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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 For the unannounced complaint investigation started on 11/25/13 and completed on 11/27/13, the sample included (8) eight residents for focused review and (2) two closed records for review. The sample included (5) five additional residents to verify specific concerns during the survey.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, information received from the complainant, and resident interview, the facility failed to provide reasonable accomodation of needs regarding call lights for 2 of 8 sampled residents (Resident #5, and #8), 4 supplemental residents (Resident #11, #12, #13, and #14), and 1 confidential resident (Resident A). Failure to answer call lights in a timely manner may result in falls, avoidable incontinence, increased behaviors, and a decreased quality of life. Findings include: Information received from two separate complainants identified concerns regarding staff	F 246	All staff have been re-educated and inserviced on the importance of insuring call lights are within reach of residents and answering call lights in a timely manner. All residents have the potential to be affected. All resident rooms have been checked to make sure that call lights are easily accessible to residents. Monitoring systems are in place for random audits of accessibility of call lights and that call lights are answered in a timely manner. Random audits will be done on each unit, with results reported monthly at the QA meeting. This will be done until compliance is obtained. Social Services will meet with alert residents to verify call lights are accessible and are being answered in a reasonable time. The issue will continue to be addressed in the monthly resident council meeting. Completion date is 12/20/2013. DON and Social Services are responsible for this process. Policy changes have been made and all staff have been educated on policy changes and care of residents with oxygen. All residents with oxygen therapy have the potential to be affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rhonda Lamberg — TITLE: Administrator — (X6) DATE: 12/20/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is (...ne . that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disc ...ble 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are ...closable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 246	Continued From page 1	F 246		

failure to answer call lights in a timely manner.

- Observation on 11/25/13 at 11:30 a.m. showed Resident #5 activated her call light. Observation showed the resident got up unassisted from bed, ambulated to the bathroom, and then ambulated to a chair located near her bed. The call light remained on until 11:56 a.m., at which time a staff nurse (#6) entered the room and asked the resident if she needed help getting into her wheelchair. Observation showed three different staff members passed by Resident #5's room during the 26 minutes her call light remained on and unanswered.

Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia. The resident's current Minimum Data Set (MDS), dated 10/24/13, identified severe cognitive impairment and limited assistance from one person for transfers and ambulation. Resident #5's current Care Guide (used by the certified nursing assistants [CNAs] to direct resident care) stated, ". . . Transfer . . . Transfer belt . . . Constant supervision for transfers . . . transfers with assist of 1 . . . Ambulation . . . Ambulatory . . . Staff to walk resident . . ."

- Observation on 11/25/13 at 11:28 a.m. showed Resident #12 activated his call light. At 11:47 a.m. (19 minutes later), an unidentified staff member entered the room, shut the door, and turned off the call light.

- Observation on 11/26/13 at 9:00 a.m. showed the call light activated in Resident #11's room. Resident #11 called out from inside the room, "Help please. Can I get some help please?" At 9:10 a.m., Resident #11's roommate came out

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 246	Continued From page 2	F 246		

into the hallway and asked the surveyor, "Can somebody help him please? He's hollering." The surveyor entered the room, and Resident #11 stated, "I don't know what's going on. This isn't what I ordered [indicating his breakfast tray]." Resident #11 stated he had his call light on "ever since I got up," and "a long time, 20 minutes at least." A staff nurse (#8) then entered the room and assisted Resident #11.

- Review of Resident #11's medical record occurred on 11/26/13. An admission MDS, dated 09/11/13, identified intact cognition.

- During an interview on 11/26/13, Resident A's family member stated facility staff leave the resident alone in the bathroom for a long time and he/she often assists the resident off the toilet. The family member stated about three weeks ago he/she came to visit and found Resident A seated on the toilet. The resident stated his/her "butts sore" and to help him/her off the toilet. The family member turned on the call light but no one came to assist so he/she assisted the resident.

- Observation on 11/26/13 at 9:05 a.m. showed two CNAs (#12 and #13) assisted Resident #8 from his wheelchair to bed, provided personal cares, and covered him with a blanket. Before exiting the room, the CNAs searched for the resident's call light. The two CNAs (#12 and #13) and an unidentified nurse lifted Resident #8's bed away from the wall (the bed had no wheels), found the call light attached to a lowered siderail, and handed it to the resident.

Review of Resident #8's MDS, dated 10/24/13, identified both long and short term memory problems and required extensive assistance of

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 246	Continued From page 3 two or more staff members for bed mobility and transfers. - Observation on November 25-27, 2013 identified Resident # 13's call light on the floor between the wall and resident's bed (touching the wall), inaccessible to the resident. On 11/26/13 at 11:20 a.m., when asked how Resident #13 would call for staff help, the resident stated, "I don't know. I would just yell." - Observation on November 25-27, 2013 identified Resident #14's call light on the floor between her bed and the wall, inaccessible to the resident. On 11/27/13 at 10:20 a.m., when asked how Resident #14 would call for staff help, the resident stated, "Good question."	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, information received from the complainant, review of facility policy, and staff interview, the facility failed to provide necessary care and services regarding as needed (prn) oxygen use for 2 of 4 sampled residents (Resident #5 and #8) receiving oxygen and 1 closed record (Resident	F 309	Policy changes have been made and all staff have been educated on policy changes and care of residents with oxygen. All residents with oxygen therapy have the potential to be affected.	

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	C 11/27/2013

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 309	Continued From page 4 #10). Failure to check saturations prior to administering prn oxygen may result in unnecessary/inappropriate use of oxygen. Findings include: Information received from the complainant identified staff administered oxygen unnecessarily and failed to check oxygen saturations. Review of the facility policy titled "Oximeter Readings" occurred on 11/17/13. This policy, revised January 2010, stated, ". . . Residents who use oxygen will have an oximetry reading done weekly, and more frequently when using nursing judgement. . . . O2 [oxygen] should be off 15-20 minutes prior to doing the oximetry. . . ." - Review of Resident #5's medical record occurred on all days of survey. Resident #5's current care plan stated, ". . . Cardiac function alteration . . . Hypertension . . . Oxygen saturation PRN . . . Oxygen - 2 LPM/NC [liters per minute per nasal cannula] - to keep sats [saturations] >[greater than]90% PRN . . ." Current physician's orders included: "Oxygen - 2 LPM/NC continuous prn repeating to keep sats >90%." Record review identified Resident #5 used oxygen every day from August 1 - November 26, 2013; however, staff only checked the resident's saturations on one day (10/18/13) during this time period. Observation on 11/26/13 at 4:40 p.m. showed Resident #5 in bed with oxygen via nasal cannula. A certified nursing assistant (CNA) (#7) stated, "Anytime she's [Resident #5] in bed she has her oxygen on."	F 309	All residents with O2 will have O2 saturation measurements with and without O2 per policy. Physicians have been notified of the policy changes, and PRN O2 orders have been discontinued. Nurses are responsible to monitor sats and apply oxygen, and document oxygen levels. Titration orders will be done by specific physician orders. Monitoring of O2 sats on room air and oxygen will be done weekly on all residents with O2 per policy; and the provider will be notified if changes need to be made. Weekly audits will be done until the compliance is achieved then monthly, to assure that the policy is being followed; and results will be reported monthly at the QA meeting. Completion date is 12/20/2013. DON is responsible for this process.	

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 309	Continued From page 5	F 309		

During an interview on the morning of 11/27/13, a supervisory nurse (#1) stated staff "spot check" Resident #5's oxygen saturations and confirmed staff do not check saturations regularly.

Failure to consistently monitor saturations prior to administering prn oxygen may result in residents receiving oxygen unnecessarily.

- Record review for Resident #8 occurred on November 25-27, 2013 and diagnoses included Alzheimer's disease and anxiety. The current care plan stated, " . . . Oxygen Therapy - to keep oxygen sats > 90% PRN . . . " .

Review of Resident #8's oxygen monitoring log from September 09- November 26, 2013 showed the resident used oxygen 25 days. Staff failed to check saturations prior to the administration of the oxygen.

Observation on 11/26/13 at 8:15 a.m. showed Resident #8 seated in his wheelchair in the dining room without oxygen. At 9:05 a.m., two CNAs (#12 and #13) assisted the resident to bed. Before leaving the room, the CNA (#12) placed a nasal cannula on Resident #8 and turned the oxygen on at 2 LPM. The CNAs failed to check the resident's oxygen saturation and notify the nurse prior to the administration of oxygen.

During an interview on the morning of 11/27/13, an administrative nurse (#5) stated staff check oxygen saturation randomly. This nurse confirmed staff did not check saturations regularly.

- Review of Resident #10's medical record

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 309	Continued From page 6 occurred on November 26-27, 2013. Resident #10's care plan stated, ". . . Cardiac function alteration . . . Oxygen - 2 LPM/NC - O2 2-3 L [liters] prn to keep O2 sat above 90 [percent] PRN. . . ." A physician order, dated 07/26/13, stated, ". . . O2 2L-3L PRN to keep O2 Sat above 90." Record review identified Resident #10 used oxygen eight times from July 26 - October 01, 2013; however, staff only checked the resident's room air oxygen saturations on one day (July 26th).	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder 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 2 of 4 sampled residents (Resident #2 and #5) observed receiving toileting assistance from staff and frequently incontinent of urine received appropriate treatment and services to maintain as much bladder continence as possible. Failure to provide Resident #2 with	F 315	All staff have been re-educated and in-serviced on assisting resident with toileting and providing pericare to prevent UTI and restore as much bladder function as possible. All residents have the potential to be affected. Ongoing resident assessment and monitoring are being done to insure that toileting needs are being met. Call lights are to be answered in a timely manner to assist with preventing incontinence; and pericares are done as needed. Linens are not to be used in briefs.	

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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	(X5) COMPLETION DATE
F 315	Continued From page 7	F 315		

toileting per his schedule resulted in incontinence; and failure to assist Resident #5 to the toilet and provide perineal cares may result in urinary tract infections and affect the resident's dignity and self-esteem.

Findings include:

- Review of Resident #2's medical record occurred on November 25-27, 2013. The Minimum Data Set (MDS), dated 11/07/13, identified severe cognitive impairment, frequently incontinent of bowel and bladder, and required extensive assistance for toilet use.

Resident #2's current care plan stated, ". . . Toileting: Peri-care w/ [perineal care with] each incontinent episode, toilet every 2 hours, even if resident states he doesn't have to go . . . Wears a pullup-staff assist to change, Urinal within reach . . ."

Observation on 11/26/13 showed no urinal within reach and the following observations:
* 8:10 a.m. - Resident #2 awake and lying on his bed.
* 10:05 a.m. - A certified medication aide (CMA) (#3) entered Resident #2's room and administered his morning medications.
* 10:20 a.m. - a certified nursing assistant (CNA) (#4) entered Resident #2's room and asked if he needed to use the rest room. The resident stated, "No, not right now." (The care plan stated to assist to the bathroom even if the resident refuses).
* 11:40 a.m. - a CNA (#4) assisted Resident #2 to the bathroom. Observation showed the resident wore two types of incontinence products and one product was saturated with urine. The CNA stated

Random audits are completed by nursing and will be reported monthly at the QA meeting. Included in these audits are call light in reach and answered timely, toileting being offered, and peri cares done.

Completion date is 12/20/2013. DON is responsible for this process.

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 315	Continued From page 8	F 315		

facility staff dressed the resident about 6:30 a.m. and probably assisted him to the bathroom at that time. She stated the resident refused to go to breakfast and chose to stay in bed.

During an interview on 11/26/13 at 4:50 p.m., a family member (A) stated Resident #2 often soaks through both incontinence products.

During an interview on the morning of 11/27/13, three administrative nurses (#1, #2, and #5) stated facility staff are expected to assist Resident #2 to the bathroom as care planned.

- Observation on 11/25/13 at 11:30 a.m. showed Resident #5 activated her call light. Observation showed the resident got up unassisted from bed, ambulated to the bathroom, and used the toilet. Resident #5 then ambulated to a chair located near her bed. The call light remained on until 11:56 a.m., at which time a staff nurse (#6) entered the room and asked the resident if she needed help getting into her wheelchair. Observation showed three different staff members passed by Resident #5's room during the 26 minutes her call light remained on and unanswered.

Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, a history of urinary tract infections (UTIs), and a history of falls. The resident's current MDS, dated 10/24/13, identified severe cognitive impairment, limited assistance from one person for transfers and ambulation, extensive assistance from one person for toileting and personal hygiene, and frequent urinary incontinence. Resident #5's current Care Guide (used by the CNAs to direct resident care) stated,

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 315	Continued From page 9 ". . . Toileting . . . Peri-care [perineal care] w/ [with] each incontinent episode . . . wears a brief - staff assist to change . . . Transfer . . . Transfer belt . . . Constant supervision for transfers . . . transfers with assist of 1 . . . Ambulation . . . Ambulatory . . . Staff to walk resident . . . Safety . . . Resident assessed at risk for falls . . . Bed alarm . . ." Failure to ensure Resident #5 received necessary assistance to the bathroom and appropriate incontinence cares following toileting may result in UTIs, skin breakdown, and a loss of comfort/dignity.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 4 sampled residents (Resident #3) and 1 supplemental resident (Resident #15) transferred by staff without a gait belt and for 1 of 3 sampled residents (Resident #5) with a silent bed alarm. Failure to use a gait belt when assisting residents and failure to answer silent	F323	Staff continue to be educated on hire and all current staff have been inserviced with written education on the proper use of gait belts, transferring and ambulating residents safely, and timely answering of all call lights and silent bed/chair alarms. Education also given on keeping care plans and care guides updated, and following the plan of care. All residents have the potential to be affected.	

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 323	Continued From page 10 bed alarms in a timely manner may result in resident injuries. Findings include: Review of the facility policy titled "Gait Belts" occurred on 11/27/13. This policy, revised March 2012, stated, "Policy: Gait belts will be used on residents who require staff assistance with transfers or ambulation. Each resident . . . will have their own gait belt which will be kept in a designated area of their room. . . ." Information received from the complainant identified concerns regarding staff failure to transfer residents safely and appropriately. -Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia and a history of falls. The resident's current Minimum Data Set (MDS), dated 10/24/13, identified severe cognitive impairment and limited assistance from one person for transfers and ambulation. Resident #5's current Care Guide (used by the certified nursing assistants [CNAs] to direct resident care) stated, ". . . Toileting . . . Peri-care [perineal care] w/ [with] each incontinent episode . . . wears a brief - staff assist to change . . . Transfer . . . Transfer belt . . . Constant supervision for transfers . . . transfers with assist of 1 . . . Ambulation . . . Ambulatory . . . Staff to walk resident . . . Safety . . . Resident assessed at risk for falls . . . Bed alarm . . ." Nurses' notes identified the following: *07/07/13 at 6:20 a.m.: ". . . at 0550 [5:50 a.m.] resident was found on the floor sitting upright next to her bed. No injuries found . . ."	F 323	Physical Therapists will continue to train nursing staff on hire and twice yearly on transferring residents safely, along with the proper use of gait belts. Nursing Service instructs staff on answering silent bed/chair alarms through inservices and direct observations. Transferring techniques, including proper use of gait belt, will continue to be taught through C.N.A. class (by Physical Therapist), with staff doing return demonstrations. Random audits are completed by nursing and will be reported monthly at the QA meeting. Included in these audits are call light in reach and answered timely, answering of silent alarms, and proper use of gait belts. Completion date is 12/20/2013. DON and Physical Therapy are responsible for this process.	

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 323	Continued From page 11	F 323		

*07/08/13 at 6:37 a.m.: ". . . After last rounds tried to get out of bed w/o [without] help 2x, found standing next to bed. . . ."
*07/08/13 at 9:02 p.m.: ". . . resident has been trying to get out of bed on own bed alarm in place . . ."
*07/12/13 at 9:30 p.m.: ". . . still at times take [sic] self to br [bathroom]. reinstructed to use call light for assistance. . . ."
*10/21/13 at 4:56 p.m.: ". . . resident was found in bathroom with depends half off and had large loose stool resident was cleaned . . ."
*10/30/13 at 3:05 a.m.: ". . . No attempts to get out of bed without assist this shift so far . . ."
*11/22/13 at 11:38 p.m.: ". . . After resident was put to bed, she was seen twice trying to get up from bed and saying that she wanted to get out of here and that this is not her home . . ."

Observation on on 11/25/13 at 11:30 a.m. showed Resident #5 activated her call light. Observation showed the resident got up unassisted from bed, ambulated to the bathroom, and then ambulated to a chair located near her bed. The call light remained on until 11:56 a.m., at which time a staff nurse (#6) entered the room and asked the resident if she needed help getting into her wheelchair. Observation showed three different staff members passed by Resident #5's room during the 26 minutes her call light remained on and unanswered.

During an interview on 11/26/13 at 4:40 p.m., a CNA (#7) stated Resident #5 has a "silent" bed alarm (an alarm that activates the call light when the resident attempts to get out of bed). The CNA stated that if Resident #5's call light is on, it is usually because she is moving in bed, as she is too confused to use the light to call for

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 323	Continued From page 12	F 323		

assistance.

Failure to respond to Resident #5's bed alarm in a timely manner resulted in the resident ambulating/using the bathroom unassisted and may result in avoidable falls/injuries.

- Observation on 11/26/13 at 9:00 a.m. identified two CNAs (#10 and #11) in Resident #3's room looking for a gait belt. One CNA (#10) stated the resident usually has a gait belt in her room and exited the room to get another one. The other CNA (#11) walked next to the resident, without using a gait belt, as the resident walked with a walker to the bathroom. The CNA (#11) completed perineal cares and as she pulled up the resident's pants, Resident #3's knees slightly buckled. At this time, the first CNA (#10) returned with a gait belt which the other CNA (#11) placed around the resident's waist and assisted Resident #3 to her bed.

The staff member failed to follow the facility's policy by not using a gait belt on Resident #3 who required staff assistance.

- Review of Resident #15 Care Guide occurred on 11/26/13. The current Care Guide stated, ". . . Transfers: Transfer belt, Transfers with assist of one and gait belt. . . ."

A random observation on 11/26/13 at 9:00 a.m., showed an unidentified staff member assisted Resident #15 to ambulate in the hallway. The staff member placed her right arm around Resident #15's waist and held the resident's left arm with her left hand. The staff member failed to use a gait belt.

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 333	Continued From page 13			
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and professional reference, and staff interview, the facility failed to follow professional standards for medication administration for 4 of 8 sampled residents (Resident #1, #2, #4, and #8) who received medications later than the scheduled time for administration. Failure to administer medications at the scheduled time placed these residents at risk for adverse health effects. Findings include: Review of the facility policy titled "ADMINISTRATION OF MEDICATIONS" occurred on 11/27/13. This policy, dated May 2005, stated, "PURPOSE: To insure that prescribed medications are given at the proper times. Medications that are set up on a scheduled basis must be given within one hour before or one hour after the scheduled time. PROCEDURE: 1. Medications prescribed by the physician will be administered according to the time schedule developed by nursing services . . ." Berman, Snyder, Kozier, and Erb, Fundamentals of Nursing, Concepts, Process, and Practice, 8th ed., Pearson Prentice Hall, New Jersey, 2008, Page 73, stated, ". . . Make sure the correct medications are given . . . at the scheduled time .	F333	All licensed staff have been provided with written education and inservice training on following proper procedure for signing off medications and following policy regarding administration of medications. All residents have the potential to be affected. Medication passes are audited to insure that meds are administered according to policy; which states that medications are to be administered within 1 hour before and 1 hour after scheduled med pass. Medications will be administered by medication aide, nurse, or both to insure timeliness of administration. Auditing is being done weekly until in compliance then monthly by Nurse Manager to verify medications are given, and signed off, within the one hour time frame. This is being done by observation and review of electronic medical record. Completion date is 12/20/2013. DON is responsible for this process.	

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 333	Continued From page 14	F 333		

. . Report all incidents involving clients . . ."

- On 11/26/13 at 10:05 a.m. a certified medication aide (CMA) (#3) stated, "I'm going to give him [Resident #2] his meds [medications]". Observation showed the CMA administered an aspirin, lasix (a diuretic), lisinopril (for hypertension), Ocuvite (a vitamin), vitamin E, cholecalciferol (vitamin D), metoprolol (for hypertension and heart function), potassium, and also removed and replaced a nitroglycerin patch (for chest pain). Review of the physician's orders and the medication administration record (MAR) identified 7:00 a.m. as the scheduled time for the nitroglycerine patch and 8:00 a.m. for all the other medications.

Review of Resident #2's November 2013 MAR identified facility staff administered medications late on the following days:
* 11/01/13: 8:00 a.m. medications 1 hour and 48 minutes late
* 11/02/13: 7:00 a.m. medication 3 hours late; 8:00 a.m. medications 2 hours late
* 11/03/13: 7:00 a.m. medication 2 hours and 35 minutes late; 8:00 a.m. medications 2 hours late
* 11/04/13: 8:00 a.m. medications 2 hours and 34 minutes late
* 11/08/13: 7:00 a.m. medication 2 hours and 30 minutes late; 8:00 a.m. medications 5 hours and 40 minutes late
* 11/10/13: 8:00 a.m. medications 5 hours and 9 minutes late
* 11/12/13: 7:00 a.m. medication 3 hours and 39 minutes late; 8:00 medications 4 hours late
* 11/17/13: 7:00 a.m. medication 2 hours late
* 11/18/13: 7:00 a.m. medication 1 hour and 49 minutes late
* 11/22/13: 7:00 a.m. medication 2 hours and 36

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 333	Continued From page 15	F 333		

minutes late; 8:00 a.m. medications 1 hour and 36 minutes late
* 11/25/13: 7:00 a.m. medication 1 hour and 57 minutes late

Resident #2's medical record lacked documentation as to why facility staff administered the above medications late.

- Review of Resident #1's medical record occurred on November 25-27, 2013. Daily medications scheduled for administration at 7:30 a.m. and 8:00 a.m. included levothyroxine (for hypothyroidism), aspirin, cranberry tablet, multivitamin, lisinopril, Sinemet (for Parkinson's disease), nitroglycerin patch, Miralax and Senna (for bowel regulation), and three types of eye drops.

Review of Resident #1's November 2013 MAR identified facility staff administered medications late on the following days:
* 11/01/13: 7:30 a.m. medications 2 hours and 49 minutes late; 8:00 a.m. medications 1 hour and 49 minutes late
* 11/02/13: 7:30 a.m. medications 2 hours and 30 minutes late; 8:00 a.m. medications 2 hours late
* 11/03/13: 8:00 a.m. nitroglycerin patch 1 hour and 41 minutes late; all other 8:00 a.m. medications 4 hours and 30 minutes late
* 11/09/13: 8:00 a.m. medications 2 hours and 55 minutes late
* 11/10/13: 7:30 a.m. medications 4 hours and 30 minutes late; 8:00 a.m. medications 4 hours late
* 11/19/13: 8:00 a.m. medications 1 hour and 44 minutes late
* 11/20/13: 8:00 a.m. medications 1 hour and 39 minutes late
* 11/22/13: 7:30 a.m. medications 4 hours and 45

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 333	Continued From page 16	F 333		

minutes late; 8:00 a.m. medications 4 hours and 15 minutes late
* 11/23/13: 7:30 a.m. medications 1 hour and 35 minutes late
* 11/24/13: 7:30 a.m. medications 3 hours late; 8:00 a.m. medications 2 hours and 30 minutes late
* 11/25/13: 7:00, 7:30, 8:00, and 10:00 a.m. medications given between 3 hours and 50 minutes and 6 hours and 50 minutes late
* 11/26/13: 7:30 a.m. medications 2 hours and 55 minutes late: 8:00 a.m. medications 1 hour and 55 minutes late

Resident #1's medical record lacked documentation as to why facility staff administered the above medications late.

- Review of Resident #4's medical record occurred on November 25-27, 2013. Daily medications scheduled for administration at 7:30 a.m. and 8:00 a.m. included Sinemet, Oxycontin (for pain), levothyroxine, omeprazole (for acid reflux), Miralax and Senokot, a multivitamin, and an eye drop.

Review of Resident #4's MAR the week of November 20-27, 2013 identified facility staff administered medications late on the following days:
* 11/20/13: 7:30 a.m. medications 2 hours and 58 minutes late; 8:00 a.m. medications 2 hour and 28 minutes late
* 11/21/13: 8:00 a.m. medications 2 hours and 48 minutes late
* 11/22/13: 7:30 a.m. medications 2 hours and 6 minutes late; 8:00 a.m. medications 1 hour and 36 minutes late
* 11/23/13: 8:00 a.m. medications 2 hours and 34

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 333	Continued From page 17	F 333		

minutes late
* 11/24/13: 8:00 a.m. medications 2 hours and 56 minutes late
* 11/25/13: 8:00 a.m. medications 1 hour and 26 minutes late

Resident #4's medical record lacked documentation as to why facility staff administered the above medications late.

- Review of Resident #8's medical record occurred on November 25-27, 2013. Resident #8's daily medications scheduled for 7:00 a.m. included levothyroxine 8:00 a.m. medications included amlodpine (blood pressure medication), Avapro (blood pressure medication), glipizide (diabetic medication), Seroquel (antipsychotic), tamusulosin (prostrate medication), ropinirole (Parkinson disease), Prozac (an antidepressant), Sinemet, Aggrenox (blood thinner), clonazepam (anxiety medication).

Review of Resident #8's November MAR identified facility staff administered medications late on the following days:
* 11/01/13: 7:00 a.m. medication 2 hours 46 minutes late; 8:00 a.m. medications 1 hour and 46 minutes late
* 11/02/13: 7:00 a.m. medication 3 hours late; 8:00 a.m. medications 2 hours late
* 11/03/13: 7:00 a.m. medication 2 hours and 27 minutes late; 8:00 a.m. medications 1 hour and 27 minutes late
* 11/09/13: 7:00 a.m. medication 2 hours and 33 minutes late; 8:00 a.m. 1 hour and 33 minutes late.
* 11/22/13: 7:00 a.m. medication 2 hours and 32 minutes late; 8:00 a.m. medications 1 hour and 32 minutes late.

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 333	Continued From page 18 * 11/24/13: 7:00 a.m. medication 2 hours and 28 minutes late; 8:00 a.m. medications 1 hour and 28 minutes late. Resident #8's medical record lacked documentation as to why facility staff administered the above medications late. During an interview on 11/27/13 at 12:40 p.m. administrative staff members (#1, #2, #5, and #9), agreed the documentation showed Resident #1, #2, #4, and #8 received their morning medications late.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	All staff have been re-education and inservices have been given regarding proper infection control practices; this includes hand hygiene policies (CDC) when exiting rooms and after glove removal, providing personal and pericares, after touching contaminated items/areas, equipment, and isolation practices including proper gowning, tying of gowns, and removal of gowns. All residents have the potential to be affected. Observations of hand hygiene entering and exiting rooms, after providing cares, and proper gowning will be done weekly and reported monthly at the QA meeting. Once compliance is obtained, monthly observations with quarterly reporting will be done. Infection Control Coordinator will make rounds on all nursing units, each shift, weekly to monitor infection control practices and educate staff as	

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 441	Continued From page 19 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to follow standard infection control practices for 2 of 2 sampled residents (Resident #4 and #8) observed in contact isolation and 1 of 5 sampled residents (Resident #5) observed during toileting/perineal care. Failure to follow infection control practices related to hand hygiene has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "Infection Control and Prevention" occurred on 11/27/13. This undated policy stated, ". . . Care of Resident Infected or Colonized with MDRO [Multiple Drug Resistant Organisms] . . . Hand hygiene: MOST IMPORTANT! Staff - wear gloves for contact with resident & [and] immediate environment (anything in room) - use soap & water or alcohol-based hand rub	F 441	appropriate. Report will be made monthly at the QA meeting. Please note: Document referenced as "Infection Control and Prevention" as "undated policy..., Care of Resident Infected or colonized with MDRO (Multiple Drug Resistant Organisms) Hand Hygiene: Most Important" is a handout for C.N.A. education class and not a facility policy, (contains a compilation of infection control practices and teaching methods). Completion date is 12/20/2013. DON and Infection Control Coordinator are responsible for this process.	

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 441	Continued From page 20	F 441		

after gloves are removed
- use alcohol-based hand rub if no contact with moist body surface or substance . . .
Gown - use if clothing may have contact with body substances or the resident or their environment, i.e. bath or pericare, transfers, feeding in the room, shaving . . . To put on a gown: Slip your arms into the sleeves and tie the neck ties and then the ties in the back at the waist. Gloves go on after the gown is in place. . . ."

- Review of Resident #4's medical record occurred on November 25-27, 2013 and identified Methicillin Resistant Staphylococcus Aureus (MRSA) in her nares and on contact isolation precautions.

Observation on 11/26/13 at 8:35 a.m. identified a certified nursing assistant (CNA) (#14) wore a gown and gloves and fed Resident #4 breakfast in her room. During the meal, the CNA (#14) left the room on two occasions to get additional items the resident requested. The CNA (#14) removed her gown and gloves but failed to perform hand hygiene both times she exited the resident's room.

- Review of Resident #8's medical record occurred on November 25-27, 2013 and identified MRSA in his urine and on contact isolation precautions.

Observation on 11/26/13 at 9:05 showed two CNAs (#12 and #13) donned gloves and gowns and assisted Resident #8 with perineal cares. Observation showed the CNA's (#13) gown tied loose at the neck, not tied at the waist, and fell off her shoulders during cares. After perineal cares,

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

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 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 441	Continued From page 21	F 441		

the CNA (#13) removed her gloves and gown and exited the room without performing hand hygiene. The CNA (#13) then donned a new gown and gloves and re-entered the room with a blanket. Observation showed the CNA failed to tie the gown. The CNA (#12) removed her gloves, tossed them into a trash can, and removed the trash bag from the can. She then assisted Resident #8 with his nasal cannula and turned on the oxygen concentrator. The CNA (#13) removed her gloves and gown and removed the hoyer lift from the room while holding the soiled gloves in her hand. She then sanitized her hands outside the room. The CNA (#12) removed her gown (gloves were already off), exited the room with the trash, and disposed of the trash in the soiled utility room. The CNA (#12) failed to perform hand hygiene before exiting Resident #8's room.

- Observation on 11/26/13 at 4:40 p.m. showed a CNA (#7) assisted Resident #5 out of bed and to the bathroom. The CNA donned gloves and removed the resident's brief and pants, which were soiled with stool. The CNA put a new brief and pants on Resident #5, performed perineal care, assisted Resident #5 to transfer to her wheelchair, removed the gait belt, and applied hand sanitizer to Resident #5's hands. The CNA then removed his soiled gloves and washed his hands. The CNA failed to remove his soiled gloves after performing incontinence cares.

During an interview on the afternoon of 11/26/13, administrative staff members (#1, #2, and #9) stated facility staff are aware of the policy and procedures related to contact precautions and hand hygiene and are expected to follow them.