents #9 and #25 fluids placed the residents at risk of dehydration and recurrence of the pressure ulcer.</p> <p>- Review of Resident #16's medical record occurred on all days of survey. Resident's #16's current diagnoses included dementia, esophageal stricture, and constipation. The resident's current Minimum Data Set (MDS), dated 04/18/10, identified short and long term memory problems, moderately impaired daily decision making, extensive assistance required for eating, consumption of insufficient fluids, and a stage II pressure ulcer.</p> <p>Resident #16's Cognitive Loss Resident Assessment Protocol Summary (RAPS), dated 08/03/09, stated "... memory loss and need for assistance with decisions secondary to her dementia &amp; [and] recent stroke. ..." The resident's Nutrition Assessment, dated 04/14/10, stated "... Fluids averaging 61% in past 3 days. Potential for dehydration related to occasionally</p> | F 327                                                                      |                                                                                                                          |  |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                     |                                                                                                                          |                            |                                                 |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>355074 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br>05/06/2010 |
| NAME OF PROVIDER OR SUPPLIER<br><br>TRINITY HOMES   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>305 8TH AVE NE<br>MINOT, ND 58701                                               |                            |                                                 |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                 |
| F 327                                               | <p>Continued From page 55</p> <p>leaves 25% or more at meals and diuretic use. Offer and encourage fluids at and between meals. . . ."</p> <p>Resident #16's current care plan, dated 09/01/09, stated "Problem, NUTRITION/FEEDING . . . (04/19/10) . . . Approach . . . Food/Fluid Intake Da [Days] [dated 01/15/07], Food/Fluid PM [Evenings] [dated 01/15/07] . . . Problem, POTENTIAL FOR DEHYDRATION - Occasionally leaves 25% or more of fluids offered, (04/19/10) . . . Approach, Edema Checks - weekly edema checks Every [sic] week on W [Wednesday] [dated 04/11/07], Monitor for S&amp;S [signs and symptoms] dehydration Every [sic] week on W [Wednesday] [dated 11/14/07] . . ."</p> <p>Resident #16's medical record identified the stage II coccyx pressure ulcer healed on 04/27/10.</p> <p>Observation of facility staff providing cares for Resident #16 were as follows:<br/>*05/04/10, 9:20 a.m. - Certified nursing assistants (CNAs) (#7) and (#8) assisted the resident with toileting in the resident care unit's tub room. After toileting, the CNAs (#7) and (#8) pushed the resident in her wheelchair to the Lounge for an activity of listening to the newspaper being read. Intermittent observation of this activity, identified facility staff failed to offer fluids to Resident #16 and the other four residents in the Lounge.<br/>*05/04/10, 10:50 a.m. - CNAs (#9) and (#10) pushed Resident #16 in her wheelchair to her room and assisted the resident to the toilet. After toileting, the CNAs (#9) and (#10) returned the resident to her wheelchair and to the Lounge to watch television. The CNAs failed to offer fluids to Resident #16.<br/>*05/04/10, 11:40 a.m. - Resident #16 seated in</p> | F 327                                                               |                                                                                                                          |                            |                                                 |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 327                                                    | <p>Continued From page 56</p> <p>her wheelchair at the dining room table with a glass of water on the table, at a full arm's length from the resident, and the resident unable to access the glass of water.</p> <p>*05/04/10, 3:20 p.m. - CNAs (#11) and (#12) assisted the resident with toileting in the resident care unit's tub room. After toileting, the CNAs (#11) and (#12) pushed the resident in her wheelchair to the Lounge for an activity. The CNAs failed to offer fluids to Resident #16.</p> <p>*05/05/10, 9:35 a.m. - CNAs (#13) and (#14) assisted the resident with toileting in the resident care unit's tub room. After toileting, the CNAs (#13) and (#14) pushed the resident in her wheelchair to the Lounge for an activity of listening to the newspaper being read. The CNAs failed to offer fluids to Resident #16. Intermittent observation of this activity, identified facility staff failed to offer fluids to Resident #16 and the other three residents in the Lounge.</p> <p>During interview, on 05/06/10 at 8:30 a.m., a nursing management staff member (#2) agreed the CNA staff members should have offered fluids to Resident #16 during the episodes of cares noted above.</p> <p>Facility staff identified Resident #16 at risk of dehydration, dependent on staff, and displayed a history of pressure ulcers. Failure to offer Resident #16 fluids during cares placed this resident at risk of dehydration and recurrence of the coccyx pressure ulcer.</p> <p>- Review of Resident #20's medical record occurred on May 04-06, 2010 and identified diagnoses of failure to thrive, anemia, depressive disorder, and chronic pain.</p> | F 327                                                                      |                                                                                                                          |                            |                                                        |

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

|                                                     |                                                                            |                                                                  |                                                        |
|-----------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
|-----------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------|

|                                                          |                                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b> |
|----------------------------------------------------------|------------------------------------------------------------------------------------|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|
| F 327                    | <p>Continued From page 57</p> <p>Resident #20's annual Minimum Data Set (MDS), dated 04/30/10, identified the resident required extensive one person physical assistance with eating, failed to consume adequate fluids during the 3 day assessment period, a nutritional problem of leaving 25% or more of food uneaten at most meals, and nutritional approaches of receiving a mechanically altered diet and dietary supplemental between meals. The RAPS, dated 04/30/10, stated, "... Insufficient fluid in last 3 days. Diuretic ... Triggers with daily Lasix and Spironolactone. Monitor for s/s [signs/symptoms] of edema. Triggers for insufficient fluids in the last 3 days proceed to care plan and nutrition questionnaire on 04/24/10."</p> <p>Review of Resident #20's Nutrition Questionnaire, dated 04/24/10, identified an overall fluid intake of 50-75% and stated "... fluids averaging 56% at meals- potential for dehydration related to occasionally leaves 25% or more at meals- she is able to request and drink fluids on her own and has water pitcher in room and snacks offered between meals.</p> <p>Review of Resident #20's current plan of care, dated 08/07/09, stated "Problem: Potential for Dehydration- diuretic use and occasionally leaves 25% or more of fluids offered (04/29/09) ... Approach: Monitor for S/S dehydration every week on Sa [Saturday] (started 11/15/08)." Observation on 05/05/10 at 2:50 p.m. showed two certified nursing assistants (CNAs) (#39 and #41) transferred Resident #20 from her bed and placed her into a wheelchair. Upon completion of care, these CNAs failed to offer fluids to Resident #20. Observation showed a water glass on the bedside table out of Resident #20's reach. During interview at 4:05 p.m., a CNA (#41) stated she did</p> | F 327               |                                                                                                                          |                            |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            |                                                        |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 327                                                    | Continued From page 58<br>not know if Resident #20 consumed her afternoon snack, which staff provided earlier, as she assisted a different resident. At 4:10 p.m., Resident #20 stated staff failed to offer or provide her with an afternoon snack and stated "I have water, but I can't reach it" (referring to the water glass on her bedside table.) At 4:15 p.m., observation showed CNA (#41) provided and assisted Resident #20 to drink 6 ounces of cranberry juice.<br><br>Facility staff identified Resident #20 required one person physical assistance to eat and consume fluids and at risk of dehydration. Failure of staff to offer Resident #20 fluids during cares placed the resident at risk of dehydration.                                                                                                                                                                                         | F 327                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            |                                                        |
| F 333<br>SS=D                                            | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of policy and procedure, review of professional reference, resident interview, and staff interview, the facility failed to ensure residents are free of significant medication errors regarding administration of medications to residents who do not wish to self administer medications (Resident #17, #23, and #35), for 3 of 4 days (May 04-06, 2010) of survey. Failure to ensure medications facility staff administered medications according to accepted professional standards and principles placed these residents at risk of not taking their medications as ordered and all residents at risk of taking medications prescribed for other residents. | F 333                                                                      | Review of policies and procedures done with staff involved. All medications are to be given to the resident and the staff is to observe the resident actually taking the medication. Staff member involved has been counseled.<br><br>All residents have the potential to be affected by medications left with residents.<br><br>Education will be given to all professional staff and medication aides. This education will include standards of care and review of the policy and procedures for medication administration.<br><br>Observations will be done randomly on a weekly basis to insure that all staff are following proper procedure for medication administration. These observations will be done by Staff Education Nurse and Nurse Managers. Audits will be done on a monthly basis and reported to the Quality Assurance Committee.<br><br>The Director of Nursing will be responsible for this process. | 6/1/10                     |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 333                                                    | <p>Continued From page 59</p> <p>Findings include:</p> <p>Kozier and Erb's, "Fundamentals of Nursing, Concepts, Process and Practice," 8th edition, Pearson, Prentice Hall, New Jersey, page 846, states "Practice Guidelines, Administering Medications . . . Do not leave medications at the bedside, with certain exceptions . . . Check agency policy. . . ."</p> <p>Review of the facility policy and procedure, ADMINISTRATION OF MEDICATIONS, occurred on 05/06/10. This policy and procedure, revised in 04/07, stated "OBJECTIVE: 1. To administer medications as ordered by the doctor for treatment of injury and disease. . . . STEPS IN PROCEDURE: . . . 4. Administer oral medications and remain with resident until the medication has been taken. Never leave a medication in a resident's room. . . ."</p> <p>Review of the facility policy and procedure, SELF ADMINISTRATION OF MEDICATION, occurred on 05/06/10. This policy and procedure, revised in 04/07, stated "POLICY, Residents have the right to self administer medications if desired unless determined unsafe. . . ."</p> <p>- Observations in the dining room included the following medication passes:<br/>*05/04/10, 8:10 a.m. - Resident #23 seated at the dining room table with a number of medications, which she consumed independently. Two other residents were seated at the table.<br/>*05/05/10, 8:10 a.m. - Resident #23 and Resident #17 seated next to one another at the dining room table, each with a number of medications, which they consumed independently. One other resident</p> | F 333                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 333                                                    | <p>Continued From page 60</p> <p>sat at the table.</p> <p>*05/06/10, 8:25 a.m. - Resident #35 seated at the dining room table with a number of medications, which she consumed independently. No other residents sat at the table.</p> <p>During interview, on 05/05/10 at 8:45 a.m., a licensed nurse (#37) reported the medication nurse will leave medications with some residents to be consumed during their meals. This staff member reported the medication nurse will follow up with each resident to be sure the resident consumed the medications.</p> <p>During interview, on 05/05/10 at 5:15 p.m., Resident #17 reported the facility staff leave medications at the dining room table for her and her tablemate, Resident #23, to take without supervision at all meals.</p> <p>- Review of Resident #17's current Minimum Data Set, dated 04/01/10, identified no short or long term memory problems. The facility identified the resident was interviewable.</p> <p>Review of the medical records for Resident #17, #23, and #35 occurred on May 04-06, 2010. The residents' records included the "Self Admin [Administration] of Meds [Medications] Questionnaire" which stated "1. RESIDENT WISHES TO SELF - ADMINISTER MEDICATIONS" and indicated "NO" for Resident #17, #23, and #35. The questionnaire is dated as follows:<br/>Resident #17 - 03/26/10<br/>Resident #23 - 05/01/10<br/>Resident #35 - unknown</p> <p>During review of the residents' medication</p> | F 333                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 333                                                    | Continued From page 61<br>administration records (MARs) and interview, on 05/06/10 at 9:15 a.m., a certified medication aide (CMA) (#11) reported the facility staff administered the following types of medications to the residents at the time of the observations previously noted:<br>*Resident #17 - vitamin and mineral supplements, thyroid, blood pressure, chest pain, bladder, anti-seizure medications, and medications affecting blood clotting.<br>*Resident #23 - vitamin and mineral supplements, pain, bowel, bladder, steroid, and fluid control medications.<br>*Resident #35 - vitamins, pain, blood pressure, diabetic, anti-depressant, bladder, blood pressure medications, and medications affecting blood clotting.<br><br>During interview, on 05/06/10 at 8:30 a.m., a nursing management staff member agreed leaving medications with residents who staff have not assessed to self administer medications is not an acceptable practice.<br><br>Failure to administer medications in a safe manner, leaving the medications for the residents to self administer, placed the residents at risk of not consuming the correct medications in a timely manner. This practice placed other residents at risk of consuming medications not prescribed for them. Failure to consume prescribed medications in a timely manner and consuming medications not prescribed may result in illness and complications. | F 333                                                                      |                                                                                                                          |                            |                                                        |
| F 371<br>SS=E                                            | 483.35(i) FOOD PROCURE,<br>STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | F 371                                                                      |                                                                                                                          | 6/1/10                     |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |                                                        |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 371                                                    | <p>Continued From page 62</p> <p>considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>1. Based on observation, review of policy and procedure, professional literature review, and staff interview, the facility failed to ensure proper concentration of sanitizer solution and failed to store food under sanitary conditions in 1 of 1 kitchen on 2 of 4 days of survey (May 3-4, 2010). These practices have the potential to increase the risk of food borne illness and can affect all residents who eat food stored and prepared in these areas.</p> <p>Findings include:</p> <p>The 2005 FDA Food Code, Public Health Reasons, page 440 states, "the effectiveness of chemical sanitizers can be directly affected by the . . . concentration of the sanitizer solution used . . . Therefore, it is critical to sanitization that the sanitizers are used properly and the solutions meet the minimum standards. . ."</p> <p>The 2005 Food Code, Public Health Reasons, page 377, states ". . . Soiled wiping cloths, especially when moist, can become breeding grounds for pathogens that could be transferred to food. Any wiping cloths that are not dry (except those used once and then laundered) must be stored in a sanitizer solution at all times, with the</p> | F 371                                                                      | <p>Overhead cleaning has been done. Bleach to water bucket was recalibrated to proper strength. Families/residents were reminded to clean and maintain their personal refrigerators, which was done.</p> <p>All residents have the potential to be affected.</p> <p>Bleach mix calibration updated in policy. Appropriate measuring containers and test strips obtained.</p> <p>Plant operations will assist dietary staff in high cleaning, removing grates, etc.</p> <p>Families and residents will be reminded to clean their refrigerators if they become delinquent.</p> <p>Random bleach concentration testing, over head cleaning and personal refrigerator checks will be observed/done weekly and reported to Q.A. committee monthly.</p> <p>Dietary manager will be responsible.</p> |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                     |                                                                                                                          |                            |                                                 |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>355074 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br>05/06/2010 |
| NAME OF PROVIDER OR SUPPLIER<br><br>TRINITY HOMES   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>305 8TH AVE NE<br>MINOT, ND 58701                                               |                            |                                                 |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                 |
| F 371                                               | <p>Continued From page 63</p> <p>proper sanitizer concentration in the solution. Wiping cloths soiled with organic material can overcome the effectiveness of, and neutralize, the sanitizer. The sanitizing solution must be changed as needed to minimize the accumulation of organic material and sustain proper concentration. Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit . . ."</p> <p>Review of a facility policy regarding sanitation of kitchen equipment, titled "Proper Sanitation of Equipment--Can opener", occurred on 05/04/10. This policy, revised May 2000, stated, "Procedure: 1. Equipment and supplies . . . c. Sanitizing solution [bleach]* . . . *Bleach must be 100 parts per million (ppm)."</p> <p>Review of the dietary instruction form regarding testing of chlorine strips occurred on 05/04/10. This form, untitled and undated, stated, "Test strip for chlorine read: please dip strip into water for 10 seconds and compare strip to color chart and be sure it reads 50-100 ppm. Do a chlorine test with each change of water."</p> <p>- The initial tour of the kitchen occurred on 05/03/10 at 10:30 a.m. with the administrative dietary staff members (#38 and #44), and a dietary staff member (#46). During the tour, observation showed a red bucket of solution inside a two compartment sink with a wiping cloth immersed in the solution. The dietary staff member (#44) identified the solution as a chlorine solution (water and bleach), and indicated staff used the solution to sanitize surfaces and appliances in the kitchen. When asked to test the concentration of the solution, a dietary staff</p> | F 371                                                               |                                                                                                                          |                            |                                                 |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 371                                                    | <p>Continued From page 64</p> <p>member (#45) obtained test strips and tested the solution with four test strips at the same time. The four test strips remained unchanged in color, which would indicate no sanitizer present in the solution. Observation of test strips identified the staff use the strips to test concentration levels of chlorine solutions. The dietary staff member (#45) stated she used one capful of bleach to one bucket of water to make the bleach solution, and the solution tested contained this mixture. Further observation showed a red bucket of solution located on the counter in the bakers' area. The dietary staff member (#44) identified the bucket contained chlorine solution. When asked to test the concentration of this solution, the dietary staff member (#38) obtained a chlorine test strip and tested the solution. The test strip remained unchanged in color.</p> <p>The main tour of the kitchen occurred on 05/04/10 at 1:45 p.m. with administrative dietary staff members (#38 and #44), and a dietary staff member (#46). During the tour, observation showed a dietary staff member (#47) mixed a bucket of bleach and water solution, and she stated she used an approximately 3/4 full capful of bleach to mix with the bucket of water. This surveyor requested a ppm test of the solution. The staff member (#47) obtained a chlorine test strip, tested the solution, and obtained a result of 25 ppm. The staff member stated she expected the solution ppm to range from 50-100 ppm, so she added another capful of bleach to the water. When she re-tested the solution, the results read 50 ppm.</p> <p>An interview occurred with the administrative dietary staff members (#38 and #44) and the dietary staff member (#47) at the conclusion of</p> | F 371                                                                      |                                                                                                                          |  |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 371                                                    | <p>Continued From page 65</p> <p>the main tour of the kitchen. The dietary staff member (#44) stated a chemical supply company representative visited the facility on 05/03/10 and provided the facility with new chlorine test strips. She stated the chlorine strips used to test chlorine solutions on the initial dietary tour were either the incorrect strips (quaternary testing strips-used to test quaternary solution mixes), or the chlorine strips were old and outdated. The staff member also confirmed she was unsure of what chlorine to water solution measurements were needed to obtain desired ppm results.</p> <p>During the initial tour of the kitchen on 05/03/10 at 10:30 a.m., observations showed the following items with a build-up of dust:</p> <ul style="list-style-type: none"> <li>*Two mounted wall fans, in the dishroom and located at both ends of the dish machine</li> <li>*Floor underneath the dish machine</li> <li>*Pipes located directly above the deep fryer, range, and stove top</li> <li>*A ceiling fan facing a three compartment sink</li> <li>*Two ceiling vents located directly above the meat/cooks' area</li> <li>*Two fans located in the produce/vegetable walk-in cooler</li> <li>*Three of four fans located in the dairy cooler</li> </ul> <p>During the main tour of the kitchen on 05/04/10 at 1:45 p.m., observation of the above items showed the build-up of dust remained.</p> <p>During the main dietary tour, a dietary staff member (#46) stated the fans in the dish room were scheduled to be wiped down every night. The administrative dietary staff member (#44) stated staff clean the fans in the walk-in coolers every six months, but should clean them more frequently due to the build-up of dust.</p> | F 371                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 371                                                    | <p>Continued From page 66</p> <p>2. Based on observation, review of professional literature, and staff interview, the facility failed to ensure residents' personal food items remained stored under sanitary conditions in 2 of 6 residents' personal refrigerators on 2 of 2 days observed (May 3-4, 2010). These practices have the potential to increase the risk of food borne illness and can affect all residents who eat food stored in personal refrigerators.</p> <p>Findings include:</p> <p>The 2005 Food Code, Public Health Reasons, page 401, states, "It is not the intent of this provision to give a product an extended shelf life beyond that intended by the manufacturer. Manufacturers assign a date to products for various reasons, and spoilage may or may not occur before pathogen growth renders the product unsafe . . . if the product becomes inferior quality-wise due to time in storage, it is possible that safety concerns are not far behind . . . ."</p> <p>The 2005 Food Code, Public Health Reasons, page 375, states, "Food that is inadequately packaged . . . could become contaminated by microbes, dust, or chemicals . . . Packaging must be appropriate for preventing the entry of microbes and other contaminants . . . These contaminants may be present on the outside of containers and may contaminate food . . . Certain foods may be difficult to identify after they are removed from their original packaging. Consumers may be allergic to certain foods or ingredients . . . The mistaken use of an ingredient, when the consumer has specifically requested that it not be used, may result in severe medical consequences. . . ."</p> | F 371                                                                      |                                                                                                                          |  |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 371                                                    | <p>Continued From page 67</p> <p>- During the initial tour, on 05/03/10 at approximately 11:20 a.m., observation identified the following items in a resident's personal refrigerator:<br/>*Room 363 - Two half pints of skim milk, one sealed and dated 04/08/10 (25 days prior), and the other opened and dated 04/14/10 (19 days prior).</p> <p>Observation of residents' personal refrigerators on 05/04/10 between 9:45 a.m. and 10:00 a.m. identified the following items:<br/>*Room 310 - A half pint of whole milk, sealed and dated 02/18/10 (75 days prior). A styrofoam cup, which lacked a label, date, or cover, with a dried white substance inside.<br/>*Room 363 - The two half pints of skim milk found 05/03/10 remained. Also, a half pint of two percent milk, opened and dated 12/20/09 (135 days prior), and a sealed half pint of skim milk dated 03/24/10 (41 days prior) were observed.</p> <p>An interview occurred on 05/04/10 at 1:45 p.m. with the administrative dietary staff members (#38 and #44). When asked who is responsible for ensuring the safety of food stored in residents' personal refrigerators, these staff members stated the nursing staff, family members of residents, and/or residents are responsible.</p> <p>During an interview on 05/05/10 at 3:20 p.m., an administrative staff member (#6) stated the family members of residents' or a resident's power of attorney (POA), is responsible for upkeep with the resident's refrigerators. When asked, she also stated no documentation existed regarding education done by the facility to family members and/or Power of Attorneys, regarding food safety</p> | F 371                                                                      |                                                                                                                          |  |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |        |                                                        |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |        | (X5)<br>COMPLETION<br>DATE                             |
| F 371                                                    | Continued From page 68                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F 371                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |        |                                                        |
| F 373<br>SS=D                                            | <p>and upkeep of residents' personal refrigerators.</p> <p><b>483.35(h) FEEDING ASST -<br/>TRAINING/SUPERVISION/RESIDENT</b></p> <p>A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law.</p> <p>A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).</p> <p>In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.</p> <p>A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems.</p> <p>Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.</p> <p>The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.</p> <p>NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160:</p> <ul style="list-style-type: none"> <li>o A State-approved training course for paid feeding assistants must include, at a minimum, 8</li> </ul> | F 373                                                                      | <p>Paid feeding assistants are regular staff who work in other areas. All paid feeding assistants must go through an 8 hour paid feeding assistant program provided by the Staff Education Nurse. <i>* The paid feeding assistant program covers exactly the same information that is covered in the Certified Nursing program.</i> Residents will all be evaluated to make sure that it is appropriate for them to be fed by a paid feeding assistant. Feeding assistants will continue to be under the supervision of an RN or LPN. Residents #19 and 20 did not have assessments due to them being admitted before we started doing feeding assessments, but assessments have since been completed. All residents utilizing feeding assistants have had their assessments reviewed and updated.</p> <p>All residents who need assistance with feeding have the potential to be affected.</p> <p>All residents will have quarterly feeding assessments completed with the MDS. This information added to the care plan/care guide as appropriate. Residents who have no difficulty with eating may have a feeding assistant feed them at meal times, and this will be incorporated into the plan of care and addressed on the care plan.</p> | 6/1/10 |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 373                                                    | <p>Continued From page 69</p> <p>hours of training in the following:</p> <ul style="list-style-type: none"> <li>Feeding techniques.</li> <li>Assistance with feeding and hydration.</li> <li>Communication and interpersonal skills.</li> <li>Appropriate responses to resident behavior.</li> <li>Safety and emergency procedures, including the Heimlich maneuver.</li> <li>Infection control.</li> <li>Resident rights.</li> <li>Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.</li> </ul> <p>A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, review of facility policy and procedure, professional literature, and staff interview, the facility failed to assess and care plan 2 of 2 sampled residents (Resident #19 and #20) observed fed by paid feeding assistants (PFAs) (#15 and #31). In addition, the facility failed to determine whether a PFA could safely feed a resident (Resident #16) identified with swallowing difficulty. Failure to ensure a PFA feeds only residents with no complicated feeding problems has the potential to place residents at risk for choking and aspiration.</p> <p>Findings include:</p> <p>The Centers for Medicare and Medicaid Services</p> | F 373                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                        |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                                                                                                                                                                                                                                                                                                           |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                                                                                                                                                                                                                                                                                                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                   |  | (X5)<br>COMPLETION<br>DATE                             |
| F 373                                                    | <p>Continued From page 70</p> <p>(CMA) has outlined the standard of practice regarding allowing PFAs to assist residents with eating and stated, "The intent of this regulation is to ensure that employees who are used as paid feeding assistants are: . . . assisting only those residents without complicated feeding problems and who have been selected as eligible to receive these services from a paid feeding assistant; and providing assistance in accordance with the resident's needs, based on individualized assessment and care planning."</p> <p>Review of the facility policy titled, "Paid Feeding Assistants" occurred on 05/05/10. This policy stated, ". . . Paid Feeding Assistants feed only residents who have no complicated feeding problems (i.e., difficulty swallowing, recurrent lung aspiration . . .). An assessment of each resident must be completed by a nurse to determine if the resident may be fed by a Paid Feeding Assistant. The use of a Paid Feeding Assistant to feed a resident must be included on that resident's plan of care. . . .</p> <p>Procedure: 1. The nurse will asses the resident on admission and as problems arise with condition changes. . . . 2. The nurse will assign the Paid Feeding Assistant to the resident's that they can feed. 3. The nurse will place on the care plan that a Paid Feeding Assistant can feed the resident following the assessment. . . . 6. All Paid Feeding Assistants will have an annual competency test."</p> <p>- Observation on in the 3rd West Unit dining room on 05/04/10 at 12:15 p.m. identified a staff member (#31) fed Resident #20. The facility employed staff member (#31) as a PFA.</p> <p>Review of Resident #20's medical record</p> | F 373                                                                      | <p>Monthly random audits of the resident MDS and Care Plan will be done by the Charge Nurses and/or Nurse Manager to ensure that the residents that are being fed by feeding assistants are have no feeding,/swallowing/ and/or chewing difficulties. These reports will be given to Quality Assurance and be reported quarterly.</p> <p>The Director of Nursing will be responsible for this process.</p> |  |                                                        |

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

|                                                     |                                                                            |                                                                  |                                                        |
|-----------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
|-----------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------|

|                                                          |                                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b> |
|----------------------------------------------------------|------------------------------------------------------------------------------------|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|
| F 373                    | <p>Continued From page 71</p> <p>occurred on May 04-06, 2010. Medical diagnoses included failure to thrive, anemia, depressive disorder and chronic pain. Resident #20's significant change Minimum Data Set (MDS) dated 05/01/09, identified the resident as independent in eating and an annual MDS dated 04/30/10, identified extensive one person physical assistance with eating.</p> <p>Review of Resident #20's current plan of care dated 08/07/09, identified the problem "Nutrition/Feeding" and an approach of allowing a PFA to assist/feed the resident. Review of Resident #20's "Feeding Assessment," dated 11/06/08, stated "... Choking noted with swallowing? No. Comments: Res [resident] needs food to be set up and encouraged to eat. Resident assessed for any complicated feeding problems and may be fed by a feeding assistant. No."</p> <p>A dietary note, dated 04/22/10 and completed by a nursing staff member, identified Resident #20 as "having problems with chewing regular meat" and recommended mechanical soft texture foods. A "Nutrition Questionnaire" dated 04/24/10 and completed by the Licensed Registered Dietician (LRD), identified the resident currently displayed "chewing problems." The facility implemented a change in the diet texture on 04/22/10 and moved the resident to a "feeder table."</p> <p>During interview on 05/05/10 at 8:30 a.m., an administrative nursing staff member (#2) stated nursing staff complete a feeding assessment on residents upon admission, annually, or with significant change in condition. This staff member confirmed the facility failed to complete an assessment in 2009 and has not completed an</p> | F 373               |                                                                                                                          |                            |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 373                                                    | <p>Continued From page 72<br/>assessment thus far in 2010 for Resident #20.</p> <p>- Observation in the dining room on 05/04/10 at 8:45 a.m., identified staff member (#15) fed Resident #19. The facility identified staff member (#15) as a paid feeding assistant.</p> <p>Review of Resident #19's medical record identified diagnoses of gastroesophageal reflux disease (GERD), dementia, and chronic paranoid schizophrenia. Resident #19's quarterly MDS, dated 03/02/10, identified the resident as requiring extensive assistance with eating.</p> <p>Resident #19's current plan of care, dated 03/18/10, included the problem of GERD, totally dependent on staff for eating, and eats some finger foods independently. The care plan failed to identify a PFA could feed Resident #19.</p> <p>Resident #19's nurses notes, dated 04/15/10 at 12:41p.m., stated, "... Left side of face drooping, not making eye contact and not talking. Update sent to [doctor name]. ... 22.02, [10:02 p.m.]Staff reports resident was pocketing food @ [at] suppertime, Pale. Left side of face droopy. Lower lip protuberant. Drools @ times. No adverse behaviors [sic]." The facility failed to provide any additional information referring to the above documentation.</p> <p>Review of the medical records showed no evidence of an assessment related to Resident #19's pocketing food, drooling, or left sided drooping. The medical record lacked evidence of a completed and documented assessment to determine whether a PFA could safely feed Resident #19.</p> | F 373                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 373                                                    | <p>Continued From page 73</p> <p>On 05/06/10 at 11:25 a.m., and administrative nursing staff member (#6) stated Resident #19 was going through a medication adjustment at the time of the notation in the nurses notes. The facility provided no further information.</p> <p>The facility failed to ensure PFAs feed only residents with no complicated feeding problems. Allowing PFAs to feed residents with complicated feeding problems has the potential to place residents at risk for choking and aspiration.</p> <p>- Observation on 3 of 4 days of survey (May 04-06, 2010) identified an erasable message board at the nurse's station on Resident #16's resident care unit. The message board included a list of residents on the unit who nursing staff assessed for feeding assistance by a paid feeding assistant (PFA). The list included Resident #16.</p> <p>Resident #16's medical record, reviewed on all days of survey, identified the facility admitted the resident in 11/03. Current diagnoses included dementia and esophageal strictures. The resident's current Minimum Data Set (MDS), dated 04/18/10, identified chewing and swallowing problems.</p> <p>Resident #16's Nutrition Assessment, dated 04/14/10, "... Due to swallowing issues is now on Pureed Texture. ... She has had problems past year with swallowing issues. 02/04/09 found ulcer to esophagus and has had several throat dilations since. ..."</p> <p>Resident #16's current care plan, dated 09/01/09, stated "Problem, NUTRITION/FEEDING - at risk for choking r/t [related to] swallowing impairment. ... Approach [dated 11/12/09] Diet - Pureed ..."</p> | F 373                                                                      |                                                                                                                          |  |                                                        |

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

|                                                     |                                                                     |                                                                  |                                                 |
|-----------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>355074 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY<br>COMPLETED<br><br>05/06/2010 |
|-----------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------|

|                                                   |                                                                            |
|---------------------------------------------------|----------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>TRINITY HOMES | STREET ADDRESS, CITY, STATE, ZIP CODE<br>305 8TH AVE NE<br>MINOT, ND 58701 |
|---------------------------------------------------|----------------------------------------------------------------------------|

|                          |                                                                                                                              |                     |                                                                                                                          |                            |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|

F 373 Continued From page 74  
The resident's Care Guide, provided to the facility's direct care staff, dated 05/04/10, stated "Eating, Fed by CNA [certified nursing assistant] or nurse only - feeds self some. . . . Hx [History] swallowing problems. . . ."

During interview, on 05/05/10 at 10:45 a.m., a supervisory nursing staff member (#1) reported the resident's name on the list on the erasable board did indicate the PFA could assist Resident #16. This staff member identified the resident did have a history of swallowing problems but "has been doing really well." The staff member (#1) reported the unit did not have any PFAs assisting residents at the time of the survey.

During interview, on 05/06/10 at 8:30 a.m., a management nursing staff member (#2) confirmed Resident #16's name on the erasable board indicated PFAs could assist the resident to eat. This staff member (#2) agreed Resident #16's name should not be on the list of residents to be assisted by PFAs due to the resident's history of swallowing problems.

Placement of Resident #16's name on the list of unit residents PFAs may assist to eat placed the resident at risk of illness and complications related to swallowing problems if fed inappropriately by unqualified staff.

F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT  
SS=D IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of

F 373

F 428

An allergy was typed in the allergy box instead of pulling the look-up button on the medical record. Because this was done incorrectly, the allergy did not get pulled into the record to flag the pharmacist of the allergy. MD for resident #21 notified-resident was NOT allergic to medication, allergy removed from allergy list and orders received to continue with medication. Physician order was NOT to discontinue medication-the order was to discontinue allergy of Prilosec.

6/1/10

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                          |  |                                                        |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 428                                                    | <p>Continued From page 75</p> <p>nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review, review of professional reference, and staff interview, the consultant pharmacist failed to report medication irregularities to the physician and director of nursing, for 1 of 1 sampled resident (Resident #21) identified with an allergy to a prescribed medication. Failure to report the irregularity placed the resident at risk of illness and complications related to the allergy.</p> <p>Findings include:</p> <p>"Nursing 2009 Drug Handbook," 29th edition, Lippincott, Williams, and Wilkins, Philadelphia, pages 925-926, identifies Prilosec as an "antiulcerative and reflux drug" and states "Adverse Reactions, CNS [central nervous system]: . . . dizziness . . . GI [gastrointestinal]: abdominal pain, constipation . . . nausea, vomiting. Musculoskeletal: back pain. . . ."</p> <p>Review of Resident #21's medical record, on May 05-06, 2010, identified the facility admitted the resident in January 2001. Current diagnoses included chronic pain, chronic airway obstruction, epigastric mass, myalgia, and anxiety. The medical record identified the resident is allergic to Prilosec.</p> <p>Resident #21's currently prescribed medications included Prilosec, 20 milligrams (mg), two times</p> | F 428                                                                      |                                                                                                                          |  |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                            |                                                        |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 428                                                    | Continued From page 76<br>each day, initiated on 02/09/07. Review of the the resident's medication administration records (MARs) for January through May 05, 2010 showed the facility staff administered the prescribed Prilosec to the resident as ordered.<br><br>Review of the monthly Consultant Pharmacist's Medication Regimen Review for February, March, and April 2010 showed the consultant pharmacist failed to identify Resident #21's allergy to the prescribed Prilosec.<br><br>During interview, on 05/06/10 at 9:30 a.m., a supervisory nursing staff member (#37) reported she was not aware of Resident #21's allergy to Prilosec. Later in the morning, this staff member provided a physician's telephone order to discontinue the Prilosec.<br><br>During discussion with a nursing management staff member (#2) regarding this issue, on 05/06/10 at 11:30 a.m., the facility failed to provide additional information.<br><br>Resident #21's medical record identified her allergy to Prilosec. The facility staff provided the medication to the resident for more than three years. The consultant pharmacist's monthly medication reviews failed to identify the resident's medication allergy. This failure placed Resident #21 at risk of illness and medication side effects which may have added to her existing symptoms. | F 428                                                                      | All residents have the potential to be affected by being given medications which they are allergic to.<br><br>Ward secretaries and nurses have been educated on the proper way to enter allergies, and all staff have been given a detailed instruction list on how to enter the allergies correctly. All current resident records have been reviewed and all allergies are entered correctly.<br><br>Medical record reviews will be done randomly on a monthly basis to insure that residents are not receiving any medication that has been identified as an allergy. These reviews will be done by ward secretaries and reported to the Charge Nurses and Nurse Managers. Audits will be reported to the Quality Assurance Committee.<br><br>The Director of Nursing will be responsible for this process. |                            |                                                        |
| F 431<br>SS=E                                            | 483.60(b), (d), (e) DRUG RECORDS,<br>LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | F 431                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6/1/10                     |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 431                                                    | <p>Continued From page 77</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, facility policy, staff interview, and review of professional literature, the facility failed to date vials of insulin and lidocaine when opened in 4 of 9 (2-West, 2-East, 3-West, and 3-East) nursing units. Failure to identify the open date for the insulin and lidocaine vials allows usage beyond the manufacturer's</p> | F 431                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 431                                                    | <p>Continued From page 78</p> <p>recommended discard time frames. This practice may affect the potency and sterility of the medications.</p> <p>Findings include:</p> <p>Diabetic Care, Volume 26, Number 9, September, 2003, pages 2666-2667, "How long should Insulin be used once a vial is started?" stated, "... Although an expiration date is stamped on each vial of insulin, a loss of potency may occur after the bottle has been in use for more that one month ... Insulin products are sterile until the first dose is withdrawn by syringe. ... After first use, the contents of the vial ... are technically no longer sterile ... Sterile products should be used in as short a time as possible to minimize concerns about microbiological contamination once the container has been punctured. The CPMP [Committee for Proprietary Medicinal Products] has proposed a maximum - use period of 28 days for sterile products ... including insulin products ... changes in insulin action can lead to significant changes in blood glucose control."</p> <p>A facility policy "Outdated Supplies," revised February 2010, stated, "... 3. When multi dose vials are opened, they will be marked with the date and time. Once opened they are good for 30 days or as per instructions on the vial. ... "</p> <p>- Inspection of the medication room on the 2-West and 2-East units occurred on 05/05/10 at 3:45 p.m.. Observation showed two opened multi-use vials of Lidocaine 1%, not identified with an open date. During this observation, a nursing staff member (# 3) stated the vials of lidocaine should have open dates on them.</p> | F 431                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                        |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | (X5)<br>COMPLETION<br>DATE                             |
| F 431                                                    | Continued From page 79<br><br>- Observation of the medication room refrigerator on the 3rd West Unit occurred on 05/05/10 at 5:45 p.m., with staff nurse (#32) showed one "in use" opened insulin vial which lacked identification of the date when nursing staff opened the vial. Staff nurse (#32) stated the facility expected nursing staff to date vials upon opening/using them for the first time.<br><br>Observation of the medication room refrigerator on the 3rd East Unit occurred on the morning of 05/06/10, with staff nurse (#41) showed one "in use" opened insulin vial which lacked identification of the date when nursing staff opened this vial. Staff nurse (#41) stated the facility expected nursing staff to date vials upon opening/using them for the first time. | F 431                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                        |
| F 441<br>SS=D                                            | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program                                          | F 441                                                                      | Education provided to individuals involved with improper hand hygiene and peri-cares. All employees also educated on the importance of having residents wash their hands after using the bathroom. Environmental Aide educated on proper handling of linen.<br><br>All residents with restraints have the potential to be affected.<br><br>Inservices were given to all nursing staff May 25 & 26, 2010. These inservices included education on maintaining our current infection control practices so that we maintain a safe, sanitary and comfortable environment and to help prevent the development and transmission of infectious diseases. |  | 6/1/10                                                 |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                   |                            |                                                        |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                                                                                                                                                                                                                                                                                  |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                                                                                                                                                                                                                                                                                |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                          | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 441                                                    | <p>Continued From page 80</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens<br/>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, review of the facility policy and procedures, and staff interview, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to ensure the prevention, control, and spread of infection within the facility, on 2 of 3 days of observation of infection control practices (May 04-05, 2010). Failure to implement an active infection control program has the potential to affect the health and safety of all facility residents, staff, and visitors.</p> <p>Findings include:</p> <p>Review of the facility policy and procedure titled "HANDWASHING/HAND HYGIENE" occurred on 05/05/10. The policy, revised February 2010, stated,</p> | F 441                                                                      | <p>Random weekly audits/observations will be completed. The Nurse Managers and DON will be responsible for monitoring and reporting monthly to the Quality Department to insure compliance with this regulation. Once compliance is obtained, audits will be done quarterly.</p> <p>The Director of Nursing and Infection Control Nurse will be responsible for this process.</p> |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                     |                                                                                                                          |                            |                                                 |
|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>355074 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br>05/06/2010 |
| NAME OF PROVIDER OR SUPPLIER<br><br>TRINITY HOMES   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>305 8TH AVE NE<br>MINOT, ND 58701                                               |                            |                                                 |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                 |
| F 441                                               | <p>Continued From page 81</p> <p>"PURPOSE: TO ASSURE COMPLIANCE WITH THE MOST IMPORTANT MEASURE TO PREVENT THE TRANSMISSION OF DISEASE CAUSING MICROORGANISMS, POLICY...</p> <p>When is Handwashing (Soap and Water) necessary . . .</p> <ul style="list-style-type: none"> <li>* When hands are visibly soiled</li> <li>* Before and After eating or handling food and assisting residents with meals.</li> <li>* Before and After assisting a resident with toileting . . .</li> <li>* After personal use of the toilet . . ."</li> </ul> <p>Review of the facility policy titled "Resident Hand Hygiene" occurred on 05/06/10. The policy, dated 03/10/10, stated:</p> <p>"PURPOSE: To provide opportunities for hand hygiene for residents to enhance their health and the health of others in the facility.</p> <p>Procedure . . .</p> <p>2. Residents will be provided the opportunity for hand washing after toileting when providing their own cleansing of the peri area. Hand hygiene can be either at the sink in the bathroom or with a wet washcloth . . ."</p> <p>- Observation on 05/05/10 at 3:30 p.m., showed a certified nursing assistant (CNA) (#27) toileted Resident #25. The CNA (#27) completed pericare with gloved hands following the resident's bowel movement, applied a clean brief, pulled up the residents pants, and assisted the resident into the wheelchair. With the gloves used for pericare, the CNA (#27) applied an oxygen mask over the residents tracheostomy and secured it. The CNA (#27) removed the resident's gait belt, touched the handles of the cupboard, opened the doors and placed the container of periwipes and the gait</p> | F 441                                                               |                                                                                                                          |                            |                                                 |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                                                                                                                          |                            |                                                 |
|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>355074 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br>05/06/2010 |
| NAME OF PROVIDER OR SUPPLIER<br><br>TRINITY HOMES   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>305 8TH AVE NE<br>MINOT, ND 58701                                               |                            |                                                 |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                 |
| F 441                                               | <p>Continued From page 82</p> <p>belt inside. The CNA (#27) then removed the resident's soiled clothing protector, replaced it with a clean one, and secured it around the resident's neck. The CNA (#27) attached the leg rests to the wheelchair and applied hand sanitizer to the resident's hands. The CNA (#27) then removed the gloves used to provide pericare and washed his hands.</p> <p>An interview with an administrative staff member (#19) occurred the afternoon of 05/06/10. The staff member agreed the CNA (#27) should have removed his gloves and washed his hands once Resident #25 was safe. The staff member stated the CNA should not touch a tracheostomy oxygen mask with the same gloves after providing pericare.</p> <p>- On the morning of 05/04/10, a CNA (#26) assisted Resident #8 with toileting and incontinence cares. Observation showed the CNA (#26) provided urinary and bowel incontinence cares, removed the gloves used to provide the incontinence care, assisted ambulating the resident with a gait belt and walker to a chair in the resident's room, positioned the resident's bedside table adjacent to the chair, and touched the resident's water glass including inside the rim, before returning to the bathroom where she emptied the garbage, then performed hand washing in the sink.</p> <p>- Observation at 8:20 a.m. on 05/05/10 showed a CNA (#4) assisted Resident #5 to the bathroom. Observation showed Resident #5 incontinent of urine and stool with feces visible on the outside of the brief and on her inner thighs. The CNA (#4) removed the soiled brief, positioned the resident on the toilet, and without changing her gloves,</p> | F 441                                                               |                                                                                                                          |                            |                                                 |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 441                                                    | <p>Continued From page 83</p> <p>exited the bathroom, walked to the resident's closet, and removed a clean brief and container of wipes. The CNA (#4) then completed perineal cares, removed her gloves and washed her hands.</p> <p>During an interview on 05/06/10, an administrative nurse (#6) stated she would expect staff to remove their gloves before obtaining clean supplies from the closet and performing incontinent cares using front to back technique.</p> <p>- Observation on 05/04/10 at 10:00 a.m. showed a CNA (#28) ambulated Resident #12 from his recliner into the bathroom and assisted the resident to lower his pants and incontinent product. Resident #12 expelled stool and urine and completed his own perineal cares. Upon completion of perineal cares, staff member (#28) assisted the resident to place his incontinent product and closed his pants. Prior to leaving the bathroom, a staff member (#28) failed to offer the resident an opportunity for hand washing. The staff member (#28) ambulated Resident #12 to his recliner and failed to offer the resident a wet washcloth to cleanse/wipe his hands. Observation showed Resident #12's a.m. snack of a juice sitting on a table within reach and the staff member (#28) encouraged the resident to drink it.</p> <p>Observation on 05/04/10 at 3:40-3:45 p.m. showed a CNA (#39) in the bathroom with Resident #12. Observation identified Resident #12 seated on the toilet, voided, and completed his own perineal cares. Upon completion of perineal cares, staff member (#39) assisted the resident to place his incontinent product and close his pants. Prior to leaving the bathroom, staff member (#39) failed to offer Resident #12</p> | F 441                                                                      |                                                                                                                          |                            |                                                        |

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

PRINTED: 06/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355074</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/06/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY HOMES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>305 8TH AVE NE<br/>MINOT, ND 58701</b>                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 441                                                    | <p>Continued From page 84</p> <p>an opportunity for handwashing with soap and water or a wet washcloth.</p> <p>Observation on 05/05/10 at 8:00-8:20 a.m. showed a CNA (#40) ambulated Resident #12 into the bathroom and assisted the resident to lower his pants and incontinent product. Observation showed Resident #12 voided and completed his own perineal cares. Upon completion of perineal cares, staff member (#40) assisted Resident #12 to raise his incontinent product and close his pants. Prior to leaving the bathroom, staff member (#40) failed to offer Resident #12 an opportunity for handwashing with either soap and water or a wet washcloth.</p> <p>During interview on 05/06/10 at 10:00 a.m., an administrative nurse (#34) stated she expected staff to prompt or offer handwashing to residents who complete their own perineal cares.</p> | F 441                                                                      |                                                                                                                          |                            |                                                        |