Electronically Delivered

October 3, 2024

Licensee
Trinity Terrace
3330 213th Street West
Farmington, MN 55024

RE: Project Number(s) SL20413015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 29, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20413	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINTY TERRACE	3330 213TH STREET WEST FARMINGTON, MN 55024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20413015 On August 26, 2024, through August 29, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 50 residents; 17 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 27, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance	0 550		

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0 550	Continued From page 2 procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 26, 2024, at 11:14 a.m. during the facility tour with housing manager (HM)-B, the surveyor observed the licensee's grievance	0 550		

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0 550	Continued From page 3 procedure posted on the main bulletin board. Although the posted grievance procedure included the contact information for the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Adult Abuse Reporting Center (MAARC), the posting lacked the name, telephone number and email contact information for individuals who were responsible for handling resident grievances. On August 26, 2024, at 11:45 a.m., HM-B reviewed the posted grievance procedure and stated it did not include the name, telephone number, and email contact for the individuals who were responsible for handling resident grievances. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of	0 650		

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0 650	Continued From page 4 staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee record (unlicensed personnel (ULP)-E) contained a performance evaluation. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E ULP-E was hired on May 25, 2010, to provide direct care to residents under the comprehensive home care license, and under the assisted living license beginning August 1, 2021. On August 27, 2024, at 7:57 a.m., the surveyor observed ULP-E administer medications to R6. ULP-E's employee record lacked evidence of a	0 650		

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0 650	Continued From page 5 completed annual performance evaluation. On August 27, 2024, at 11:10 a.m. corporate quality consultant (CQC)-G stated ULP-E did not have a performance evaluation in their employee files, and she would look to see if one was completed with the staffing shortages in leadership. The licensee's Supervision of Licensed and Unlicensed Personnel policy, last updated on August 1, 2021, indicated annual performance reviews are required and completed by the licensed assisted living director (LALD) for each staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780		

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0 780	Continued From page 6 (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 28, 2024, at 10:00 a.m., survey staff toured the facility with environmental services director (ESD)-F. During the tour of resident dwelling units, the surveyor observed smoke alarms were not installed in the bedrooms. During the facility tour interview on August 28, 2024, ESD-F stated when the building was constructed bedroom smoke alarms had not been installed.	0 780		

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0 780	Continued From page 7 TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 28, 2024, at 10:00 a.m., survey staff toured the facility with environmental services director (ESD)-F. During the tour, the surveyor observed the following:	0 800		

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0 800	Continued From page 8 Building physical environment: 1. The trash chute doors did not self-close and positively latch on the first, second, and third floors. 2. The door closer was missing on the labeled one-hour fire door for the third floor food storage room. 3. The labeled one-hour fire door for the library did not positively latch. 4. There were gaps between the fire caulking and the conduit in the third floor electrical room. 5. Two labeled fire doors were held open by wedges in the resident dining room. Devices used to hold open fire doors must not prohibit the required operation and closing feature of the door. 6. In the basement storage room adjacent to the elevator room, there was a hole in the ceiling. The physical environment must be properly maintained to prevent fire and smoke from spreading in the building. 7. In the basement mechanical room, an extension cord ran under the door. During the facility tour interview on August 28, 2024, ESD-F stated this extension cord was used when the air conditioning unit was used in the parking garage. The improper use of extension cords creates a fire hazard. 8. One emergency light did not work when tested by ESD-F in the parking garage. 9. In the basement mechanical room, the inspection tag on the backflow device was dated 2021. Testable backflow devices must be tested at least annually by a certified backflow assembly tester. During the facility tour interview on August 28,	0 800		

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0 800	Continued From page 9 2024, ESD-F verified the above listed physical environment observations while accompanying on the tour. Occupied resident dwelling units: 1. An extension cord was used in dwelling unit 216. The improper use of extension cords creates a fire hazard. 2. In dwelling unit 301, fire caulking was missing around the conduit in the mechanical closet. 3. In dwelling unit 311, the carpet was frayed between the living room and bathroom. During the facility tour interview on August 28, 2024, ESD-F verified the above listed dwelling unit observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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0 810	Continued From page 10 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 28, 2024, environmental services director (ESD)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety	0 810		

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0 810	Continued From page 11 and evacuation training, and employee evacuation drills for the facility. TRAINING Record review indicated the licensee failed to provide training to employees on the facility FSEP upon hire evident by the lack of training documentation to support this had been completed. During an interview on August 28, 2024, at 2:45 p.m., campus administrator (CA)-H stated new employees completed emergency preparedness fire safety training with a third-party online course provider and records to support employee FSEP training were not available. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. A resident training record for fire safety and evacuation without a date was provided for review. During an interview on August 28, 2024, at 2:45 p.m., CA-H stated residents were trained on fire safety and evacuation, but records were not available to support this had been completed in the last year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:	0 950		

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0 950	Continued From page 12 "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the	0 950		

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	20413	A. BUILDING: _____ B. WING _____	08/29/2024

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0 950	Continued From page 13 residents). The findings include: R2 R2 started receiving services from the licensee on March 15, 2021, with a diagnosis of diabetes and chronic kidney disease. R2's record contained an Assisted Living Contract dated July 30, 2021, with a separate page for designated representative; however, the page lacked the required verbatim verbiage. R2's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R3 R3 started receiving services from the licensee on June 10, 2022, with diagnoses that included diabetes and chronic kidney disease. R3's record contained an Assisted Living Contract dated June 10, 2022, with a separate page for designated representative; however, the page lacked the required verbatim verbiage.	0 950		

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0 950	Continued From page 14 R3's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On August 27, 2024, at 11:05 a.m. corporate quality consultant (CQC)-G stated she did not have the correct verbiage for designated representative for R2 and R3. CQC-G further stated they had the correct verbiage in the blank contract, but the correct it was not given to them to sign. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of	01500		

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01500	Continued From page 15 vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased	01500		

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01500	Continued From page 16 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D was hired on August 8, 2023, to provide direct care to residents at the assisted living facility. On August 26, 2024, at 12:00 p.m. ULP-D was observed administering medications to R2. ULP-D's employee training records lacked evidence ULP-D had successfully completed	01500		

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01500	Continued From page 17 annual training as required in the following areas: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557. 2. Review of assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. 3. Review of infection control techniques used in the home and implementation of infection control standards. 4. Effective approach to problem solve when working with challenging behaviors. 5. Review of the facilities policies relating to assisted living. 6. The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-E ULP-E was hired on May 25, 2010, to provide direct care to residents at the assisted living facility. On August 27, 2024, at 7:57 a.m., the surveyor observed ULP-E administer medications to R6. ULP-E's employee training records lacked evidence ULP-E had successfully completed annual training as required int eh following areas: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557. 2. Review of assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. 3. Review of infection control techniques used in the home and implementation of infection control standards. 4. Effective approach to problem solve when working with challenging behaviors. 5. Review of the facilities policies relating to assisted living.	01500		

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01500	Continued From page 18 6. The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On August 27, 2024, at 11:10 a.m. corporate quality consultant (CQC)-G stated ULP-D and ULP-E did not have the required annual training. The licensee's Orientation and Annual Training policy dated August 1, 2021, indicated all staff that perform direct-care services will complete at least eight (8) hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	01530		

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01530	Continued From page 19 dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-D, ULP-E) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D was hired on August 8, 2023, to provide direct care to residents at the assisted living facility. On August 26, 2024, at 12:00 p.m. ULP-D was observed administering medications to R2. ULP-D's employee record contained a document	01530		

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01530	Continued From page 20 from Educare (an electronic training software) titled my transcript. The transcript indicated ULP-D completed five dementia training modules, totaling five hours of dementia training. ULP-D's employee record failed to include the eight hours of required Dementia training. ULP-E ULP-E was hired on May 25, 2010, to provide direct care to residents at the assisted living facility. On August 27, 2024, at 7:57 a.m., the surveyor observed ULP-E administer medications to R6. ULP-E's Educare transcript indicated ULP-E completed 0.75 hours of dementia training. ULP-E's employee record failed to include at least two hours of the required annual dementia training. On August 27, 2024, at 11:10 a.m. corporate quality consultant (CQC)-G stated ULP-D did not have the required dementia training for onboarding, or the required two hours of annual training. In addition, CQC-G further stated ULP-E's had not completed the required two hours of annual dementia care training. The licensee's Orientation and Annual Training policy dated August 1, 2021, indicated all staff will be trained in dementia training required by Minnesota (MN) Statute Assisted Living 144G.64. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01750	Continued From page 21	01750		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure insulin via a prefilled insulin pen was administered according to manufacturer instructions by one of two unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R6 was admitted on October 18, 2022, with diagnoses that included diabetes. R6's service plan dated May 15, 2024, indicated R6 received assistance with medication	01750		

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01750	Continued From page 22 administration. R6's prescriber orders dated June 20, 2024, included Insulin Glargine Solostar 100 unit/milliliter (ml); inject 32 units into subcutis layer of skin two times daily. On August 27, 2024, at 7:57 a.m., ULP-E obtained R6's insulin Glargine Solostar pen and dialed the pen to the prescribed 32 units without priming the pen first. ULP-E then provided the insulin pen to R6 who self-injected the insulin. On August 27, 2024, at 8:10 a.m., ULP-E stated she had not been trained to prime the insulin pen prior to dialing the prescribed dose. On August 27, 2024, at 10:03 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated all ULP were trained and expected to prime the insulin pen with two units prior to dialing the prescribed dose. The manufacturer instructions for use for the insulin Glargine Solostar pen dated 2022, indicated the following: -Step 1: Remove the pen cap with clean hands. Check the reservoir to make sure the insulin is clear and colorless and has no particles- if not, use another pen. -Step 2: wipe the pen tip (rubber seal) with an alcohol swab. Remove the protective seal from the new needle, line the needle up straight with the pen, and screw the needle on. Do not make the needle too tight. If you have a push-on needle, keep it straight as you push it on. After you have attached the needle. Take off outer needle cap and save it (you will need it to remove the needle after your injection). Remove the inner needle cap and throw it away.	01750		

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01750	Continued From page 23 -Step 3: Dial a test dose of two units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication set up included all the required content for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01770		

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01770	Continued From page 24 The findings include: During the entrance conference on August 26, 2024, at approximately 10:00 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided medication management services to their residents, including medication set up. R3 was admitted on June 10, 2022, with diagnoses that included diabetes and chronic kidney disease. On August 27, 2024, at 11:32 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R3. R3's service plan dated August 7, 2024, indicated R3 received assistance with medication management. R3's signed prescriber orders dated July 24, 2024, included: -lactulose 10 grams/15 milliliter (ml); 1 solution by mouth one time per day (administer one cup (30 ml) preset up by registered nurse), (chronic kidney disease) R3's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On August 27, 2024, at 12:12 p.m., corporate quality consultant (CQC)-G stated the licensee did not document the setup of R3's lactulose cups. The licensee's Medication Management Services	01770		

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01770	Continued From page 25 policy dated August 1, 2021, indicated the licensee would document the date of medication setup or reviewed, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications had an opened date and a pharmacy label for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01890		

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01890	Continued From page 26 R6 was admitted on October 18, 2022, with diagnoses that included diabetes. R6's service plan dated May 15, 2024, indicated R6 received assistance with medication administration. R6's prescriber orders dated June 20, 2024, included Insulin Glargine Solostar 100 unit/milliliter (ml); inject 32 units into subcutis layer of skin two times daily. On August 27, 2024, at 7:57 a.m., unlicensed personnel (ULP)-E obtained R6's insulin Glargine Solostar pen and dialed the pen to the prescribed 32 units without priming the pen first. ULP-E then provided the insulin pen to R6 who self-injected the insulin. The surveyor noted there was no open date on the insulin pen. On August 27, 2024, at 10:04 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated insulin should be dated when opened. The Lantus (insulin Glargine Solostar pen) instructions for use dated December 2020, indicated the insulin pen could be used for 28 days after the initial use of the pen. The licensee's Medication Management Services policy dated August 1, 2021, indicated all drugs with manufacturer's instructions for discontinue after a declared number of days from opening would be labeled with the date opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20413	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINTY TERRACE	3330 213TH STREET WEST FARMINGTON, MN 55024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 27 days	01890		
02240 SS=D	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20413	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINTY TERRACE	3330 213TH STREET WEST FARMINGTON, MN 55024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02240	Continued From page 28 or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement was received for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 began receiving assisted living services on June 10, 2022. R3's record lacked evidence of written acknowledgement for receipt of the Minnesota Bill of Rights. On August 27, 2024, at 11:07 a.m., corporate quality consultant (CQC)-G stated R3's record lacked evidence of receiving the Minnesota Bill of	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20413	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINTY TERRACE	3330 213TH STREET WEST FARMINGTON, MN 55024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02240	Continued From page 29 Rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 28, 2024, during the engineer's survey visit, the engineer observed R7's room with one unsecured oxygen cylinder and two oxygen	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20413	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINTY TERRACE	3330 213TH STREET WEST FARMINGTON, MN 55024

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02310	Continued From page 30 cylinders in a closet in the nurse's office. On August 29, 2024, at 9:00 a.m. corporate quality consultant (CQC)-G stated during a telephone call that she was aware of the unsecured oxygen in the nurse's station and has already corrected it but was unaware of the resident room with unsecured oxygen. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated cylinders must be secured (chains or racks) to prevent them from falling over. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/27/24*
Time: 09:50:00
Report: 1043241224

Food and Beverage Establishment Inspection Report

Location:
Trinity Terrace
3330 213th Street W
Farmington, MN55024
Dakota County, 19

Establishment Info:
ID #: 0035127
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Farmington Health Services

Phone #: 6514601104
ID #: 51070

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

5-200B Plumbing: cross connections

5-203.14A ***** Priority 1 *****

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

NO AIR GAP OBSERVED BETWEEN THE END OF THE ICE BIN PIPE TO THE FLOOR DRAIN. ADVISED STAFF TO PROVIDE AT LEAST A 1 INCH AIR GAP. COMPLY WITH ABOVE RULE.

Comply By: 08/27/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111C ***** Priority 2 *****

MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.

FLY SWATTER OBSERVED IN KITCHEN. ADVISED STAFF TO DISCONTINUE USAGE AND TO PROVIDE AN APPROVED TRAPPING DEVICE. COMPLY WITH ABOVE RULE.

Comply By: 08/27/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

WATER LEAKING FROM ICE BIN ON TO THE FLOOR. ADVISED STAFF TO REPAIR. COMPLY WITH ABOVE RULE.

Comply By: 08/27/24

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

SINK & SURFACE LACTIC ACID: = 1875 PPM at Degrees Fahrenheit
Location: SANITIZER DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: LETTUCE
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: SOUR CREAM
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: BOILED EGGS
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	1

Inspection was completed with Tracey Fearon as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Establishment has a commercial kitchen. Foods are cooked at the main kitchen and are transported to the kitchen of this establishment for hot holding prior to service. Currently, pass-through between the two kitchens are under construction and foods are being transported outside of the building. Advised staff to provide food protection during transportation.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

Type: Full
Date: *08/27/24*
Time: 09:50:00
Report: 1043241224
Trinity Terrace

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1043241224 of 08/27/24.

Certified Food Protection Manager: Mallory L. Benson

Certification Number: FM95480 Expires: 05/01/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Chelsea Hatfield
CDM

Signed: _____

Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us