STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	C 07/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident was completed July 30-31, 2024. During the report investigation the facility was found noncompliant with regulatory requirements.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		9/4/24

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

Electronically Signed | 08/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	C 07/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 1 by: Based on review of State Survey Agency reports, record review, review of facility policy, and staff interview, the facility failed to report an incident of serious bodily injury for 1 of 1 sampled resident (Resident #1) who experienced serious injury after a fall from a lift to the State Survey Agency (SSA). Failure to report an event that resulted in serious bodily injury in the prescribed time frame does not comply with regulations established to protect residents. Findings include: Review of the facility policy titled "Abuse, Neglect and Exploitation" occurred on 07/31/24. This policy, revised August of 2023, stated, ". . . Definitions: . . . Mistreatment: inappropriate treatment . . . of a resident . . . Adverse Event: an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. . . . Serious bodily injury: an injury involving extreme physical pain, . . . requiring medical intervention such as surgery, hospitalization . . . All actual or alleged incidents of . . . Catastrophic events will be reported immediately to the supervisor, charge nurse, department manager, or manager on call. . . . The supervisor notified is responsible to initiate protective approaches . . . The supervisor will then contact the Director of nursing and/or Director of Social Services to initiate the investigation process. The Director of Nursing and/or Director of Social Services will report . . . to the Administrator and/or their designee and the State Health Department. . . . All alleged violations involving abuse, neglect . . . or mistreatment . . . are reported immediately, but	F 609	Resident #1 sustained a fall on 7/26/24 at 1900 from a mechanical hoyer lift causing one laceration of 5 cm on her forehead. All residents that use a mechanical hoyer lift for transfers have the potential to be affected. The two C.N.A.s who were involved in resident #1 fall were reeducated on the mechanical hoyer lift on July 30 with Physical Therapy staff. All nurses and C.N.As were educated as well on the incident involving mechanical hoyer lift fall on 7/29/24 with a read and sign. All C.N.As will have hands on education on the two mechanical lifts (hoyer and EZ lifts) on 9/4/2024 using a checklist on transferring a resident. All nurses will be informed of missing the deadline to report potential neglect and abuse. All nurses will be educated on the required reporting timeframes and how to access and complete abuse and neglect reporting form online. Nurses will be instructed in the importance of reporting in a timely manner to facilitate an effective investigation. This was completed at all nurses meeting on August 30 at 1445. Timeframes, with information on how to access the reporting website, with examples of how to report will be printed and accessible in all nurses stations. All new permanent and contract nurses will be orientated on this process upon hire.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	C 07/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours . . ." Review of Resident #1's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 04/25/24, identified the resident had severely impaired cognition. A nurse's note, dated 07/27/24 at 10:09 a.m., stated, "GNA [sic] called this nurse and stated in the process of transferring the resident with the hoyer [full body mechanical] lift, the resident fell out of the sling falling onto the floor and hitting her head. This nurse observed resident on her left side lying over one of the legs of the hoyer lift sustaining two lacerations to her face. . . MD [medical doctor] . . . made aware and give new order to send resident to the ER [emergency room] . . . Resident picked up at 2035 [8:35] pm." During an interview on 07/30/24 at 10:30 a.m., an administrative nurse (#1) explained the fall occurred on 07/26/24 at approximately 7:00 p.m. During an interview on 07/30/24 at 11:44 a.m., a social service director (#3) indicated the house supervisor contacted her on 07/27/24 at 1:54 p.m. to ask about reporting the incident. She further stated the house supervisor submitted the initial report to the SSA. The SSA received the initial allegation report on 07/27/24 at 2:10 p.m., approximate 19 hours after the fall resulting in serious injury. The facility staff failed to report the incident of serious bodily injury to the facility administration and SSA within 2 hours.	F 609	Nursing leadership and social services will review all reports of abuse and neglect and all injuries of unknown origin to ensure they were reported accurately. Monitoring will be completed daily (on business days) for one month, weekly for two months and then quarterly thereafter. Audits of staff transferring residents using the hoyer lift including resident #1 will begin on 9/4/2024 and will be 5 per unit per week for 4 weeks or until compliance is obtained. Audits will then continue with 5 per unit monthly for 3 months or until compliance is achieved and then 5 per quarter until compliance is obtained. The nurse managers are responsible for completion of the audits. Audits will begin on 9/4/2024. All audits will be presented to the QA committee during scheduled meetings. The DON/ADON are responsible for this process. Date of completion will be by September 4, 2024.	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		9/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	C 07/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being for 1 of 1 sampled resident (Resident #1) who had a fall from a mechanical lift with facial laceration. Failure to document the fall assessment timely, ensure post-fall follow up is performed and documented. Failure to perform and document neurological assessments following a fall with facial laceration has the potential to delay identification and treatment of further or worsening signs/symptoms of injury. Findings include: Review of the facility policy titled "Injuries, Skin Tears And Falls" occurred on 07/31/24. This policy, revised January 2023, stated, ". . . Falls documentation will be completed and vitals will be documented . . . If the resident sustains a fall, an event will be completed . . . If there is a head injury . . . an initial neuro [neurological] check will be completed and further neuro checks will be scheduled. Neuro checks will be completed every 15 minutes x [times] 4, then every two hours x	F 684	Resident #1 sustained a fall on 7/26/24 at 1900 from a mechanical lift causing 5cm laceration on her forehead that did not require sutures. All residents who have experienced a fall have the potential to be affected. Falls and neurocheck policy was reviewed with Nurse #7 she was shown on August 30 how to properly complete fall assessment huddle, as well as importance to complete and document vital signs and neurological checks in a timely manner. A mandatory nurses meeting was held on August 30 at 1445 to educate all nurses on the fall policy, when to report falls to nursing supervisor and DON, how to complete the Initial Allegation website reporting form and process to complete fall huddle assessment, neuro-checks with vital signs, notifications to physician and family and adjust the careplan if necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	C 07/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4 12, for a total of 24 hours, unless otherwise ordered by provider. . . ." Review of the facility policy titled "Neurological Assessment (post fall/head injury)" occurred on 07/31/24. This policy, revised May 2021, stated, ". . . Documentation of the neurological assessment must be completed under the observation 'Neurological Checks' in the . . . EHR [electronic health record]. . . ." Review of the "Facility Reported Incidents Reporting Form" occurred on 07/30/24. This form, dated 07/27/24, stated ". . . Date of the allegation (incident) 07/26/24 . . . Time of the allegation 1900 [7:00 p.m.] . . . Was the Resident injured? Yes . . . Injury Type . . . Severe Injury Need for suture . . . Briefly describe the alleged incident and/or injury Two CNAs [certified nurse aides] were transferring resident by hoyer [full body mechanical lift] . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, anxiety, osteoarthritis, and weakness. A quarterly Minimum Data Set (MDS), dated 04/25/24, indicated severe cognitive impairment. The care plan, reviewed 05/01/24, stated, ". . . requires the use of a mechanical lift hoyer and 2 staff to transfer due to Dementia and degenerative disc disease . . . At risk for falls . . ." Review of nursing progress notes identified the following: * 07/27/24 at 10:09 a.m., "GNA [sic], called this nurse and stated in the process of transferring the resident with the hoyer lift, the resident fell out of the sling falling onto the floor and hitting	F 684	A new fall committee form has been developed to ensure the fall huddle, assessment, neuro checks with vital signs, careplan and notifications are complete on each fall. A new form for nursing was created so neuro checks can be documented on paper so the nurse can carry with them rather than having to go to a computer to input completion. Nursing leadership will review all falls in fall committee Monday through Friday to identify that follow up and documentation has been completed. A checklist has been made to monitor the completion of fall huddle assessments, vitals, neuro checks, notification of physician and family and care plan adjustments. Monitoring all falls will be completed daily, Monday through Friday during morning report by the fall committee and will be an ongoing process with no end date. All audits on falls with completed neurochecks with vitals signs will be presented to the QA committee during scheduled meetings. The DON/ADON/CERS are responsible for this process. Date of completion will be by September 4, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	C 07/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5	F 684		

her head. This nurse observed resident on her left side lying over one of the legs of the hoyer lift sustaining two lacerations to her face. Resident assessed and transfer [sic] to her bed. neuro checks initiated. MD [medical doctor] . . . made aware and give new order to send resident to the ER [emergency room] for evaluation. Call placed to 911. POA, [Power of Attorney] [name] made aware. Resident picked up at 2035 [8:35] pm." The medical record showed documentation of the fall occurred 15 hours after the fall occurred and lacked a date and time of the incident.
* 07/27/24 at 10:41 a.m., "Call from ER, resident given 2 Tylenol for pain , CT [computerized tomography] scan to the head, negative, Baseline, no vocal . . . Resident returned to facility at 0110am [1:10 a.m.]. Skin glue to face laceration. Resident baseline. . . ." Documented nine and a half hours after resident returned from ER.

Review of the "Fall Event" form, dated 07/27/24 at 9:29 a.m., showed one neurological check completed, with the resident complaint of "headache", but failed to identify the date/time the neurological assessment completed.

Resident #1's medical record lacked documentation of vital signs and neurological assessment at the time of the fall, lacked documentation of further neurological assessment post fall and/or orders to discontinue neurological assessments.

During an interview on 07/30/24 at 2:45 p.m., an administrative nurse (#1) stated the house supervisor or supervisory nurse is expected to be notified of all falls and ensure all documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	C 07/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6 is completed per policy, and he expected staff to document timely, correctly and perform neurological assessments after a fall with head injury for 24 hours unless discontinued by the provider. The administrative nurse (#1) confirmed the medical record lacked documentation of neurological assessments for Resident #1. During an interview on 07/31/24 at 7:00 a.m., a staff nurse (#7) indicated she completed three neurological assessments immediately following Resident #1's fall and one neurological assessment upon Resident #1's return from the ER but failed to document them in the EHR, and confirmed she failed to complete additional neurological assessments per policy.	F 684		