North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1042	A. BUILDING: _____ B. WING _____	C 08/24/2023

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) COMPLETE DATE
L1810	33-07-03.2-18,1 PHARMACEUTICAL SERVICES The facility shall obtain the services of a licensed pharmacist who shall develop policies and procedures for the provision of pharmaceutical services within the facility consistent with chapter 61-03-02, state laws, and federal laws. These policies and procedures must be approved by medical staff or medical director and governing body and must include provisions for: This State Licensing Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to follow regulations outlined in Chapter 61-03-02 Consulting Pharmacist Regulations for Long-Term Care Facilities for 1 of 1 emergency kit (E-kit). Failure to label the exterior of the E-kit with a list of the name, strength, and quantity of the medications, and the earliest expiration date of the medications in the kit limited staffs' knowledge of the medications available for use and the timeliness of the pharmacist replacing expired medication. Failure to remove expired medications may result in residents receiving ineffective medications in an emergent situation. Findings include: Section 61-03-02-02.2. of the Consulting Pharmacist Regulations for Long-Term Care Facilities, states, ". . . e. Labeling-Exterior. The	L1810	All residents have the potential to be impacted by expired medications in the ekit. The list of medications will be placed on the outside of the ekit with the name, strength, and quantity of each drug along with the earliest expire date of each drug. We have switched our ekit and pharmacy supplier to Thrifty White Drug. They come in weekly to replace the entire ekit. We will still do our audits, but this will also greatly decrease the chance for an expired medication in the ekit. QA audits will be done by the consultant pharmacist weekly to check for any expired medications in the ekit and that the list is visible on the outside of the ekit. This will be done weekly for 4 weeks or until compliance is achieved, the monthly	9/28/23

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

Electronically Signed | 09/14/23

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L1810	Continued From page 1 exterior of an emergency kit shall be labeled to clearly and unmistakably indicate that it is an emergency drug kit and it is for use in emergencies only; such label shall also contain a listing of the name, strength, and quantity of the drugs contained therein and an expiration date. . . . i. Expiration date. The expiration date of an emergency kit shall be the earliest expiration date on any drug supplied in the kit. Upon the occurrence of the expiration date, the Provider Pharmacist shall open the kit and replace expired drugs. . . ." Observation of the E-kit occurred on 08/23/23 at 10:20 a.m. with a nurse (#4). The locked E-kit contained a list of its medications on the inside of the container. The nurse (#4) stated she was "not sure" who checked for expired medications, then opened the kit. The E-kit contained four medications of various quantities with the earliest expiration date of 07/31/23 (azithromycin - antibiotic, clindamycin - antibiotic, furosemide - diuretic, and risperidone - antipsychotic). The facility failed to place the list of the names, doses, and quantity of the medications, and the earliest expiration date on the outside of the E-kit and failed to replace the expired medications. During an interview on 08/23/23 at 10:25 a.m., a nurse manager (#5) stated pharmacy checked for expired medications monthly and refilled the E-kit after staff removed a medication.	L1810	for 4 months or until compliance is achieved, then quarterly for 2 quarters or until compliance is achieved. All audits will be reported to the QA committee in September and 2 subsequent quarterly QA meetings. All findings will be reported to the DON/ADON who will be responsible for this process. Date of correction: September 28th, 2023	

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey and complaint survey started on 08/21/23 and concluded 08/24/23. During the complaint investigation, the issues identified by the complainant were found in compliance.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility investigation, and review of facility policy, the facility failed to ensure adequate supervision and assistance for 1 of 2 sampled residents (Resident #68) who required staff assistance with transfers and experienced a fall with fracture injury. Findings include: Review of the facility policy titled "Fall prevention policy" occurred on 08/23/23. This policy, dated May 2022, stated, ". . . residents will be assessed for risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls . . . provide additional interventions as directed by the resident's assessment . . . rounding to be performed hourly . . . ambulation and toileting assistance . . . the plan of care will be revised	F 689	The staff member (CNA#7) was placed on leave immediately after the incident was reported for resident #68, and subsequently terminated when the investigation was complete. She never returned to duty prior to termination. At the September 20, 2023 CNA meeting and at the September 27, 2023 Nurses meeting, staff will be instructed to follow the resident #68□s care plan regarding her ADLs and fall prevention. All residents who require assistance with ADL, specifically transfer have a potential risk of accident if care plan is not followed. All residents will be kept as free from accidents as possible. All staff will be	9/28/23

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F 689	Continued From page 1 and updated as needed . . ." Review of Resident #68's medical record occurred on all days of survey. The care plan at the time of the fall showed Resident #68 transferred and ambulated with the assist of one. Nursing progress notes identified the following: *06/28/2023 at 11:39 p.m.," . . . was on the other other side of the hall, when this nurse heard someone calling 'help' from the other side of the hall, asked one of the CNAs [certified nurse aide] to see where the yell was coming from . . . found resident lying on her right side on the floor in her room . . . asked what happened . . . resident stated she went to get her shirt from her closet and when she was going back to her bed she fell . . ." *06/29/2023 at 01:15 a.m., "Resident continuously complaining of severe left shoulder pain after the fall . . . stated she fell and landed on her left side . . . On call provider notified with order to send the resident to the ER [emergency room] for evaluation . . ." *06/29/2023 at 6:58 a.m., Resident back to facility at 5:35 a.m. . . has a fracture on left upper arm . . . wearing a splint on the affected arm . . ." Physician Progress Notes, dated 07/06/23, stated, ". . . had a fall one week prior and found to have displaced left humeral shaft fracture . . . having quite a bit of pain . . . medications for pain . . ." Review of the facility's investigation of the incident identified the following: * ". . . [Resident #68] suffered a fall last night around 11:30 p.m., was sent to the ER, and	F 689	educated to honor all resident wishes as to clothing, as well as following the care plan for all ADLs at the September 20, 2023 CNA meeting or the September 27, 2023 Nurses Meeting. Those not in attendance will review of the Plan of Correction and sign off. Residents needing assistance with transfer should not be left unattended until in the designated and or desired safe position. All falls are reviewed by our fall committee on normal office days, Monday through Friday daily as they occur. The committee will verify or determine a root cause, discuss, and implement changes in the resident care plan, and or recommend any other changes necessary to protect the residents. QA audits will be done on all residents, including #68, to ensure that staff are following the care plan regarding level of assistance required for each resident, including ambulation and transfers. Audits will be completed by Nurses on each unit, Unit Managers, and/or DON/ADON. Each Unit will have 10 audits per week for 4 weeks or until compliance is achieved, followed by 10 audits per unit monthly for 4 months or until compliance is achieved. Audits will then continue at 10 per unit quarterly or until compliance is achieved. All audits will be reported to the QA committee and at the September and 3 subsequent quarterly QA meetings.	

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F 689	Continued From page 2 returned early this morning with a diagnosis of a fractured left upper arm. When the day staff were asking [Resident #68] about her fall this morning, after she woke up, she said she got up alone, to get a shirt out of her closet and fell on her way back to bed. She reported that she asked the CNA [#7] to assist her to get a clean shirt and CNA [#7] told her she didn't need a clean shirt and didn't assist her. That is when [Resident #68] did it herself. She had an accident and wanted her PJ's [pajamas] to match . . ." * The facility investigative team completed the following summary, dated 06/29/23, with a CNA [#7], a witness to the incident. The CNA stated, ". . . [Resident #68] requested to change her shirt so it matched her pajama pants . . . [CNA #7] admitted saying, 'it is not going to kill you to wear the shirt you have on.' . . . [CNA #7] said she had to go and left [Resident #68] standing at her dresser. [Resident #68] fell right after [CNA #7] left the room. During an interview on 08/24/23 at 11:43 a.m., an administrative staff (#1) confirmed Resident #68 required the assistance of one staff member for transfers/ambulating and stated she expected staff to follow the care plan. The facility failed to ensure Resident #68 received care and services necessary to attain the highest degree of safety possible during cares to prevent a fall with injury.	F 689	All findings will be reported to the DON/ADON who will be responsible for this process. Date of correction: September 28, 2023	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692		9/28/23

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F 692	Continued From page 3 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 1 of 1 sampled resident (Resident #315) with documented weight variances indicating severe weight loss. Failure to reassess weight variances may delay needed treatment for weight loss/gain and alter the resident's ability to maintain a sufficient health/nutritional status. Findings include: Review of Resident #315's medical record occurred on all days of survey. Diagnoses included cerebral infarction (stroke), dysphagia (difficulty swallowing) and gastrostomy tube (a tube inserted into the stomach to provide	F 692	The unit manager requested additional weights be conducted for resident #315, and staff directed to note and report any variations. Weights for resident #315 are being monitored by dietician and Unit manager. All residents could be at risk of weight loss or gain, as well as erroneous weights. Our policy will be changed to reflect that residents will be weighed weekly beginning 9/25/23. Weights are to be obtained using the same devices. A new form will be developed to allow staff to note variations more easily. Weight	

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F 692	Continued From page 4 nutrition). Resident #315's admission orders, dated 08/17/23, included TwoCal HN + Banatrol for enteral nutrition (which Resident #315 was receiving in the hospital). Due to unavailability of the TwoCal, the dietician ordered Osmolite + Banatrol on 08/17/23. Review of Resident #315's weights from 08/17/23 through 08/21/23 showed the following: 08/17/23: 287.2 lbs (pounds) - admission weight 08/18/23: 292 lbs 08/19/23: 270.5 lbs (22.5 pound weight loss from 08/18) 08/20/23: 262 lbs (8.5 pound weight loss from 08/19) 08/21/23: 259 lbs The documented weights indicate a 28.2 pound weight loss since admission. Resident #315's medical record failed to show the facility staff notified the provider or dietician of the weight loss. During an interview on 08/23/23 at 1:19 p.m., administrative staff member (#1) confirmed the documented weights "are off and need to be addressed to figure out why."	F 692	changes greater than three pounds will be reported to the Unit Manager and Dietician. The resident□s provider will be notified by the unit manager or designee when a 3 lb. verified loss or gain is noted in the resident□s chart. All CNAs will be educated regarding accurate weights and appropriate notification process at CNA meeting September 20, 2023. Nurses will be educated on September 27, 2023. Those not in attendance will review of the Plan of Correction and sign off. QA audits will be done checking weights for residents to determine if there was a weight loss/gain and if appropriate notifications were made. Audits will be completed by Unit manager, DON/ADON or designees. Each unit will audit 5 weights per unit per week to check for weight gain/loss and notifications for 4 weeks or until compliance is achieved, followed by 10 audits per unit per month or until compliance is achieved. Audits will then continue at 10 per unit quarterly or until compliance is achieved. All audits will be reported to the QA committee and at the September and 3 subsequent quarterly QA meetings. All findings will be reported to the DON/ADON who will be responsible for this process. Date of correction: September 28, 2023	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		9/28/23

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F 759	Continued From page 5 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent during administration of medications for 1 of 7 residents (Resident #315) observed. Four medication errors occurred during staff administration of 32 medications, resulting in a 12% error rate. Failure to properly prepare and administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the facility policy titled "Gastric Tube Residual Assessment, Medication Administration, and Tube Feeding Administration" occurred on 08/23/23. This policy, revised January 2023, stated, ". . . J. Remove the bulb or plunger of syringe and reinsert into gastric tube K. Administer each medication [per gravity] flushing with . . . water after each dose. . . ." Review of Resident #315's medical record occurred on all days of survey. Diagnoses included cerebral infarction (stroke), dysphagia (difficulty swallowing), hypertension, and a gastrostomy tube (a tube inserted into the stomach to provide nutrition).	F 759	The nurse noted in the 2567 was reeducated regarding proper medication administration through resident #315's PEG tube. Nurse #6 was reeducated immediately on 8/23/23 prior to beginning of shift at 2pm on how to properly administer medications through a PEG tube and not to use the tip of a syringe to stir before administering by gravity and rinsing the cup to ensure full dose of medication was given and again at competencies on proper medication administration. All nurses were reeducated at the August 30 and September 18th Nurse Competency sessions. All residents with a PEG tube have the potential to be affected by improper administration of medications through a PEG tube when not following the facility policy. Retraining of Nurses on proper PEG tube Medication Administration will be completed at the September 27, Nurses Meeting. Instructions included, but not limited to: dilution of medications, not using syringe to stir as medications can stick to side of syringe or spill out of the	

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F 759	Continued From page 6 The following physicians' orders for Resident #315 stated to administer the medications via gastric tube and flush with 25 milliliters (ml) of water before and after each medication: * Clonidine HCl 0.2 mg tablet twice a day (treats high blood pressure) * Hydrochlorothiazide 50 mg tablet twice a day (treats high blood pressure) * Losartan 50 mg tablet twice a day (treats high blood pressure) * Metoprolol tartrate 50 mg tablet twice a day (treats high blood pressure) Observation on 08/22/23 at 5:17 p.m. showed a nurse (#6) prepared the clonidine and placed it into a 30 ml plastic medication cup. The nurse carried the cup into Resident #315's room, set the cup on a paper towel placed on the overbed table, and poured water into the medication cup. As the nurse mixed the medication and water to dissolve the medication, the cup overflowed/splashed over the cup. The nurse (#6) used a syringe to draw up the contents in the cup, placed the tip of the syringe into the residents feeding tube port, pushed the plunger of the syringe to administer the medication through the feeding tube, and removed the syringe. A visible ring of medication remained at the bottom of the medication cup. The nurse closed the port to the feeding tube, threw the medication cup into the garbage can, and left the residents room to prepare the next medication. The nurse (#6) utilized the same process when preparing/administering the remaining three medications, again with water overflowing/splashing out of the medication cups onto the paper towel. After administering the	F 759	cup, allowing medications to flow by gravity through syringe and PEG tube, administering medications one at a time , and ensuring all medication is completely administered from the medication cup, and preventing spills of medication when preparing a medication. Those not in attendance will review of the Plan of Correction and sign off. QA audits will be done watching medication administration for all residents with a PEG tube. The nurse manager or designee will complete 5 observations a week on each resident with a PEG tube for 4 weeks or until compliance is achieved, followed by 10 audits a month on each resident with a PEG tube for 4 months or until compliance is achieved. Audits will continue at 10 per resident with a PEG tube quarterly or until compliance is achieved. All audits will be reported to the September QA committee and at the September and 3 subsequent quarterly QA meetings. All findings will be reported to the DON/ADON who will be responsible for this process. Date of correction: September 28th, 2023	

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F 759	Continued From page 7 hydrochlorothiazide and losartan, a visible ring of medication remained on the bottom of the medication cup; and after administering the metoprolol, observation showed two pieces of the metoprolol at the bottom of the cup. The nurse (#6) failed to administer the medications per facility policy (per gravity) and failed to administer the full prescribed dose of the clonidine, hydrochlorothiazide, losartan, and metoprolol to Resident #315.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal	F 761		9/28/23

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F 761	Continued From page 8 and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure safe and secure storage of medications for 1 of 4 medication carts (4 East wing) observed during medication pass. Failure to store all medications securely may result in unauthorized access to medications. Findings include: Observation on 08/22/23 at 5:17 p.m. showed 17 closed bottles of stock medications and a large pile of Refresh eye drop vials on top of the medication cart. The nurse (#6) left the cart unattended with the medications on top of the cart on five different occasions over a period of 25 minutes while performing medication administration. The cart was located in a high traffic area where numerous residents, staff, and visitors pass by. During an interview on 08/23/23 at 1:31 p.m., an administrative nurse (#1) stated she expects no medications left on top of any carts when the cart is not in sight of the nurse.	F 761	Nurses and Med Aides were instructed to not leave any medications unattended on or in the med cart and that all medications should be locked in cart when not attended by a nurse or medication aide. Nurse #6 was educated that all medications and supplements will be stored inside the cart and cart locked when not attended immediately on 8/23/23 prior to beginning of shift at 2pm and again at the nurses meeting. All residents, staff and visitors have the potential to impacted by medications left unattended/unsecured or on the top of medication carts. All nurses and Certified Medication Aides were educated regarding the proper storage and securing of medications. CMA staff will be educated again on 9/20 and nurses and CMAs will be educated on 9/27 at the nurses meeting. Those not in attendance will review of the Plan of Correction and sign off. The nurse manager or designee will complete 10 observations per unit per week for 4 weeks or until compliance is achieved of the medication carts to observe that the carts are locked and there are no medications left on top of the cart. This will be followed by 10 observations per unit per month for 4 months or until compliance is achieved.	

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 08/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 9	F 761	After that there will be 10 audits per unit quarterly or until compliance is achieved. All audits will be reported to the QA committee and at the September QA meeting and 3 subsequent quarterly QA meetings. All findings will be reported to the DON/ADON who will be responsible for this process. Date of correction: September 28th, 2023	