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 10/18/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey and complaint survey, started on 10/15/18 and concluded on 10/18/18.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		11/16/18

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

Electronically Signed | 11/13/2018

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the electronic medical record for 1 of 36 sampled residents (Resident #152) accurately reflected the resident's code status. Failure to ensure the resident's electronic medical record accurately reflected his/her wishes may prevent facility staff from knowing the resident's choices in the event of a medical emergency. Findings include: Review of Resident #152's medical record occurred on all days of survey and contained a paper form identifying Resident #152 as a "No Code." The electronic medical record identified "Full Code." During an interview on 10/17/18 at 9:10 a.m. a licensed nurse (#16) stated he/she looked in the electronic chart to identify a resident's code status or on the front of the paper chart for a red dot (no code) or a green dot (full code). Resident #152's paper chart contained a red dot. During an interview on 10/17/18 at 9:15 a.m. a supervisory nurse (#17) confirmed Resident #152's code status in the electronic chart failed to	F 578	Staff addressed Code status with resident #152. Resident voiced understanding and request to have DNR Code status. The request confirmed Code Level form and Provider order both signed on 08/23/18. Verified that his chart had DNR red dot sticker to indicate DNR, and updated section on advanced directives on the face sheet to reflect DNR status on banner bar. All residents have the potential to be affected if Code Level status is incorrect in any part of the resident record, which could result in resident request not be followed. Trinity Homes staff received education in October, which included following resident requests and ensuring the documentation is consistent between the paper chart and the EHR. Staff meetings are being held on November 13-14, 2018 for all nursing staff to address deficiencies, including this deficiency. Copies of the education for the POC have been placed in all appropriate departments as an inservice, and staff	

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F 578	Continued From page 2 match the code status in the paper chart. The facility failed to ensure the code level status was consistent in all areas of the medical record.	F 578	has been educated through the read and sign process. QA audits started the week of November 4th, 2018. Audits will be completed weekly for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits. All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken. The Director of Nursing is responsible for this process.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the	F 644		11/16/18

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F 644	Continued From page 3 PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures For Long Term Care Services, the facility failed to complete a status change assessment for 2 of 3 sampled residents (Resident #99 and #177) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs. Findings include: The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process,	F 644	Resident #99 is not currently expressing any thoughts of suicide or self harm; however contact was made with DDM/Ascend and it was decided it is best to submit a "status change" to the initial Level II that was approved prior to admission. A new Level I for resident #177 was submitted for "status change". DDM/Ascend representative stated that because both had dementia and behaviors related to dementia that this did not substantiate a need for a Level II. Both new submissions were completed on November 12, 2018. All residents have the potential of not receiving appropriate care if Level I/Level II screenings are not completed when there is a change in condition. A new process was developed for identifying changes in residents status. CEPS Director will look at all resident records when a resident leaves the facility for any medical care; reviewing records for new diagnosis of mental illness. MDS nurses and HIM will review all records	

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F 644	Continued From page 4 and that condition later emerged or was discovered. . . ." - Review of Resident #177's medical record occurred on all days of survey. The record showed an initial PASARR completed on 07/08/11 and identified no mental illness, mental retardation or conditions related to mental retardation. Resident #177's medical record identified the following current diagnoses: bipolar disorder (dated 09/08/11). The record lacked evidence of an updated Level I screening/change in status assessment since the additional diagnoses. - Review of Resident #99's medical record occurred on all days of survey. The record showed an initial PASARR completed on 03/17/14 and identified the resident met criteria and will require a Level 2. A Level 2 PASARR screening, dated 08/18/14, stated Resident #99 is not currently suicidal or combative. Resident #99's medical record identified the following: * 06/06/18 ". . . Patient is being seen today on account of worsening depressive symptoms of irritability and suicidality. . . ." * 07/02/18 " . . . resident has been to the ED (emergency department) for eval (evaluation) twice in the past month for worsening depressive symptoms/suicidal comments. . . ." * 09/09/18 ". . . The patient does express a desire to [end it all] . . . When asked how log she has had suicidal thoughts, the patient resounded [for quite some time]. . . ." * 09/12/18 ". . . The patient was recently see at	F 644	and diagnosis' when completing the MDS and notify HIM and Admission Coordinator. All changes will also be communicated to the DON; and the DON and Admission Coordinator will review and assess for the need of a new PASARR. All appropriate staff were educated on this process November 11, 2018. QA audits start November 11, 2018. Audits will be completed weekly for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits. All QI audits will be reviewed weekly for compliance by the CEPS Director and the data will be presented to the QAPI committee monthly. The DON and CEPS Director are responsible for educating their employees on this process. The CEPS Director is responsible for this process.	

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F 644	Continued From page 5 the ER (emergency room) on September 9, 2018 due to worsening agitation and behavior . . . Patient has been observed to have worsening behavioral issues on the unit . . . She tends to verbalize suicidal thoughts. . . ." The record lacked evidence of an new Level I screening due to Resident #99's change in status. During an interview on 10/18/18 at 3:45 p.m., an administrative nurse (#1) agreed a new Level I PASARR screening had not been completed for Resident #99.	F 644		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		11/16/18

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F 657	Continued From page 6 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/05/18. Based on observation, record review, review of facility policy, and staff interview, the facility failed to review/revise the comprehensive care plans to reflect the current status for 5 of 36 sampled residents (Resident #33, #71 #99, #187 and #295). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Planning" occurred on 10/18/18. This policy, revised 2016, stated, ". . . Care Plan Review: On each shift the CNA's (Certified Nurse Assistants) and Nurse review care plans and care guides so that each resident's care plan is reviewed by the three shifts monthly adding or deleting problems, goals, and approaches as appropriate." - Review of Resident #33's medical record occurred on all days of survey and showed a positive Clostridium Difficile Toxin (CDT) (a bacteria found in feces) test on 10/07/18. A progress note, dated 10/07/18 at 12:45 p.m., stated, "Spoke with [physician name] in regards to pts [patient's] positive CDT results . . . New	F 657	For resident #33 the care plan was revised; changing "history of C. Diff." to "Positive for C. Diff." and changed transferring from Hoyer lift to PAL lift with assist of 2. Resident #71, removed toileting with staff assist of 2 and added assist to bedside commode with staff assist of 1 and gait belt. Care plan revised for resident #187 to include chest belt utilized for positioning on resident's personal wheelchair. The care plan was revised for resident #295 by adding PICC line with goals and interventions. Resident #99 was assessed by Nurse Practitioner and recently had increase in Seroquel dose. Care plan includes a behavior modification assessment and plan for mood, behavior and suicidal ideation. All residents have the potential to be affected if the care plan is not revised by an interdisciplinary team in a timely manner. Failure to update the care plan in a timely manner limits the ability of staff to communicate care needs and does not ensure continuity of care for each resident. All Trinity Homes staff received education	

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F 657	Continued From page 7 orders given . . ." Resident #33 remained in contact isolation due to the positive CDT test. Resident #33's care plan failed to identify the resident's active CDT. Resident #33's current care plan stated ". . . Toileting: Hoyer [full body mechanical] lift with staff assist of 2 to toilet . . ." Observation on 10/16/18 at 11:30 a.m. showed a CNA (#7) and two unidentified CNAs assisted the resident to and from the bathroom using the sit-to-stand lift. During an interview on 10/18/18 at 11:00 a.m., an administrative nurse (#1) confirmed Resident #33's care plan needed updating regarding the CDT and the use of the sit-to-stand lift. - Review of Resident #71's medical record occurred on all days of survey. The current care plan stated, ". . .Transferring: Staff assist of 2. . . . Staff to assist with toileting every 2-4 hours and prn [as needed]. . . . " Observation on 10/16/18 at 9:18 a.m. showed a CNA (#2) assisted Resident #71 from the wheelchair (w/c) to the bedside commode and then back to the w/c with assist of one and gait belt. During an interview on 10/18/18 at 11:45 a.m., an administrative nurse (#1) confirmed Resident #71's care plan needed updating regarding the resident's use of the bedside commode and transfer assist of 2 staff. - Review of Resident #99's medical record occurred on all days of survey. Physician notes, dated 06/06/18 - 09/12/18 identified the resident	F 657	to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his/her care. Staff meetings are being held on November 13-14, 2018 for all nursing staff to address the deficiencies, including this deficiency. Copies of the POC of the deficiencies were placed in all of the appropriate departments as an inservice, and staff has been educated through the read and sign process. QA audits started the week of November 4th, 2018. Audits will be completed weekly for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits. All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be	

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F 657	Continued From page 8 had worsening irritability, agitation, depression, and suicidal thoughts. The care plan failed to identify Resident #99's worsening irritability, agitation, depression, and suicidal thoughts with goals and interventions. During an interview on 10/18/18 at 3:30 p.m., an administrative nurse (#1) agreed Resident #99's care plan failed to reflect the resident's current care needs. - Review of Resident #187's medical record occurred on all days of survey. The current care plan stated, ". . . Mobility: Non-Ambulatory, . . . Manual wheelchair for long distances, staff to propel. . . ." Observation throughout the survey showed Resident #187 with a chest belt in place while seated in the wheelchair. The care plan failed to include the use of a chest belt while in the wheelchair. During an interview on 10/17/18 at 12:33 p.m., an administrative nurse (#1) agreed the care plan failed to include the chest belt. - Review of Resident #295's medical record occurred on all days of survey. The medical record identified the resident had a peripherally inserted central catheter (PICC) line used for intravenous antibiotics. The care plan failed to identify Resident #295's PICC line with goals and interventions. During an interview on 10/18/18 at 10:05 a.m., an	F 657	taken. The Director of Nursing is responsible for this process.	

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F 657	Continued From page 9 administrative nurse (#1) stated she expected staff to add the PICC line to Resident #295's care plan.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: NEUROLOGICAL CHECKS 1. Based on record review, review of facility policy and procedure, and staff interview, the facility failed to provide care in accordance with professional standards for 2 of 3 sampled residents (Resident #90 and #189) who experienced a fall and sustained a head injury. Failure to complete neurological assessments following such a fall has the potential for a head injury to go undetected. Findings include: Review of the facility policy titled "Neuro [Neurological] Checks" occurred on 10/18/18. This policy, dated January 2016, stated ". . . When a resident is suspected to have sustained a head injury, a neurological assessment should be done every fifteen (15) minutes for one (1) hour following the suspected injury and then every two (2) hours for twenty-four (24) hours or as ordered by the physician . . . " - Review of Resident #189's medical record	F 658	Residents #90 and #189 did not have Neuro Checks completed as per policy. Neuro Checks Nursing Home policy and Neurological Observations in the EHR were revised to reflect neurological assessment to be completed every 15 minutes for 1 hour following suspected head injury, and then every 2 hours for 24 hours or as ordered by provider. All staff that perform neurological assessments were given an in-service on the Neuro Check policy and the appropriate form to document the assessments. All staff that perform blood glucose checks and administer insulin were given an in-service on the blood glucose standing orders and the appropriate documentation of the initial blood glucose level, intervention and appropriate follow up blood glucose level. All staff that perform PICC line dressing changes were given an in-service on the PICC line policy and the required	11/16/18

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F 658	Continued From page 10 occurred on all days of survey. A progress note, dated 10/11/18, stated, ". . . Around 0300 [3:00 a.m.] . . . found him on the floor . . . he fell he hit the left outer side of his left knee [small circular abrasion], the left side of his elbow [elongated oval shaped abrasion], & [and] the posterior left side of his head he hit on the bed frame & got a long laceration approx [approximately] over 1 inch long . . . plus a little abrasion between his left finger 4 & 5 . . . Update faxed to the NP [Nurse Practitioner] & called the on call hospice nurse to let her know of his fall & injuries." Documentation showed nursing staff completed the initial neuro check on 10/11/18 at 3:00 a.m., however staff failed to complete the remaining neuro checks per policy. - Review of Resident #90's medical record occurred on all days of survey. Progress notes stated the following: * 08/12/18 at 11:35 p.m. "CNA [certified nursing assistant] staff reported that resident tilted out of Hoyer lift during transfer - feet never hit the floor, but the right side of the forehead hit the edge of the bed frame. A 0.5 cm [centimeter] x 0.5 cm abrasion noted to the right forehead. No bleeding, swelling, or bruising noted at this time. No other injuries noted at this time." * 08/12/2018 at 12:28 p.m. "Called [physician name] to notify him of the resident's fall and he said to continue with neuro check protocols." Documentation showed nursing staff completed the initial neurological check on 08/13/18 at 11:42 p.m. and another on 08/14/18 at 4:48 a.m., however, staff failed to complete neurological	F 658	documentation of the dressing change in the IVC Central Line Care Observation form. All staff that administer insulin via pen were given an in-service on the proper way to prime an insulin pen. The staff then completed an insulin priming demonstration to ensure their competency of meeting the professional standard. The Instructions for use Humalog Kwikpen guide is the resource that resides on each nursing unit and located in the nurse educators' office. All residents have the potential to be affected when not receiving services that meet professional standards and are at risk for unobserved adverse effects which include head injuries, hypoglycemia, infection and inaccurate amount of medication administered. QA audits started the week of November 4th, 2018. Audits will be completed weekly for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits. All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for	

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(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 658	Continued From page 11 checks as per facility policy. During an interview on 10/18/18 at 11:45 a.m., an administrative nursing staff member (#1) stated she would expect staff to complete neuro checks per policy. BLOOD GLUCOSE LEVEL 2. Based on record review and staff interview, the facility failed to ensure staff followed standards of practice for 1 of 8 sampled residents (Resident #80) receiving insulin. Failure to reassess blood glucose for residents with low blood glucose may result in adverse affects related to hypoglycemia. Findings include: Review of Resident #80's medical record occurred all days of survey. A physician's standing order stated, "If glucose is < [less than] 80 or resident is suspected of having insulin reactions, check glucose. If BG [blood glucose] is 60-70, give 6 oz. [ounces] fruit juice or regular pop, or 3 glucose tabs, or 1 tube (10gm) [grams] of glucose gel. . . . Recheck glucose in 15 minutes and repeat above if necessary. . . ." Resident #80's medical record showed blood glucose levels of 66 milligrams per deciliter (mg/dl) on 09/25/18, 69 mg/dl on 09/28/18, and 63 mg/dl on 9/29/18. The facility failed to follow physician's standing orders and reassess Resident #80's blood glucose level in 15 minutes following a low blood glucose level. During an interview on 10/17/18 at 3:44 p.m., an	F 658	the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken. The Director of Nursing is responsible for this process.	

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F 658	Continued From page 12	F 658		

administrative nurse (#1) stated Resident #80 ate all of his meal following the low blood glucose readings. On 10/18/18 at 10:30 a.m., this nurse indicated she expected staff to recheck low blood glucose levels according to standing orders.

PICC LINE

3. Based on information received from the complainant, record review, and staff interview, the facility failed to follow professional standards of practice for 1 of 3 residents (Resident #293) with a peripherally inserted central catheter (PICC) line. Failure to change a PICC line dressing as ordered may result in an infection at the site.

Findings include:

Review of the facility policy titled "Central Venous Lines (PICC Lines, Central Lines, Ports) Insertion, Maintenance and Discontinuation occurred on 10/18/18. This policy, dated November 2017, stated, ". . . Dressing Change: Routine dressing changes are to be completed every seven days. . . ."

Review of Resident #293's medical record occurred on 10/18/18. The physician's orders identified PICC line dressing change weekly (Mondays) and as needed. Review of Resident #293's Treatment Record dated, 07/10/18 to 07/31/18, showed facility staff failed to change the PICC line dressing on Monday July 23 and Monday July 30th.

During an interview on 10/18/18 at 2:56 p.m. a supervisory nurse (#14) stated the facility had no

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F 658	Continued From page 13 documentation of the PICC line dressing change for the above dates. PRIMING INSULIN PENS 4. Based on observation and manufacturer's guidelines, the facility failed to follow professional standards of practice when priming insulin pens for 1 of 3 residents (Resident #72) observed receiving insulin. Failure to remove the needle shield prior to priming an insulin pen may result in the resident receiving an inaccurate amount of insulin. Findings include: Review of manufacturer's guidelines for NovoLog insulin stated, ". . . Preparing your NovoLog FlexPen. Pull off the big outer needle cap. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. . . ." Observation on 10/17/18 at 5:40 p.m. showed a licensed nurse (#5) prepared an insulin pen for injection for Resident #72. After placing the needle on the insulin pen, the nurse failed to remove the outer shield before priming the insulin	F 658		

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F 658	Continued From page 14 pen. With the shield still in place, the nurse was unable to visualize a stream of insulin from the needle and was not able to determine if another prime of the insulin pen was needed.	F 658		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to ensure 1 of 1 resident (Resident #80) with vision difficulties had access to a professional vision assessment. Failure to assess a resident's vision needs may result in the resident not being able to carry out activities of daily living (ADLs). Findings include: Observations throughout the survey showed Resident #80 bumping into things with his walker, drifting to the right when ambulating, and feeling for the wall and wheelchair when transferring. Review of Resident #80's medical record	F 685	A professional vision assessment was done for Resident #80 on November 6, 2018, and the recommendation was for reader glasses, which were given to the resident. All residents have the potential to be affected if vision and hearing assessments aren't ordered based on resident symptoms and needs. Trinity Homes staff received education regarding the importance of assessing residents for visual and hearing needs, and following through if identified that a resident needs to see a specialist. Staff	11/6/18

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F 685	Continued From page 15 occurred on all days of survey and identified a diagnosis of cerebral infarction, unspecified. The most recent Minimum Data Set (MDS) assessment, dated 08/21/18, coded Resident #80's vision as highly impaired. The medical record failed to show a professional vision assessment had been done. During an interview on 10/17/18 at 2:15 p.m., a staff nurse (#6) stated Resident #80 possibly had limited peripheral vision on the left related to his stroke. She explained when food was placed directly in front or to the left of Resident #80, he did not eat independently. When food was place to the right of Resident #80, he ate independently. During an interview 10/18/18 at 10:30 a.m., an administrative nurse (#1) stated if a resident had vision difficulties the facility coordinated a professional vision assessment. She confirmed the facility failed to coordinate a professional vision assessment for Resident #80.	F 685	meetings are being held on November 13-14, 2018 for all nursing staff to address deficiencies, including this deficiency. Copies of the education for the POC have been placed in all appropriate departments as an inservice, and staff has been educated through the read and sign process. QA audits started the week of November 4th, 2018. Audits will be completed weekly for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits. All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken. The Director of Nursing is responsible for this process.	
F 689 SS=E	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	F 689		11/15/18

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F 689	Continued From page 16 §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 observation and family and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 4 of 36 sampled residents (Resident #50, 52, 71 and 105) and one supplemental resident (Resident #61). Failure to properly transfer Resident #105 and #71 and ensure call lights within reach for Residents #50, 52, 61, 71 and 105) placed residents at risk of accidents and injuries. Findings include: - Observation showed on 10/15/18 at 3:10 p.m., showed resident #52 in bed. Call light behind resident on bedside table out of reach. Review of Resident #52's medical record occurred on all days of the survey. The current care plan stated, ". . . Current Interventions: hourly rounds, call light within reach . . . Falls committee recommendations: continue with plan of care . . . ." - Observations on 10/15/18 at 3:14 p.m. and 10/16/18 at 3:35 p.m., showed Resident #61 sitting in her recliner with call light on the bed and not within the resident's reach. - Observation on 10/15/18 at 4:33 p.m., showed Resident #50 sitting in her wheelchair with the call light located on the floor. The resident	F 689	Follow up done to verify residents #50, #52, #61, #71 and #105 (and all residents) have call light in reach. Resident's care plan reviewed and staff re-educated on following plan of care and using a gait belt for all transfers. All residents have the potential to be affected if staff do not follow the plan of care and use appropriate techniques, e.g. gait belt when transferring resident. Trinity Homes direct care staff received education which included following resident care plans and following safe transfer techniques. Staff meetings are being held on November 13-14, 2018 for all nursing staff to address deficiencies, including this deficiency. Copies of the education for the POC have been placed in all appropriate departments as an inservice, and staff has been educated through the read and sign process. QA audits started the week of November 4th, 2018. Audits will be completed weekly for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we	

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F 689	Continued From page 17 complained of pain to her left hip as she struggled to reposition in the wheelchair. The resident was upset she was unable to reposition in the wheelchair. The resident was unable to reach the call light, this surveyor activated it. After 3-4 minutes a certified nurse aide (CNA) (#20) answered the call light and assisted the resident. Review of Resident #50's medical record occurred on all days of survey. The current care plan stated, ". . . [Resident #50] is at risk for falls due to weakness. Call light within reach. . . ." - Review of Resident #71's medical record occurred on all days of survey. The current care plan stated, ". . .Transferring: Staff assist of 2. Ensure appropriate foot wear worn. [Resident #71] to sit up slowly and wait before slowly standing then wait. . . ." Observation on 10/16/18 at 9:18 a.m. showed a CNA (#2) transferred Resident #71 from the wheelchair to the bedside commode and back to the wheelchair with a gait belt. Staff failed to transfer Resident #71 with an assist of two. - Observation showed on 10/16/18 at 9:49 a.m., CNA's (#10 and #11) transferred Resident #105 from her wheelchair to the toilet lifting her under both arms. While performing perineal care, the CNA's stood the resident several times, each time lifting under the resident's arms. The resident stated, "oh God, oh God, oh God." The CNA's failed to use a gait belt. During an interview on 10/17/18 at 9:07 a.m., CNA (#12) stated a gate belt is always supposed	F 689	will again complete weekly QA audits. All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken. The Director of Nursing is responsible for this process.	

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F 689	Continued From page 18 to be used when transferring residents. During an interview on 10/18/18 at 11:01 a.m., an administrative nurse (#1) stated the facility does not have a gait belt policy. She stated she expects staff to use a gait belt on all residents with transfers.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		11/16/18

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F 690	Continued From page 19 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family interview and staff interview, the facility failed to ensure the continued use of a catheter remained medically necessary for 1 of 1 sampled resident (Resident #157) with a foley catheter. Failure to reassess and ensure catheter placement remained appropriate after admission to the facility placed resident at risk for urinary tract infections (UTIs), urethral damage and discomfort. Findings include: Review of Resident #1's medical record occurred all days of survey. Diagnoses included history of malignant neoplasm of prostate, hemiplegia, and hemiparesis following cerebral infarction (stroke). Resident #157 admitted to the nursing facility with a foley catheter. The significant change minimum data set (MDS), dated 06/22/18, identified an indwelling catheter, severly impaired cognitive functioning and diagnosis of stroke/hemiplegia/hemiparesis. Observations throughout the survey showed Resident #157 with a foley catheter in place. During an interview on 10/15/18 at 4:12 p.m. The resident's wife asked this surveyor the reason for	F 690	Resident #157 had Foley catheter removed on October 18, 2018. All nursing staff caring for a resident with a urinary catheter were educated on the Indwelling Urinary Catheter Nurse-Directed Discontinuation protocol. Residents who are admitted with Foley catheter will be assessed to ensure that the catheter is medically necessary. All residents have the potential to be at risk for urinary tract infections (UTIs), urethral drainage and discomfort if catheter is not removed when no longer medically necessary . Staff meetings are being held on November 13, 2018 and November 14, 2018 for all nursing staff to address the deficiencies, including this deficiency. Copies of the education for the plan of correction (POC) of the deficiencies were placed in all appropriate departments as an in-service, and staff has been educated through the read and sign process. QA audits started the week of November 4th, 2018. Audits will be completed weekly for four weeks, or until compliance	

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F 690	Continued From page 20 continued catheter use. During an interview on 10/18/18 at 9:30 a.m., an administrative nurse (#5) confirmed Resident #157 had an indwelling foley catheter in place when admitted to the facility, and the facility had not reassessed to ensure the catheter remained medically necessary.	F 690	has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits. All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken. The Director of Nursing is responsible for this process.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide the necessary care and services for 2 of 5 sampled residents (Resident #71 and #162) and 1 supplemental resident	F 695	Resident #71-Oxygen tank turned on and oxygen applied after CNA failed to replace nasal cannula. Resident #593 had oxygen tank replaced after surveyor notified staff of empty tank.	11/16/18

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F 695	Continued From page 21 (Resident #593) receiving oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include: Berman and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 1397, stated, "OXYGEN THERAPY . . . Like any medication, oxygen is not completely harmless to the client. Clients receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ." - Review of Resident #162's medical record occurred on all days of survey. A physician's order stated, ". . . Oxygen at 2 L [liters] per N/C [nasal cannula] every shift (Night, Day, Evening) . . . ." Observation on 10/15/18 at 11:08 a.m. showed a certified nursing assistant (CNA) (#8) assisted Resident #162 from the bathroom to bed. The CNA failed to replace the oxygen nasal cannula after providing cares. An identified staff member placed the oxygen at approximately 12 p.m. - Review of Resident #71's medical record occurred on all days of survey. A physician's order stated ". . . Oxygen at 2 L via N/C every shift (Night, Day, Evening) . . . Oxygen Saturation (With Oxygen) QD [daily] on Thursday between 6:15 to 14:30 . . . Oxygen Saturation (Without	F 695	All residents who receive oxygen have the potential to be at risk for complications due to improper oxygen use and not following procedures for administration of oxygen. All staff that provide care and/or transport the resident were educated on the importance of checking oxygen tanks, following orders, and always having oxygen on residents who have orders. Reviewed process with nursing and plant operations in October. QA audits started the week of November 4th, 2018. Audits will be completed weekly for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits. All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken. The Director of Nursing is responsible for this process.	

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F 695	Continued From page 22 Oxygen) QD on Thursday between 6:15 to 14:30. . ." Observation on 10/16/18 at 8:05 a.m. showed Resident #71 sitting at the dining room table with nasal cannula on and the oxygen tank turned off. Observation on 10/16/18 at 9:18 a.m. showed CNA (#2) removed oxygen from Resident #71. The CNA failed to replace the oxygen nasal cannula after providing cares and before transporting the resident to activities. - Observation on 10/15/18 at 12:03 p.m., showed Resident #593 seated at the dining room table with his oxygen in place. Closer observation showed the oxygen cylinder showed empty. This surveyor notified nurse (#24) of the empty tank. Resident #593's physician's order, dated 10/12/18, stated, ". . . Oxygen Therapy Special Instructions: 3 L /NC Every Shift Night, Day, Evening. . . ."	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		11/16/18

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TRINITY HOMES	**305 8TH AVE NE MINOT, ND 58703**

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F 725	Continued From page 23 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interviews and resident group interview, the facility failed to ensure sufficient nursing staff to provide services to meet the residents' needs for 4 of 36 sampled residents (Resident F, G, H, and J), 2 supplemental residents (Resident I and K) and 5 of 9 residents attending the group interview (Resident A, B, C, D, and E). Failure to provide sufficient staffing to answer call lights in a timely manner does not promote each resident's right to physical, mental and psychosocial well-being and may result in residents experiencing falls and/or incontinence. Findings include: - During an interview on 10/15/18 at 11:05 a.m., Resident H stated, "They are always short staffed. I have colitis and I've had to wait 30-45 minutes for them [staff] to come clean me up. It is especially bad during dinner time when they are taking others to dining room and feeding them,	F 725	Staff will follow up with resident's interviewed to get more specific information; shifts, staff, etc. Verified with the staffing office and staffing sheets that the staff matrix is followed. All residents have the potential to have decreased mental, physical and emotional well-being if call lights are not being answered timely, and if needs aren't being met when call lights are answered. Meeting held with all Department Directors on October 22, and reiterated that all staff from all departments were to answer call lights, and explained procedure to be followed if staff is unable to meet resident's requests. Directors met with all of their staff and explained the importance of call lights and what each	

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F 725	Continued From page 24 that's their focus and they don't have enough help to care for us in our rooms." - During an interview on 10/15/18 at 11:39 a.m., Resident G stated, "At nights there is not enough staff, I've had to wait for long periods of time at night (after 10 p.m.) to get help getting up to use the bathroom and back into bed. Someone [staff] even told me, "I have a bad back I can't help you." - During an interview on the morning of 10/15/18, Resident K identified last week staff failed to answer the call light for 45 minutes. - During an interview on the morning of 10/15/18, Resident J's wife stated, just the other night Resident J called her at home as staff did not answer the call light. - During an interview on 10/15/18 at 4:33 p.m., Resident G stated, "I put my call light on at noon today to get out of bed and after waiting 45 minutes I got myself up because they [staff] never did come answer my call light." - During an interview on 10/16/18 at 9:10 a.m., Resident F stated, "I have to wait for a long time, 45-60 minutes after supper to get washed up and into bed, I guess they are short staffed." - During an interview on 10/16/18 at 2:35 p.m., Resident I stated, "Always short staffed and if I need help while they are feeding at dinner or supper time I can't get it. They don't have enough staff to help those of us that don't eat in the dining room."	F 725	staff member's responsibilities are. Staff meetings are being held on November 13, 2018 and November 14, 2018 for all nursing staff to address the deficiencies, including this deficiency. Copies of the education for the plan of correction (POC) of the deficiencies were placed in all appropriate departments as an in-service, and staff has been educated through the read and sign process. QA audits started the week of November 4, 2018. QA audits will be completed weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, QA audits will continue monthly for 4 months then quarterly. If compliance is not achieved, staff will be re-educated and QA audits will be completed weekly again. All QA audits will be reviewed weekly for compliance by the DON and ADON and reported to the monthly QAPI meeting. All Directors/Managers are responsible for the education and monitoring of staff to ensure call lights are being answered timely. If noted that staff are not answering lights as expected, education and corrective actions will be taken immediately. Director of Nursing and Social Work Director are responsible for this process.	

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F 725	Continued From page 25 - During a resident group interview on 10/17/18 at 10:13 a.m., Residents A, B, C, D, and E(identified interviewable by the facility) agreed they had waited up to 45 minutes to an hour for their call light to be answered and response times took longer at night than during the day. Review of resident council minutes occurred on 10/17/18. The minutes, dated 08/20/18, stated, "The only concern that was addressed other than a couple of personal concerns is staff that answer their call light, shut it off, say they will be back, and get busy doing something else. . . ."	F 725		
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	F 761		11/16/18

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F 761	Continued From page 26 facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to discard expired medications in 3 of 15 storage areas (1 medication room and 2 medication carts). Failure to discard expired medications increased the risk of residents receiving outdated medications with reduced medication efficacy. Findings include: Review of the facility policy "Discharge Of A Resident To Home Or Another Facility" occurred on 10/18/18. This policy, revised June 2018, stated, ". . . Send medications to pharmacy for bottling and labeling . . . ." Observation showed the following: * 10/17/18 at 9:10 a.m., Major Deep Sea Premium Saline with expiration date of 8/18/18 and three unidentified medications in an unlabeled daily plastic planner on the medication cart located on 3 south. An administrative staff (#1) confirmed the medication should have been discarded and the unlabeled planner should not have been in the cart. * 10/17/18 at 4:00 p.m., Tylenol regular strength individual single capsules with the expiration dates of June 2017 and December 2017 on the 4 Central medication cart. A licensed practical nurse (LPN) (#3) who was present confirmed the medication should have been discarded. * 10/17/18 at 4:30 p.m., Phenylephrine HCL 10mg with the expiration date of September 2018	F 761	All expired medications were removed from the areas in which they were found. Planner with unlabeled medication removed from medication cart and discarded. All medication storage areas are identified and assigned to specific staff to clean areas and check all medication for expiration dates. If medication is found to be expired, proper disposal of medication will occur. All residents have the potential to be at risk to receive outdated medications if proper procedures aren't followed for checking and disposing of medications. Staff meetings are being held on November 13, 2018 and November 14, 2018 for all nursing staff to address the deficiencies, including this deficiency. Copies of the education for the plan of correction (POC) of the deficiencies were placed in all appropriate departments as an in-service, and staff has been educated through the read and sign process. QA audits started the week of November 4, 2018. QA audits started the week of November 4th, 2018. Audits will be completed weekly for four weeks, or until compliance has been achieved consistently for four	

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F 761	Continued From page 27 on the 4 East medication cart. ASA suppositories with the expiration date of April 2018 in the 4 East fridge. A LPN (#4) who was present confirmed the medication should have been discarded.	F 761	weeks. At that time QA audits will be monthly for 4 months and then quarterly for 3 quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits. All QI audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken. The Director of Nursing is responsible for this process.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		11/12/18

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F 812	Continued From page 28 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of the Food and Drug Administration (FDA) Food Code 2013, review of manufacturer's instructions, review of facility policy, and staff interview, the facility failed to store, prepare, and serve food under sanitary conditions in 1 of 1 kitchen (Main kitchen) and 1 of 3 kitchenettes (West 4th Unit). Failure to ensure the cleanliness of food preparation/ storage areas and proper temperatures/procedures for food storage and cooling has the potential to result in foodborne illness to residents, staff, and visitors. Findings include: COOLING PROCESS/LEFTOVERS Review of the facility policy titled "Cooling Foods" occurred on 10/18/18. This revised policy dated October 2018, stated, ". . . All cooked foods must be cooled from 135 degrees F [Fahrenheit] to 70 degrees F within 2 hours and from 70 degrees F to 41 degrees F or lower in an additional 4 hours for total cooling time of 6 hours . . .Cool foods by the following methods based on the type of food being cooled . . . Placing the food in shallow plans . . . Separating the food into smaller or thinner portions . . . using containers that transfer heat . . . Place in freezer . . . Stirring the food in a container placed in an ice water bath . . . Adding ice as an ingredient . . . " The FDA Food Code 2013, page 90-91, stated, ".	F 812	All Nutrition Services staff have received education and reviewed the policy on how to properly read a thermometer and how to document fridge and freezer temperatures. Food in nutrition services was discarded after not finding a cooling log for 10 days. Food was discarded from a refrigerator on 4W for a temperature reading of 48 degrees. All residents have the potential to be affected staff aren't recording the final time and temperatures of the cooling process all food cooled, and if refrigerator temps aren't taken daily to ensure proper temperatures. All Nutrition Services staff have been in-serviced on November 8, 2018 on the facility's policies and practice guidelines for checking refrigerator and freezer temperatures and documenting them 3X daily. In-service training included observation of each employee reading a thermometer from a fridge and freezer and properly documenting it on the temperature log sheet. QA audits will be done weekly for 4 weeks or until compliance is achieved. Once compliance is achieved consecutively for 2 weeks, audits will be completed monthly and reported to the QAPI committee. All	

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F 812	Continued From page 29 . . Cooling . . . Cooked Time/Temperature Control for Safety Food shall be cooled . . . Within 2 hours from 57 degrees C [Celsius] (135 degrees F) to 21 degrees C (70 degrees F) and . . . Shall be cooled within 4 hours to 5 degrees C (41 degrees F) or less . . . " Observation on 10/15/18 at 10:45 a.m. showed the following leftovers in the walk-in cooler and fridge: * Roast beef dated 10/09/18 * Rice, sliced beef, ground beef, sliced turkey dated 10/12/18 * Cream corn, chicken breast, sliced ham dated 10/13/18 * Sliced roast beef dated, pork roast, ham salad, and rib soup dated 10/14/18 Review of the 2018 Cooling Logs for August, September, October indicated staff failed to record the final time and temperature of the cooling process and failed to log all food cooled between October 8 through October 18, 2018. The dietary staff member (#15) failed to provide a cooling log for the foods listed above and discarded these items. FOOD STORAGE/TEMPERATURE Review of the facility policy titled "Rotation/Storage of Foods" occurred on 10/18/18. This revised policy, revised 02/01/12, stated, ". . . Fridge temp [temperatures] should be 40 degrees or less, freezer should be 0 degrees or below . . ." A final kitchen tour occurred on 10/18/18 at 8:30 a.m. with a dietary staff member (#15).	F 812	nutrition services staff is responsible for monitoring and documenting refrigerator and freezer temperatures. Nutrition Services Director and Supervisors will complete random checks of staff performing the procedure to monitor and document refrigerator and freezer temperatures to stay in accordance with facility policy. If any concerns are identified, immediate corrective action will be applied. The Director of Nutrition Services is responsible for his process.	

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F 812	Continued From page 30 Observation of the West 4th unit fridge showed the temperature at 45 degrees F. After the internal food temperatures showed 48 degrees F, the dietary staff member discarded the food. Review of the Unit Fridge Temperature Logs indicated the staff failed to record the fridge temperatures for 14 out of 18 days in October 2018.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		11/16/18

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F 880	Continued From page 31 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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F 880	Continued From page 32 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/05/18. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow infection control practices for 3 of 23 sampled residents (Resident #33, #50, and #89) observed during cares. Failure to follow infection control practices related to proper use of personal protection equipment (PPE) (Resident #33) and hand hygiene (Resident #50 and #89) has the potential for transmission of infections to other residents and staff. Findings include: Review of the facility policy and procedure titled "Isolation Precautions" occurred on 10/18/18. This policy, revised February 2018, stated, ". . . Enteric Contact Precautions - Clostridium difficile . . . Visitors to a room with a resident with active C difficile must wear both gown and gloves. Soap and water is required for hand hygiene . . . " Review of the facility policy and procedure titled "Handwashing/Hand Hygiene" occurred on 10/18/18. This policy, revised February 2018, stated, ". . . When is Hand Hygiene (Alcohol Hand Sanitizers) necessary? . . . After contact with resident's mucous membranes and body fluids or excretions, After handling soiled equipment or utensils (e.g., used linens, bedpans, catheters and urinals), After removing gloves . . . When is Handwashing (Soap and Water) necessary? . . . After contact with a	F 880	Reviewed Enteric Precautions with all staff that enter Resident #33□s room and all others positive for c difficile including proper personal protective equipment and appropriate hand hygiene with soap and water. Reviewed the Handwashing -Hand Hygiene policy with all staff that come into contact with Resident #50 and #89 and all other residents which included when to perform hand hygiene. All residents have the potential to be affected if infection control practices are not followed related to proper use of personal protection equipment and hand hygiene and are at risk for transmission of infections to other residents and staff. Trinity Homes staff received education in October, which included Infection Prevention and Control Policies on Handwashing -Hand Hygiene. Staff meetings are being held on November 13-14, 2018 for all nursing staff to address deficiencies, including this deficiency. Copies of the education for the POC have been placed in all appropriate departments as an in-service, and staff has been educated through the read and sign process. QA audits started the week of November 4, 2018. Audits will be completed weekly	

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F 880	Continued From page 33 resident with infectious diarrhea (including . . . C [clostridium] difficile) . . ." CLOSTRIDIUM DIFFICILE - Review of Resident #33's medical record occurred on all days of survey. The medical record identified Resident #33 had a positive Clostridium Difficile Toxin (CDT) (a bacteria found in feces) test on 10/07/18. A sign outside of Resident #33's door stated, "gown to enter room, gloves to touch any surface and wash with soap and water." Observation on 10/15/18 at 4:16 p.m. showed a nurse (#18) entered Resident #33's room to administer medications to the resident. The nurse failed to don gloves or a gown and observation showed Resident #33 touching the nurse. The nurse failed to perform hand hygiene with soap and water before exiting the room. Observation on 10/16/18 at 10:54 a.m. showed an unidentified activity staff member entered Resident #33's room and failed to don gloves and a gown. The activity staff member activated the residents call light and failed to perform hand hygiene with soap and water before exiting the room. Observation on 10/16/18 at 11:45 a.m. showed an unidentified staff nurse entered Resident #33's room to administer medications. The nurse failed to don gloves or a gown and failed to perform hand hygiene with soap and water when exiting the room. During an interview on 10/18/18 at 10:00 a.m., a	F 880	for four weeks, or until compliance has been achieved consistently for four weeks. At that time QA audits will be monthly for four months and then quarterly for three quarters. If compliance is not achieved staff will be re-educated and we will again complete weekly QA audits. All QA audits will be reviewed weekly for compliance by the DON and ADON and data will be presented to the QAPI committee monthly. All Directors/Managers are responsible for the education and the monitoring process of their employees. If non-compliance is noted, immediate corrective action will be taken. The Director of Nursing and CEPS Director are responsible for this process.	

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F 880	Continued From page 34 supervisory nurse (#21) stated she expected all staff to wear a gown and gloves in Resident #33's room and perform hand hygiene using soap and water. HAND HYGIENE - Observation on 10/17/18 at 8:43 a.m., showed a certified nurse assistant (CNA) (#19) assisted Resident #50 off the bedpan after having a bowel movement (BM). The CNA washed her hands, donned gloves, and provided perineal care for Resident #50. The CNA emptied the bed pan in the toilet, wiped the bed pan and toilet seat, removed her gloves, and without completing hand hygiene, donned new gloves. The CNA picked out the resident's clean clothes from the closet, took the breakfast tray out to the hall, returned to the resident's room, removed the gloves, grabbed the garbage from the bathroom floor, exited the room, and applied hand sanitizer. The CNA (#19) failed to perform hand hygiene after removing soiled gloves, prior to providing additional cares, and/or exiting the resident's room. - On 10/16/18 at 08:57 a.m., observation showed two CNAs (#22 and #23) transferred Resident #89 to bed with a mechanical lift, donned gloves, and removed the resident's wet and soiled brief. One CNA (#22) provided perineal cares, squeezed protective cream from a tube onto the resident's perineal area, placed a new brief, and removed her gloves. Without performing hand hygiene, the CNA (#22) held a water cup for Resident #89 to drink, lowered the bed to the floor, covered the resident with a blanket, before	F 880		

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 10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 35 she performed hand hygiene. During an interview on 10/18/18 at 1:55 p.m., an administrative nurse (#1) agreed staff should have performed hand hygiene after completion of perineal cares and removal of gloves.	F 880		