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 _____	12/04/2020

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
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS) on 12/03/20 and 12/04/20. The facility was found to be in substantial compliance with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS) on 12/03/20 and 12/04/20. The facility was found not to be in substantial compliance with 42 CFR 483.80 Infection Control requirements. Survey Census: 121 Sample Size: 6 Supplemental: 0	F 000		
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	F 880		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosable 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.

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 _____	12/04/2020

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 880	Continued From page 1 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, 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	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 _____	12/04/2020

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 880	Continued From page 2 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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to ensure adequate personal protective equipment (PPE) was used when providing care to one of 121 residents (Resident (R) 4), who exhibited a potential new symptom of COVID-19. Additionally, the facility failed to take adequate measures to protect R4's roommate (R7) from potential transmission of COVID-19. This failure had the potential to spread infection, including COVID-19, to other residents and staff in the facility. Findings include: Per the "Resident Face Sheet" found in the Electronic Health Record (EHR), R4 was admitted to the facility on 03/25/20. Per the 12/03/20 "Resident Progress Note,"	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 _____	12/04/2020

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 880	Continued From page 3	F 880		

located in the Progress Notes section of the EHR, "Resident had stated to previous shift that she could not taste anything . . . Resident shows no other s/sx [signs/symptoms] of Covid at this time. Temp [temperature] is 98.6 and O2 sats [oxygen saturation] is at 99%." A subsequent 12/03/20 "Resident Progress Note" documented, "Resident is now on modified precautions per Infection control."

On 12/04/20 at 10:25 AM, R4's room was observed with a sign that read, "Modified Droplet Precautions. Everyone must: including all staff and providers: Clean Hands when entering and leaving room. Wear N95 mask or surgical mask if you are not fitted. Wear face shield. Gown and glove at the door." There was also a caddy full of the appropriate PPE to wear hanging on the door to the room. R4 was observed seated in the room, and R7 was in bed sleeping. Both residents were in view from the hallway, and the privacy curtain was not pulled between the two residents.

On 12/04/20 at 10:26 AM, Certified Nurse Aide (CNA) 6 entered R4's room wearing only a face shield and mask. She did not don gown or gloves. CNA6 retrieved R4's walker from the hallway and again entered the room without gown or gloves. She assisted R4 to get up from her chair and sit on the toilet in the bathroom. She then sanitized her hands and exited the room.

On 12/04/20 at 10:29 AM, CNA6 stated R4 was not currently on any transmission-based precautions and stated the sign and PPE caddy were just left up accidentally.

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 _____	12/04/2020

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 880	Continued From page 4 On 12/04/20 at 10:57 AM, R4 was again observed in her room, and R7 was asleep in her bed, visible from the hallway. The privacy curtain was not pulled between the two residents. On 12/04/20 at 11:05 AM, Licensed Practical Nurse (LPN) 2 stated she had been told in report that R4 had started coughing yesterday, so she was put on transmission-based precautions to be safe. These included a mask, face shield, gown, and gloves. LPN 2 stated to alert the staff, the sign was placed on the door to tell the staff what precautions were needed, and it was also passed on to staff verbally during report. LPN2 confirmed the precautions were initiated on 12/03/20 and CNA6 should have used a gown and gloves when providing care to R4. On 12/04/20 at 11:38 AM, the Infection Preventionist (IP) stated R4 experienced new loss of taste on 12/03/20, and the facility staff had decided to put her on droplet precautions to be safe, as this is a common symptom of COVID-19. The IP stated R4 had suffered a broken nasal bone, which could also contribute to the symptom, and added, "but we just don't know." The IP confirmed staff were to don a gown and gloves in addition to the mask and face shield when caring for R4. The IP also stated she did not realize R4 had a roommate, and the privacy curtain should be pulled between the two residents to prevent potential transmission of COVID-19. On 12/04/20 at 11:45 AM, the Director of Nursing (DON) stated R4 was put on transmission-based precautions because of her new loss of taste.	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 _____	12/04/2020

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 880	Continued From page 5 The DON stated R4 was on droplet precautions, and gown and gloves should be used with every encounter. The DON added the curtain should be pulled between roommates. The facility's "COVID Response Plan," updated 11/23/20, documented, "If a resident develops respiratory symptoms and/or fever, the resident and roommate will be placed on droplet precautions. Privacy curtains will be drawn between the residents."	F 880		