STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	**305 8TH AVE NE PO BOX 5030, MINOT, North Dakota, 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
F0000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey and complaint and facility reported incident (FRI) surveys started on 08/11/25 and concluded on 08/14/25. During the FRI survey, the facility was found noncompliant with regulatory requirements.	F0000		09/27/2025
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 1. Based on observation, record review, and resident and staff interviews, the facility failed to properly utilize assistive devices necessary to prevent accidents for 1 of 5 residents (Resident #29) observed for transfers. Failure to utilize a gait belt during transfers placed the resident at risk of injury. Findings include: Review of Resident #29's medical record occurred on all days of survey. The current care plan stated, ". . . Transfers: Pivot transfer to and from bed with gaitbelt and assist of 1 [staff]. Non-weight bearing to right leg. . . ." -Observation on 08/11/25 at 2:57 p.m. showed Resident #29 seated on a motorized scooter. When asked how staff assisted with transfers between the scooter and other surfaces, Resident #29 stated, "They grab the back of my pants and swing me	F0689	Resident #29 will be included in audits to ensure a gait belt is being utilized during transfers. The smoking contract with Resident #10 will be reviewed with the resident and compliance with the agreement will be enforced. Resident #10 will be included in audits to ensure smoking materials are returned to the nurse's station or front desk staff after use and not left in the resident room or wheelchair. Resident #1 who went to the grocery store was discharged home on 8/31/25. Resident #3 will be included in audits to observe that leg rests are being used on her wheelchair or Rock n Go chair when a resident is being pushed. All residents that have documentation in their care plan indicating use of a gait belt for transfers have the potential to be affected. Failure to use a gait belt puts the resident at risk for falling and injury. A gait belt will used in transfers as care planned. All residents that are care planned as active smokers have the potential to be affected. Residents must follow the facility smoking policy and return all smoking materials to the nurses station or front desk for lock up in the nurses station after use. Smoking materials left in a resident room unattended could put residents at harm if a resident should attempt to smoke within the facility. Trinity Homes and property owned by Trinity is non-smoking. If smoking materials are found in the resident room, they will be removed immediately. Social Services will review the smoking policy with residents who smoke. It will be determined, at that point, if changes to the care plan should occur and actions need to be taken with the resident.	09/27/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

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F0689 SS = E	Continued from page 1 over." Observation on 08/12/25 at 11:35 a.m. showed Resident #29 rested in bed. Two certified nurse aides (CNAs) (#8 and #9) entered the resident's room and assisted the resident to sit on the edge of the bed. The CNA (#8) grabbed the resident by the back of the pants and lifted/slid the resident to the electric scooter. The CNA (#8) failed to apply and use a gait belt to transfer Resident #29. During an interview on the afternoon of 08/13/25, an administrative nurse (#1) confirmed he expected staff to utilize a gait belt when transferring Resident #29. 2. Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to ensure residents remain free from accident hazards for 1 of 1 sampled resident (Resident #10) reviewed for smoking. Failure to provide an environment free from accident hazards by limiting access to cigarette lighters placed all residents, staff, and visitors at risk for injury from fire. Findings include: Review of the facility policy titled "Smoke Free Facility" occurred on 08/14/25. This policy, dated October 2022, stated, ". . . It is policy of this facility to provide a safe and healthy environment for residents. . . . . If a resident does not abide by the smoking policy, care plan revisions shall be documented and implemented to promote safety. . . . Smoking material found in plain view in the resident room will be removed immediately . . ." Review of the facility's admission packet occurred on all days of survey and stated, ". . . SMOKE FREE FACILITY-RESIDENT POLICY . . . Residents will not be allowed to keep lighters or cigarettes in their rooms or on Trinity Property. . . . Smoking materials found in resident rooms will be removed immediately and no smoking policy will be reviewed. . ." Review of Resident #10's medical record occurred	F0689	Continued from page 1 All residents that have been identified as being a risk to leave the property during their assessment and care planned as such, are at risk of being affected. Once a resident has been identified, through a therapy or nursing assessment as being a risk to leave the property, they will have their care plan reviewed and revised. The residents identified will be educated and reminded to sign out using the Sign Out book on each unit prior to leaving. Laminated signs will be made and posted by the elevators and main entrance as a reminder to residents to sign out. If a resident has not signed the Sign Out book and cannot be found, a Code Purple shall be initiated and the Code Purple and Missing Resident policy followed. The State Health Department be notified per regulation. All residents being pushed in a wheelchair or a Rock n go chair have the potential to be affected. These residents must have their feet and legs on leg rests. This will decrease or prevent a resident from falling from a wheelchair. All staff will be re-educated on the use of gait belts during a transfer, if indicated by the care plan. All staff will be re-educated on what to do if smoking materials are found in a resident room. Smoking residents will have the smoking contract reviewed with them now and then reviewed annually. All staff will also be educated on completion of a visual check when rounding for those residents identified with potential to leave the facility. Current residents will be instructed in writing on the use of the Sign Out book and new residents orientated to the use of the sign out book. New residents will also be shown the vending area to minimize the need to leave the facility for snacks and drinks. If a resident is missing, initiation of a Code Purple following the Code Purple and Missing Resident policy will be started and the ND Dept of Health notified with facility investigation to follow. All staff will be re-educated on use of leg rests while pushing residents in wheelchairs and Rock n go's. Any staff member observed pushing a resident without leg rests will receive immediate re-education and could include further discipline for repeat offences. Education will be completed through meetings and read and signs. This will be completed by September 18th, 2025.	09/27/2025

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F0689 SS = E	Continued from page 2 on all days of survey. The care plan stated, ". . . [resident's name] smokes tobacco when not on Trinity property. [Resident's name] has signed a contract with Trinity Homes, agreeing to this arrangement due to Trinity Homes being a non-smoking facility. . . . [Resident's name] will abide by the contract that she has signed . . . Inform nurse or Social Services of any problems or concerns. . . ." The contract, dated 04/21/21 and signed by the resident, stated, ". . . [Resident's name] is aware the Trinity Homes is a non-smoking facility and has agreed she will not smoke on any part of Trinity's property. . . . [Resident's name] has agreed to carry her cell phone and contact staff or 911 for help if/when needed. . . . The intention of this agreement is to keep [Resident #10's name] safe, as well as the residents, staff, and visitors . . ." Observation on 08/12/25 at 11:37 a.m. showed Resident #10 seated in a power wheelchair in her room preparing to go outside and smoke. The resident placed a see-through netted pouch around her neck containing a visible pack of cigarettes. Prior to leaving her room, the resident asked a certified nurse aide (CNA) (#18) to hand her a personal cell phone and placed the phone into the pouch. The surveyor and Resident #10 exited the building and the resident drove to the end of the sidewalk in front of the building (more than 20 feet away). The resident removed the cigarettes and a lighter from the pouch and lit a cigarette. When finished, the resident placed the cigarettes, lighter, and cell phone back into the pouch, entered the building, kept the smoking materials with her, and drove her wheelchair back to her room. During an interview on 08/13/25 at 2:33 p.m., a nurse manager (#1) stated residents are not allowed to have cigarettes and lighters in their rooms "but they don't always give them back." The facility failed to remove visible smoking materials from Resident #10 per facility policy and failed to implement methods and expectations for residents safe and secure storage of lighters/smoking materials. 3. Based on medical record review, review of facility policy, and staff interview, the facility failed to provide appropriate supervision to prevent an elopement for 1 of 1 sampled resident (Resident #1) who left the facility without notifying staff. Failure to	F0689	Continued from page 2 QA audits will be done weekly DON and ADON or designee on all units for observing staff using gait belts during transfers for those residents with indication for use. Five audits of transfers to ensure gait belt use with per unit will be completed weekly for 4 weeks, or until compliance is achieved. Then 5 audits per month, per unit will be completed for 3 months or until compliance is achieved. Audits will then continue at 5 per unit quarterly or until compliance is obtained. All audits will include resident #29. QA audits will be completed weekly by Social Services for all smoking residents to ensure that residents who check out smoking materials, return them to the nurse's station or front desk upon return to the nursing unit. Three audits per smoking resident will be completed weekly for 4 weeks. Then 5 audits per month, per unit will be completed for 3 months or until compliance is achieved. If still finding residents not in compliance, audits will then continue at 5 per unit quarterly or until compliance is obtained. All audits will include resident #10. QA audits reminding residents and families members to sign the resident out before leaving will be completed weekly by CEPS Nurse. Five audits of reminding random residents and families to sign out will be done weekly for 4 weeks, or until compliance is achieved. Then 5 audits per month, per unit will be completed for 3 months or until compliance is achieved. Audits will then continue at 5 per unit quarterly or until compliance is obtained. All audits will include resident #29. QA will be completed by Social Services to verify each resident and new admission has been orientated to the use of the sign out book. In addition, 3 residents per week for 4 weeks will be asked to tell social worker where the sign out books are located. Thereafter 3 residents will be asked each month for three months to explain the sign out process. QA audits will be done weekly by DON and ADON or designee on all units for observations that leg rests are used on all residents in wheelchairs or Rock n go's that are being pushed. Five audits per unit will be completed weekly for 4 weeks or until compliance is achieved. Then five audits per month, per unit will be completed for 3 months or until compliance is achieved. Audits will then continue at 5 per unit quarterly for 3 quarters. All audits will include resident #3. All Audits will begin on 9/18/25.	09/27/2025

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F0689 SS = E	Continued from page 3 monitor residents with decreased safety awareness resulted in Resident #1 exiting the facility and may have placed the resident in dangerous situations. Findings include: Review of the facility policy titled “Code Purple – Missing Resident” occurred on occurred on 08/14/25. This policy, revised July 2024, stated, “. . . If a resident is not located in their room or in the dining room on a unit, the floor nurse on that unit must do the following: Search immediate area of the nursing unit . . . Additional searching of area surrounding [the facility] . . .” Review of Resident #1’s medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 04/23/25, identified as cognitively intact. The current care plan stated, “. . . [Resident #1] was recently admitted to [the] hospital due to a fall in the home that resulted in multiple subacute pelvic fractures . . . impaired gait, impaired anticipatory and reactionary balance, and decreased safety awareness . . . Resident unsafe to return home at this time . . .” A progress note, dated 08/02/25 at 4:23 p.m., stated, “This writer was alerted by another resident that [Resident #1] had left the nursing home to go to [the] [name] convenience store [located two blocks from the facility]. This writer went to look for [the] resident and found her sitting in her wheelchair by the kerbside [sic] and she stated she was tired. [The] Resident was having a difficult time navigating the uneven terrain, and she also stated that the nursing home looked like a school to her. [The] Resident stated that she had gone to [convenience store name] to purchase a candy bar but was unable to get back due to ‘being tired.’ This writer pushed [the] resident back to her room. [The] Resident's family . . . was updated. Weekend Manager, Social services and DON [Director of Nursing] were also updated.” During an interview on 08/13/25 at 5:20 p.m., two administrative nurses (#1 and #13) confirmed staff failed to complete an incident report following Resident #1’s elopement. 4. Based on review of the facility reported incident (FRI) report, record review, review of facility policy, and staff interview, the facility failed to provide appropriate supervision/assistance to prevent accidents for 1 of 14 sampled residents (Resident #3) who fell from her wheelchair during transport. Failure to utilize foot pedals during transport	F0689	Continued from page 3 Audits will be reported to the QA Committee during scheduled meetings.	09/27/2025

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F0689 SS = E	Continued from page 4 resulted in Resident #3's sustaining an injury to her forehead. This is considered past non-compliance based on review of the corrective actions the facility implemented following the incident. Findings include: Review of the power point presentation handout related to falls occurred on 08/14/25. The handout stated, ". . . Wheelchair Leg Rests: Make sure foot pedals are in place with the resident's feet up on them prior to pushing them in the wheelchair. DO NOT PUSH A RESIDENT IN A WHEELCHAIR WITHOUT LEGRESTS ON. Leg rests may be removed and placed in the bag on the back of the wheelchair if the resident is independent with propelling their own wheelchair . . ." Review of Resident #3's medical record occurred on all days of survey. The current care plan stated, ". . . [Resident #3] is not able to perform own ADL's [Activities of Daily Living] due to behaviors and decreased mobility . . . Mobility . . . 1 staff to push chair behind. Rock-n-go for mobility and comfort. Ensure foot pedals are in use while staff is pushing chair . . . [Resident #3] is at risk for falls and fall related injuries . . . Falls Prevention . . . Ensure that the foot pedals of the resident's rock n go are on when transporting the resident . . ." Review of the FRI report, submitted to the state agency on 02/19/25, stated, ". . . [Certified nurse aide's (CNA's) [name] was pushing [Resident #3] to her room in her wheelchair and [Resident #3] fell forward out of the chair. [Resident #3] is always very agitated, restless, and last evening had been leaning over in her chair messing with her leg wraps and also continuously trying to stand up. [CNA's name] was telling her she needed to lean back in her chair, and she fell out forward. She did receive a bump on her head, was sent to the ER [emergency room], and returned with no further injury. . . ." The progress notes identified the following: * 02/18/25 at 11:15 p.m., "Resident was drowsy at start of shift. approx [approximately] 1600 [4:00 p.m.] she started to become fidgety and obsessed with bending over in wheelchair fussing with the velcro on her foot wraps. . . . She became more agitated and restless and the concern for her safety was growing. . . . She continued to fidget and attempt to get out of chair. Finding it impossible to keep her in the recliner, she was placed back in wheelchair with 1:1 observation. . . . was being wheeled to the shower room to . . . toilet her. The CNA had just	F0689		09/27/2025

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F0689 SS = E	Continued from page 5 reminded resident to sit up and not lean forward. At that moment the resident fell face first onto [the] floor. (2100 [9:00 p.m.]) She remained as per her normal orientation. . . . She had a small scratch on right cheek which was cleaned and did not bleed anymore. she had a large goose egg sized swelling to her right forehead. Resident was assessed and no other apparent injuries. . . . we attempted to place an icepack on her forehead and assess VS [vital signs]. (2115 [9:15 p.m.]) Supervisor, provider and daughter were notified. Orders to transfer to ER [emergency room] for assessment were received and family agreed. Ambulance was called (2130 [9:30 p.m.]) and arrived at (2145 [9:45 p.m.]) for transport." Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions to ensure the deficient practice does not recur by: * Completing an investigation on 02/18/25, including an interview with the CNA who transported Resident #3, * Determining the CNA transported Resident #3 without placing foot pedals on her wheelchair, resulting in a fall from her wheelchair, injury, and placed all residents at risk for falls with/without injury. * Immediately re-educating the CNA following the incident and re-educating all staff on the importance of utilizing foot pedals during resident transport. * Completing quality assurance audits to ensure resident safety during transport.	F0689		09/27/2025
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	Resident #29 will be included in all audits where staff are required to wear the appropriate PPE (gown and gloves) before entering a room with an enhanced barrier precautions (EBP) sign. Resident #59 and resident #126 will be included in audits where nurses are being observed for wearing gloves during insulin administration. Resident #12 will be included in audits where nurses are being observed for cleaning of the glucometer after each use. All residents in the facility have the potential to be affected if staff do not wear a gown and gloves during high contact activities with those residents on EBP. Staff could potentially spread infectious organisms/diseases to other residents.	09/27/2025

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F0880 SS = E	Continued from page 6 §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 §483.71 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 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.	F0880	Continued from page 6 All residents receiving insulin have the potential to be affected if staff do not wear gloves during the administration of insulin. The wearing of gloves reduces the likelihood of transmission of any infectious organisms. All residents that require glucometer testing have the potential to be affected. The glucometer must be sanitized between use to prevent the spread of blood borne pathogens. Nursing staff will be re-educated on the EBP and the importance of wearing gown and gloves during high contact activities. Nurses will be re-educated on the use of gloves during insulin administration and sanitizing of the glucometer after each use. All education will be done through meetings and read and signs. This will be completed by September 18th, 2025. QA audits will be completed weekly will be completed by DON and ADON or designee on all nursing units to ensure that EBP are being followed with wearing gown and gloves during high contact cares. Five audits per unit will be completed weekly for 4 weeks, or until compliance is achieved. Then 5 audits per month, per unit will be completed for 3 months or until compliance is achieved. Audits will then continue at 5 per unit quarterly or until compliance is obtained. All audits will include resident #29. QA audits will be completed weekly will be completed by DON and ADON or designee on all nursing units to ensure that nurses are wearing gloves with insulin administration. Five audits will be completed weekly for 4 weeks, or until compliance is achieved. Then 5 audits per unit will be checked monthly for 3 months or until compliance is achieved. Audits will then continue at 5 per unit quarterly or until compliance is obtained. All audits will include resident #59 and resident #126. QA audits will be completed will be completed by DON and ADON or designee weekly on all nursing units to ensure that nurses are sanitizing the glucometer after each use. Five audits will be checked weekly for 4 weeks, or until compliance is achieved. Then 5 audits per month per unit will be checked monthly for 3 months or until compliance is achieved. Audits will then continue at 5 per nursing unit per quarter or until compliance is obtained. All audits will contain resident #12.	09/27/2025

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F0880 SS = E	Continued from page 7 §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, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 11 sampled residents (Resident #12, #29 and #59) and 1 supplemental resident (Resident #126) observed for cares and/or medication administration. Failure to practice infection control standards related to enhanced barrier precautions (EBP), glove use, hand hygiene, and disinfecting of shared equipment has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Copy of Enhanced Barrier precautions" occurred on 08/14/25. This policy, dated September 2024, stated, ". . . Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [Multi-Drug Resistant Organism] as well as those that have . . . open wound that requires a dressing. . . . high-contact activities . . . dressing . . . transferring . . ." Review of the facility policy titled "Blood glucose/Hypoglycemia" occurred on 08/14/25. This policy, dated, December 2022, stated, ". . . Glucometers will be cleaned and disinfected after each use using a Super Sani Cloth Germicidal wipe . . . " Review of the facility policy titled "Medications-Administration Of Sub-Q [subcutaneous-under the skin]" occurred on 08/14/25. This policy, dated November 2023, stated, "ADMINISTRATION OF SUBCUATNEOUS MEDICATIONS . . . Perform hand hygiene and apply clean gloves. Select appropriate injection site . . . inject needle . . . withdraw needle . . . remove gloves and perform hand hygiene. . . " ENHANCED BARRIER PRECAUTIONS Review of Resident #29's medical record occurred on all days of survey. A history and physical note, dated 04/10/25, stated, ". . . positive wound culture.	F0880	Continued from page 7 All Audits will begin on 9/18/25. Audits will be reported to the QA Committee during scheduled meetings.	09/27/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 8 Showed MRSA [Methicillin-resistant Staphylococcus aureus - an MDRO] . . . MRSA infection of chronic ulcer . . ." The current care plan stated, ". . . has a chronic open area to her right lower leg . . . enhanced barrier precautions in place per guidelines . . ." Observation on 08/12/25 at 11:35 a.m. showed Resident #29's room with an EBP sign and a personal protective equipment (PPE) storage unit on the door. A certified nurse aid (CNA) (#9) applied a gown and gloves, and a CNA (#8) applied gloves and entered the room. The CNA (#8) applied the resident's shoes and pants, both CNAs assisted Resident #29 to sit on the edge of the bed, and the CNA (#8) transferred the resident to the scooter. The CNAs (#8 and #9) removed their soiled PPE, performed hand hygiene and exited the room. The CNA (#8) failed to apply a gown prior to dressing and transferring Resident #29. During an interview on 08/13/25 at 3:15 p.m., an administrative nurse (#10) confirmed she expected staff to wear the appropriate PPE to provide care for residents in EBP. MEDICATION ADMINISTRATION/GLUCOMETER USE Observations on 08/14/25 showed the following: -7:56 a.m. and 8:12 a.m., A nurse (#12) administered insulin to Residents #59 and #126 without wearing gloves. The nurse (#12) confirmed he failed to wear gloves during the insulin administrations. -8:30 a.m., A nurse (#11) checked Resident #12's blood sugar level using a shared glucometer and then placed the glucometer into a docking station without sanitizing it. When asked if there were more blood sugar checks to complete the nurse (#11) stated, "one more." The surveyor requested the nurse disinfect the glucometer with a Sani-cloth.	F0880		09/27/2025
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to	F0553	Resident # 6 was invited by a social worker to her 8/27/25 care plan and documented in her progress notes on 8/22/25. On 8/27/25 resident #6 declined to attend her care plan meeting. Resident # 6's first contact did attend. Resident #118's personal representative was invited to residents #118's care conference on 9/16/25 and documented in a progress note on 8/26/25. All residents and resident representatives in the facility have the potential to be affected if they were	09/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

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F0553 SS = D	Continued from page 9 request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and resident, resident representative, and staff interviews, the facility failed to ensure the right to participate in the development and implementation of a person-centered plan of care for 2 of 31 sampled residents (Resident #6 and #118). Failure to ensure residents or their representative received notice of care planning conferences and/or interviewed the resident or their representative regarding care concerns/needs if they chose not to attend the conferences, limited their right to make decisions/provide input related to the resident's care, treatment, and services. Findings include: Review of the facility policy titled "Care Planning" occurred on 08/14/25. This policy, dated April 2025, stated, ". . . It is the policy of Trinity Nursing Care Facility that a written plan of care be developed and maintained for each resident in coordination with all	F0553	Continued from page 9 not invited to a care plan meeting. All residents and resident representatives must be informed of the plan of care and can be involved in decision making and planning the care of each resident. Facility social workers will contact each resident and resident's representative one week prior to the care conference, to inform them of the location, date, and time. Contact will be done thru a phone call to the resident representative, with a message left if unable to talk directly. An email will be sent if address has been provided, if a phone contact is not completed. Notification attempts will be documented in progress notes. Written education on the importance and process of inviting residents to care conferences will be provide to social service staff and completion documented and signed by same. This will be completed by 9/18/2025. QA audits verifying resident and resident's representative were invited to their care plan meeting will be completed by Social Service staff for all care conferences and documentation made in each resident's progress notes. The social worker will audit each care plan meeting weekly for 4 weeks. Thereafter audits will be done with 5 per month and continue for 3 months. Audits will then continue at 5 per quarter for 2 quarters. All audits will begin on 9/18/2025. All audits will be presented to the QA committee during scheduled meetings.	09/27/2025

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F0553 SS = D	Continued from page 10 services and individuals involved in the care of the resident. Family members, support persons with the permission of the resident, and/or resident will be invited to attend the care planning conference. . . ." -Review of Resident #6's medical record occurred on all days of survey and identified care planning conferences held on 03/05/25 and 05/25/25. During an interview on 08/12/25 at 8:55 a.m., Resident #6 expressed unawareness of the care planning conference and never attended the conferences. The record lacked evidence Resident #6 received notice of the care conferences held on 03/05/24 and 05/25/25 care conferences and/or staff interviewed the resident regarding care concerns or needs. During an interview on 08/13/25 at 11:45 a.m., an administrative staff member (#17) confirmed the medical record lacked evidence staff invited Resident #6 to the care planning conferences or interviewed the resident regarding care concerns and needs. -Review of Resident #118's medical record occurred on all days of survey and identified a care planning conference held on 06/25/25. During an interview on 08/12/25 at 1:55 p.m., Resident #118's personal representative stated she did not receive notification from the facility regarding the care planning conference. The record lacked evidence the resident's representative received notice of the care planning conference.	F0553		09/27/2025
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F0578	Resident # 84 code has been documented in the medical record and his code status will be included in audits of current code status described below. All residents in the facility have the potential to be affected if their advanced directive is not documented and carried out when changes are made. Each resident's right to an advanced directive is important and that advanced directive shall be carried out immediately upon notification of their desire. All nurses will receive education by 9/18/2025 on the importance of verifying the code status upon return from hospital, or upon admission. The nurse will document in medical record, and promptly carrying out resident's advance directives, including	09/27/2025

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F0578 SS = D	Continued from page 11 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment for 1 of 31 sampled residents (Resident #84) reviewed for advance directives. Failure to ensure the resident's medical record reflected the most current resident wishes may result in unwanted treatment. Findings include: Review of the facility policy titled "Code Status" occurred on 08/14/25. This policy, revised October 2021, stated, ". . . Nursing services will verify order between providers orders and/or resident's decision and that the code order in the electronic health record matches whatever the resident/residents representative has signed . . ." Review of Resident #84's medical record occurred on all days of survey and identified a physician's order, dated 02/18/25, indicating a full code status.	F0578	Continued from page 11 any code status changes. Audits will be completed by the DON, ADON, or designee beginning on 9/18/2025. Audits will verify code status documentation for any resident who has returned from the hospital, and all new admissions weekly for 4 weeks. Subsequently, nursing staff will perform five audits per month for 3 months to verify current and accurate code status documentation until compliance is reached. Audits will then continue at 5 per quarter for 2 quarters until compliance is achieved. All audits will include resident number 84. All audits will be presented to the QA committee during scheduled meetings.	09/27/2025

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F0578 SS = D	Continued from page 12 The resident identification ribbon in the electronic health record (EHR) also showed a full code status. On 08/12/25 at 5:25 p.m., a management staff member (#17) presented the surveyor a code status form dated 08/12/25 indicating Do Not Resuscitate (DNR) signed by the resident's Power of Attorney (POA). The staff member (#17) stated Resident #84 returned from the hospital today (08/12/25) and the code status changed. Resident #84's medical record showed facility staff failed to change the full code status to DNR in the EHR until 08/13/25 at 8:30 a.m. During an interview on the morning of 08/13/25, an administrative staff member (#1) confirmed staff failed to change the code status to DNR.	F0578		09/27/2025
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by:	F0609	Resident #1 who went to the grocery store was discharged home on 8/31/25. All residents who are able to move themselves throughout the nursing home have the potential affected and to leave the building . A successful attempt to leave the nursing home unassisted could be an elopement incident that must be reported to the State Health Department with the required investigation and follow up completed in 5 days. All nurses will be educated on the requirement to report abuse neglect, exploitation, and elopement within the states required time frames. This will include a review of the facility Abuse, Neglect and Exploitation Policy. Nurses will be educated on how to notify the state using the online “Initial Allegation of Mistreatment, Abuse, Neglect or Theft and Facility Reported Incidents Reporting Form. Training will be completed through meetings and read & signs. This education will be completed by 9/18/2025. QA audits will be done weekly on all units to assess the nurses knowledge of identifying an elopement event and ensuring they know how to use the State Health Department Incident Report system. Two nurses on each unit weekly will be asked to demonstrate where the State Health Department Incident Report is located on the website and how to complete it. This will continue weekly for 4 weeks or until compliance is achieved. Then 2 nurses monthly per unit will be tested, for 3 months or until compliance is achieved. Audits will then continue with 2 nurses quarterly per unit being tested. The DON/ADON/Director of Social Services/Nurse managers and supervisors will be responsible for	09/27/2025

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F0609 SS = D	Continued from page 13 Based on record review, review of facility policy, and staff interview, the facility failed to ensure all alleged violations involving possible abuse/neglect were reported immediately to officials including the State Survey Agency (SSA) for 1 of 1 sampled resident (Resident #1) who eloped from the facility. Failure to immediately report alleged violations to the SSA placed Resident #1 and other residents at risk for possible neglect and/or injury. Review of the facility policy titled “Abuse, Neglect and Exploitation” occurred on 08/14/25. This policy, revised August 2023, stated, “. . . Neglect: Means the failure of the facility, it’s employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress . . . The Director of Nursing and/or Director of Social Services will report the alleged . . . neglect . . . to the Administration and/or their designee and the State Health Department. . . . An initial Allegation of Abuse Reporting form will be completed through the State Health Dept [Department] website . . . within 24 hours. The results of all investigations are reported to the Administrator or his designated representative and the State Health Department within five working days of the alleged incident . . .” Review of Resident #1’s medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 04/23/25, identified cognitively intact. The current care plan stated, “. . . [Resident #1] was recently admitted to [the] hospital due to a fall in the home that resulted in multiple subacute pelvic fractures . . . impaired gait, impaired anticipatory and reactionary balance, and decreased safety awareness . . . Resident unsafe to return home at this time . . .” A progress note, dated 08/02/25 at 4:23 p.m., stated, “This writer was alerted by another resident that [Resident #1] had left the nursing home to go to [name of store] convenience store [located two blocks from the facility]. This writer went to look for resident and found her sitting in her wheelchair by the kerbside [sic] and she stated she was tired. Resident was having a difficult time navigating the uneven terrain, and she also stated that the nursing home looked like a school to her. Resident stated that she had gone to [convenience store name] to purchase a candy bar but was unable to get back due to ‘being tired.’ This writer pushed resident back to her room. Resident's family . . . was updated. Weekend Manager, Social services and DON [Director of Nursing] were also updated.” During an interview on 08/13/25 at 5:20 p.m., two	F0609	Continued from page 13 completion of any audits. Audits will begin on 9/18/25. All audits will be presented to the QA committee during scheduled meetings.	09/27/2025

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F0609 SS = D	Continued from page 14 administrative nurses (#1 and #13) confirmed staff failed to complete an incident report following Resident #1's elopement. The medical record failed to reflect facility staff reported Resident #1's elopement to the State Health Department.	F0609		09/27/2025
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to thoroughly investigate alleged violations of neglect for 1 of 1 sampled resident (Resident #1) who eloped from the facility. Failure to thoroughly investigate Resident #1's elopement, implement corrective actions, and evaluate the effectiveness of those actions, placed Resident #1 and other residents at risk for possible neglect and/or injury. Review of the facility policy titled "Abuse, Neglect and Exploitation" occurred on 08/14/25. This policy, revised August 2023, stated, ". . . Neglect: Means the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress . . . The supervisor will then contact the Director of Nursing and/or Director of Social Services to initiate the investigation process. . . . All staff with knowledge of the alleged incident will be required to make a written, signed, and dated statement. . . . All	F0610	Resident #1 who went to the grocery store was discharged home on 8/31/25. All incidents identified as abuse, neglect, and exploitation or other facility reportable incidents will be reported to the state electronically and a thorough investigation will be completed with 5 working days by Social Services or Nursing Leadership. All nurses will be educated on the process required following an elopement or other reportable incident. This education will include review of the Abuse, Neglect and Exploitation Policy. Nurses will also be shown how to complete the online State Health Department Incident Report on their website. Education will be provided regarding the requirement to contact the DON and Administrator or their designee on all reportable incidents. They will be re-educated on the Elopement Event in the EHR. This has been updated to include how long the resident was missing from the facility, the weather conditions, what the resident was wearing (to identify if clothing was suitable for weather conditions), documenting a physical assessment, and re-educating on the procedure of leaving the facility using the sign out book at each nurse's station. Education will be done through meetings and read and signs. All education will be completed by 9/18/2025. QA audits will be done weekly by CEPs, DON, and ADON on all units to ensure completion of reportable incident investigation was finalized within 5 working days. Audits will also be completed to assess the nurses knowledge of identifying an elopement event and ensuring they know how to use the State Health Department Incident Report system. Two nurses on each unit weekly will be asked to demonstrate where the State Health Department Incident Report is located on the website and how to complete it. This will continue weekly for 4 weeks or until compliance is achieved. Then 2 nurses monthly per unit will be tested, for 3 months or until compliance is achieved. Audits will then continue with 2 nurses quarterly per unit being tested. All audits will be presented to the QA committee during scheduled meetings.	09/27/2025

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F0610 SS = D	Continued from page 15 residents involved in the allegation will be interviewed and a statement will be written up. . . . The care plan will be updated accordingly to reflect any new interventions or changes. . . ." Review of Resident #1's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 04/23/25, identified cognitively intact. The current care plan stated, ". . . [Resident #1] was recently admitted to hospital due to a fall in the home that resulted in multiple subacute pelvic fractures . . . impaired gait, impaired anticipatory and reactionary balance, and decreased safety awareness . . . Resident unsafe to return home at this time . . ." A progress note, dated 08/02/25 at 4:23 p.m., stated, "This writer was alerted by another resident that [Resident #1] had left the nursing home to go to [name of store] convenience store [located two blocks from the facility]. This writer went to look for resident and found her sitting in her wheelchair by the kerbside [sic] and she stated she was tired. Resident was having a difficult time navigating the uneven terrain, and she also stated that the nursing home looked like a school to her. Resident stated that she had gone to [convenience store name] to purchase a candy bar but was unable to get back due to 'being tired.' This writer pushed resident back to her room. Resident's family . . . was updated. Weekend Manager, Social services and DON [Director of Nursing] were also updated." During an interview on 08/13/25 at 5:20 p.m., two administrative nurses (#1 and #13) confirmed staff failed to complete an incident report following Resident #1's elopement. Facility staff failed to complete an incident report after locating Resident #1, including: * Identifying how long Resident #1 was missing from the facility prior to locating her, the weather conditions/appropriateness of her clothing, etc., * Documenting the results of the physical assessment, * Assessing Resident #1's safety awareness after being told she self-propelled her wheelchair two blocks from the facility, had difficulty navigating the uneven terrain, and thought the facility looked like "a school," * re-educating Resident #1's on the procedure for leaving the facility, i.e.: sign-out book.	F0610	Continued from page 15 Audits will begin on 9/18/25.	09/27/2025

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F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of professional reference, review of facility policy, and staff interview, the facility failed to follow professional standards of practice regarding physician's orders for 1 of 1 sampled resident (Resident #30) with orders for a physical therapy/occupational therapy (PT/OT) evaluation. Failure to transcribe and obtain a PT/OT evaluation placed Resident #30 at risk for delayed treatment. Findings include:Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, "Nurses are expected to analyze procedures . . . ordered by the physician or primary care provider. . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out." Review of the facility policy titled "Provider Orders" occurred on 08/14/25. This policy, dated September 2022, stated, ". . . PHYSICIANS ORDERS . . . all orders must be on the chart of the resident . . . Observed, sign, date and time, in red, beneath the providers written orders on Provider order sheets. . . . enter order into the electronic health record. . . ." Review of Resident #30's medical record occurred on all days of survey. Diagnoses included arthritis, weakness, and difficulty walking. A provider's progress note, dated 05/07/25, stated, ". . . chronic ambulatory dysfunction . . . wheelchair bound . . . currently a Hoyer [mechanical lift] transfer . . ." An undated physician's order, scanned into the medical record, stated, "PT/OT evaluate transfer/maneuver electric wheelchair safely." The physician's order lacked evidence facility staff acknowledged the order. The record lacked documentation of a PT/OT evaluation for electric wheelchair use. Observations on all days of survey showed an electric wheelchair Resident #30's room. During an interview on 08/11/25 3:14 p.m., Resident #30 identified she would like to receive some therapy and to use her	F0658	Resident #30 PT/OT order evaluation was entered on 8/13/25. The evaluation was conducted by Physical Therapy on 8/18/25. The findings were incorporated into resident #30's care plan and orders. All residents receiving PT/OT orders in the facility have the potential to be affected if the provider orders are not carried out at the time the order is received. This would delay treatment for the resident. All nurses will be educated on this example and the proper utilization of observing and carrying out a new provider order, to include the date. All nurses are educated on the process for checking orders. The night nurse on each unit will be reviewing all orders located in the red box in nurses' station and to ensure the order was dated, observed, and check the EHR record for order entry. Each unit manager will check the red box on their respected unit to review and verify all orders. The nurse manager will then bring the orders to be scanned into the EHR. Education will be done through meetings and read and signs. This education will be completed by 9/18/2025. The DON/ADON and/or designee will begin audits on 9/18/25 on each unit of 10 orders per week with random checks on resident paper orders to be sure they were entered, dated and carried out. Once compliance has been achieved for 4 weeks, audits will be done with 10 per month per unit and continue for 3 months until compliance is achieved. Audits will then continue at 10 per quarter or until compliance is achieved. All audits will include all orders for resident number #30. All audits will be presented to the QA committee during scheduled meetings.	09/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

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F0658 SS = D	Continued from page 17 electric wheelchair. During an interview on 08/13/25 at 8:15 a.m., a therapy manager (#6) confirmed therapy staff had not received notification of an evaluation order for Resident #30. During an interview on 08/13/25 at 11:00 a.m., an administrative nurse (#7) confirmed the provider wrote the order, failed to date it, and facility staff failed to carry out the order.	F0658		09/27/2025
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to ensure residents received the necessary services to maintain personal hygiene for 2 of 23 sampled residents (Resident #4 and #104) dependent on staff for personal hygiene. Failure to provide assistance with hair, oral, and nail care may result in poor hygiene and decreased self-esteem and quality of life. Findings include: The facility failed to provide a policy for activities of daily living. -Observation on 08/11/25 at 4:29 p.m. showed Resident #4's hair uncombed. The resident stated, "I only get my hair combed about once a week and teeth brushed occasionally." Review of Resident #4's medical record occurred on all days of survey. The care plan stated, ". . . [Resident #4's name] is not able to perform her own ADL's [activities of daily living] related to weakness and right femur fracture. . . . Grooming/Personal Hygiene: staff assistance of one for assistance at bedside. Encourage [Resident #4's name] to . . . comb hair Oral hygiene: partials/own teeth. Oral cares bid [twice a day] . . . Encourage [Resident #4's name] to brush own teeth after set up . . ." Review of Resident #4's personal hygiene task record from 07/14/25 to 08/09/25 identified the facility staff failed to assist the resident with personal hygiene (combing hair and brushing teeth)	F0677	Resident #4 and #104 will be included in all audits where staff are required to assist dependent residents with ADLs including providing nail care, combing hair and oral care provided. All residents who are dependent on staff for ADL cares in the facility have the potential to be affected. Staff must perform ADL cares on any resident that is unable to do so themselves. Failure to do so can result in poor hygiene, decreased self-esteem and quality of life. All nursing staff (RNs, LPNs, CNAs) will be re-educated on the importance of ADL provision, including mouth care techniques, appropriate hair grooming practices, safe nail care procedures and personal hygiene protocols. The examples of missed ADL cares were shared during the education. Education will be done through meetings and read and signs. Education will be completed by 9/18/2025. QA audits will be completed by the DON and ADON, or designees weekly on all nursing units to ensure staff are providing oral care, hair grooming, and nail care to all residents. Five residents per unit will be completed weekly for 4 weeks. Then 5 audits per month, per unit will be completed for 3 months. Audits will then continue at 5 per unit quarterly or until compliance is obtained. All audits will include resident #4 and #104. Audits will begin on 9/18/2025. Audits will be reported to the QA Committee during scheduled meetings.	09/27/2025

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F0677 SS = D	Continued from page 18 five times. -Observation on 08/11/2025 at 2:56 p.m. showed Resident #104's great toenails to both feet approximately three-fourths inches in length with jagged edges. Review of Resident #104's medical record occurred on all days of survey. The care plan stated, ". . . Hand and foot nail care to be done by CNA [certified nurse aid] . . ." During an interview on 08/14/25 at 1:17 p.m. an administrative staff nurse (#1) stated he expected the CNAs to assist dependent residents with all ADLs including combing hair and brushing teeth twice a day.	F0677		09/27/2025
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 1 of 6 sampled resident (Resident #6) observed during dressing changes. Failure to complete dressing changes as physician ordered placed the resident at risk for delayed wound healing. Findings include: Review of the facility policy titled "Skin Management" occurred on 08/14/25. This policy, dated December 2022, stated, ". . . Wound Care Guidelines . . . Floor nurse will observe wound daily . . . Wound care dressings will be dated and initialed. . . Floor nurse will document observed wounds . . . in the resident's EHR [electronic health record]. . . ." Review of Resident #6's medical record occurred on all days of survey. A physician's order, dated	F0684	Resident # 6 dressing changes will be monitored daily. Resident #6 will be included in all audits where nurses are required to change a wound dressing. All residents who have dressing changes in the facility have the potential to be affected and Trinity Homes will reinforce with all nurses the importance of following through on orders and asking for help from nursing leadership and other nurses when needed. Nurses will be re-educated on ensuring that all dressing changes are completed and dated upon changing the dressing. Nurses will be encouraged to ask nursing administration or other nurses for help with a task if they feel they are running out of time. This example of the missed dressing change will be presented in the education. Education will provided through meetings and read and sign. Education will be completed by September 18th, 2025. QA audits will be completed by the DON and ADON or designee on all nursing units with residents who require wound dressing changes. Audits on all residents with dressing changes will be completed weekly for 4 weeks. Then 5 audits will be completed per month, per unit for 3 months. Audits will then continue at 5 observations per unit quarterly or until compliance is obtained. All audits will include resident #6. Audits will begin on 9/18/2025. Audits will be reported to the QA Committee during scheduled meetings.	09/27/2025

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F0684 SS = D	Continued from page 19 11/27/24, identified a dressing change to the resident's right leg once a day. Observation on 08/12/25 at 9:30 a.m. showed a nurse (#12) removed a dressing dated 08/10/25 from Resident #6's right leg. The nurse (#12) stated, "I don't know what happened. They must have forgot to change the dressing yesterday."	F0684		09/27/2025
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment/services to prevent skin breakdown and pressure ulcers for 1 of 4 sampled residents (Resident #4) reviewed with pressure ulcers. Failure to consistently reposition residents for pressure relief may result in delayed healing of current pressure ulcers and/or the development of new pressure ulcers. Findings include:Review of the facility policy titled "Skin Management" occurred on 08/14/25. This policy, dated December 2022, stated, "Once residents are identified at risk of skin breakdown, prevention guidelines will be implemented, including but not limited to: turn schedule . . .Follow individualized prevention protocols for each resident . . . Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present. . . ." Review of Resident #4's medical record occurred on	F0686	Resident #4 will be included in chart reviews to ensure that staff are documenting completion of the turning/repositioning task, in the electronic health care record, as care planned. All residents on turning schedules have the potential to be affected. Residents that are identified at risk of skin breakdown (through the Braden scale) or have pressure ulcers, must be turned and repositioned as per their care plan. Failure to do so can result in the development of new pressure ulcers or delay healing of existing pressure ulcers. Once the resident has been turned/repositioned, documentation must be completed in the electronic health record. All nurses and CNAs will be educated on the importance of documentation in the electronic health care record when completing turning and or repositioning when the task has been completed. Education will provided through meetings and read and sign. This will be completed by 9/18/2025. QA audits will be completed by the DON and ADON or designees weekly on all units for all residents on a turning schedule to ensure completion of the turning/repositioning and documentation in the EMR. Five audits per unit will be completed weekly for 4 weeks, on turning/repositioning and documentation. Then 5 audits per month, per unit will be completed for 3 months. Audits will then continue at 5 per unit quarterly or until compliance is obtained. All Audits will begin on 9/18/25. Audits will be reported to the QA Committee during scheduled meetings.	09/27/2025

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F0686 SS = D	Continued from page 20 all days of survey. Diagnosis included a pressure ulcer to the sacral region noted upon admission (05/07/25) to the facility. Physician's orders stated, ". . . 05/07/2025 Turn/reposition schedule every 2/3 [2-3 hours] hours . . . 05/15/25 Consult General Surgery . . . worsening coccyx pressure ulcer . . . 06/19/25 Wound Vac (a therapeutic technique that uses suction to promote wound healing) to sacral wound . . ." Resident #4's care plan, stated ". . . Bed mobility: staff assist of 1 for re-positioning . . . has a pressure ulcer to coccyx. . . . turn evey [sic] 2-3 hours . . . resident bedbound due to stage IV sacral wound . . ." A Minimum Data Set, dated 06/25/25, identified Resident #4 dependent upon facility staff to roll left and right. Resident #4's medical record showed the resident's wound was debrided by a surgeon on 06/19/25, and included the following nursing progress note, dated 06/19/25 at 11:14 a.m., stated, ". . . Resident to MD [medical doctor] appointment at surgeon's office. Per note from [nurse practitioner's name], resident will now receive wound vac orders: white foam to tunnel and exposed bone . . . measures 10x10x2 [10 centimeters (cm) length by 10 cm width by 2 cm depth] with a 4cm tunnel at 5 oclock, [sic] 5% bone exposed, 10% yellow slough and 85% red wound bed. . . ." Review of the wound care documentation, dated 08/07/25, showed a stage IV (full thickness tissue loss, exposing underlying bone, muscle or tendon) pressure ulcer to Resident #4's sacral region and measured 11 centimeters (cm) by 10.5 cm width and 2 cm undermining. Resident #4's repositioning record, dated July 15 to August 13, 2025, identified the following: - Not repositioned: 1 day zero times - Repositioned once: 6 days - Repositioned twice: 14 days - Repositioned three times: 7 days - Repositioned four times: 1 day During an interview on 08/14/25 at 9:49 a.m., an administrative staff member (#7) confirmed Resident #4's turning and repositioning task failed to show	F0686		09/27/2025

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F0686 SS = D	Continued from page 21 staff repositioned the resident every 2-3 hours. The administrative staff member stated she expected facility staff to reposition the resident every two to three hours. During an interview on 08/14/25 at 1:17 p.m., an administrative staff member (#1) stated staff should reposition Resident #4 every 2-3 hours.	F0686		09/27/2025
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide appropriate services and assistance to maintain	F0690	Resident #4 will be educated that should she desire, a bed pan is available for bowel movements and that staff will assist in placement and removal of the bed pan. Documentation of the education will be put in the EHR and the care plan updated. Staff will be educated to offer a bedpan to resident #4 as per care plan. Completion date for this education will be 9/18/2025. A trial was initiated on 8/18, by the PT staff, to see if resident #4 was able to use a standing lift but was unsuccessful due to weakness. Resident #4 continues to be transferred by a hoyer lift. PT/OT will educate resident #4 on their weight bearing status and document in the EHR. This will be completed by 9/18/2025. Resident #4 will be included in audits. All residents who are cognitively intact (have no behaviors or refusals of care), present with coccyx wounds, and transfers with a hoyer lift have the potential to be affected. These residents could experience a loss of dignity, unnecessary incontinence and avoidable skin issues including worsening wounds. A bedpan should be offered and if desired, care planned to help maintain bowel continence. Nurses and C.N.A's will be educated that residents who have coccyx ulcers, are transferred by a hoyer lift but are otherwise cognitively intact (with no behaviors or refusals) must educated of the availability bed pan for toileting needs. This will assist in maintaining bowel continence, preventing a loss of dignity and any potential delay in healing of a wound. QA audits will be done weekly by DON and ADON or designee on all units ensuring that residents who have a coccyx wound, are cognitively intact (with no behaviors or rejection of care) and can transfer only with a hoyer lift will be offered alternatives for toileting. Three residents per unit, if identified will have audits completed weekly for 4 weeks. Then 3 audits per month, per unit will be completed for 3 months or until compliance is achieved. Audits will then continue at 5 per unit quarterly or until compliance is obtained. All audits will include resident #4.	09/27/2025

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F0690 SS = D	Continued from page 22 bowel continence for 1 of 2 sampled residents (Resident #4) observed during toileting/incontinence cares. Failure to provide alternate toileting methods may result in unnecessary incontinence, a loss of dignity, and avoidable skin issues. Findings include: Review of Resident #4's medical record occurred on all days of survey. Diagnosis included weakness, right femur fracture (occurred prior to admission) and pressure ulcer to sacral region. Physician orders, dated 07/25/25, stated, " . . . Activity Level: Up with assist . . . partial weight bearing as tolerated for two weeks and then transition to weight bearing as tolerated." The care plan stated, ". . . foley catheter R/T [related to] wound healing. . . . Toileting: Frequently incontinent. . . . brief changes assistance of 1 [staff]. . . . Toileting to be done every 2 to 4 hours and prn [as needed]. . . ." The resident's quarterly Minimum Data Set (MDS), dated 06/25/25, identified cognitively intact, dependent on staff for toileting, no physical or verbal behaviors, and no rejection of care. Observation on 08/13/25 at 11:18 a.m. showed Resident #4 incontinent of bowel with stool noted on the wound dressing. The nurses (#23 and #24) provided perineal cares, changed the incontinent product, and changed the wound dressing. During an interview on 08/11/25 at 4:41 p.m., Resident #4 stated she wears an incontinent product and "They just change me. I can't get out of bed with this fracture." During an interview on 08/14/25 at 8:00 a.m., a therapy staff member (#6), stated, "We do not get her (Resident #4) out of bed because she requires the hoyer lift [mechanical lift] and we do not want to risk her coccyx wound getting worse from shearing. The staff member (#6) also stated, "We have tried to stand her (Resident #4) at bedside and she is unable to. She just isn't there yet. We will try the sit to stand lift with two of us and see if she can do that." During an interview on 08/14/25 at 8:08 a.m., an administrative staff nurse (#7) stated Resident #4 does not get out of bed "per her choice," and staff only check and change her. The administrative staff nurse confirmed facility staff have not attempted alternate toileting methods, such as the bed pan, bedside commode, etc.	F0690	Continued from page 22 All Audits will begin on 9/18/25. Audits will be reported to the QA Committee during scheduled meetings.	09/27/2025

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F0690 SS = D	Continued from page 23 The medical record lacked evidence the facility staff educated Resident #4 on her current weight bearing status and offered alternate toileting methods, which may have resulted in avoidable incontinence, decreased dignity, and risk of further skin breakdown.	F0690		09/27/2025
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff, resident, and family interviews the facility failed to offer and/or assist with fluids for 3 of 8 residents (Resident #2, #13, and #14) who required staff assistance for fluid intake. Failure to provide fluids to dependent residents may result in dehydration, constipation, and urinary tract infections. Findings include: Review of the facility policy titled, “Fluids and dehydration” occurred on 08/14/25. This policy, revised May 2019, stated, “. . . The information gathered from the nutritional assessment, along with current standards of practice, will be used to	F0692	Residents #2, #13, #14 will be included in audits to ensure they are being offered fluids at the completion of cares and are provided assistance as needed with drinking. All residents that have been identified (through assessments and listed on the care plan) as having a potential for dehydration and are dependent on staff to complete cares, have the potential to be affected. This could lead to health issues such as constipation, UTI’s and dehydration. All nurses and C.N.A’s will be educated on the need to offer and assist dependent residents with drinking fluids upon completion of cares and at meals. Education will be done through meetings and read and signs. This will be completed by 9/18/2025. QA audits will be done weekly by DON and ADON or designee on all units ensuring that dependent residents will be offered and assisted with fluids upon completion of cares and at meals. Five audits per unit will be completed weekly for 4 weeks, or until compliance is achieved. Then 5 audits per month, per unit will be completed for 3 months or until compliance is achieved. Audits will then continue at 5 per unit quarterly or until compliance is obtained. All audits will include residents #2, #13, and #14. All Audits will begin on 9/18/25. Audits will be reported to the QA Committee during scheduled meetings.	09/27/2025

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F0692 SS = D	Continued from page 24 develop an individualized care plan that addresses the resident's specific . . . hydration concerns and preferences . . . Interventions to improve a resident's hydration status may include but not limited to the following . . . Offer the resident a variety of fluids during and between meals . . . Provide assistance with drinking . . ." - During an interview on 08/11/25 at 2:39 p.m., Resident #2 stated, "I don't know why they didn't bring me any water." Observation showed an empty glass of water sitting on the bedside table. A few minutes later, an unidentified certified nurse aide (CNA) entered the room and Resident #2 immediately asked the CNA for water. Review of Resident #2's medical record occurred on all days of survey. The physician's orders identified, ". . . chart fluids q [every] shift . . ." The current care plan stated, ". . . At risk for dehydration r/t [related to] diuretic medication use, recent infection. . . . Dehydration observation weekly as ordered . . . Offer and encourage fluids at and between meals. . . . At risk for constipation R/T opioid medication use . . . Offer and encourage fluids at and between meals . . ." - During an interview on 08/11/25 at 2:28 p.m., Resident #13's family member stated, "They [staff] drop off water and don't offer or assist her. She is weak and can't even hold a cup." Review of Resident #13's medical record occurred on all days of survey. The current care plan stated, ". . . At risk for constipation . . . Offer and encourage fluids at and between meals . . . At risk for dehydration . . . Dehydration observation weekly as ordered . . . Offer and encourage fluids at and between meals . . ." Observations on 08/13/25 showed the following: * 1:20 p.m., Two CNAs (#19 and #20) assisted Resident #13 with cares and exited the room. The CNAs (#19 and #20) failed to offer the water located on the bedside table prior to exiting the room. * 5:00 p.m. A CNA (#21) assisted Resident #13's with cares and exited the room. The CNA (#21) failed to offer the water located on the bedside table prior to exiting the room. Review of Resident #14's medical record occurred on all days of survey. Diagnoses included vascular dementia. The care plan stated, ". . . Offer and	F0692		09/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	**305 8TH AVE NE PO BOX 5030, MINOT, North Dakota, 58703**

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F0692 SS = D	Continued from page 25 encourage fluids . . . [Resident #14's name] is not able to do her own ADL's [activities of daily living] . . . Potential for dehydration. History of UTI [urinary tract infection]. . . . Resident needs total assistance with eating . . ." Observation on 08/13/25 at 3:35 p.m. showed two certified nurse aides (CNAs) (#4 and #5) assisted Resident #14 with cares and transferred the resident to the wheelchair and exited the room. The CNAs failed to offer water located on the bedside table. During an interview on 08/14/25 at 1:17 p.m., an administrative staff member (#1) stated he expected staff to offer dependent residents water with cares. 039484	F0692		09/27/2025
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 9 residents (Resident #65 and #96) observed during medication administration. Two medication errors occurred during staff administration of 27 medications, resulting in a 7% error rate. Failure to follow physicians' orders and administer medications in the correct dose and at the correct time may result in residents receiving an ineffective and/or inaccurate dose and experiencing adverse reactions. Findings include: Review of the facility's policy titled "Medication Administration and Crushing Medications" occurred on 8/14/25. This policy, approved October 2024, stated, ". . . OBJECTIVE: 1. To administer medications as ordered by a provider . . . Provider's Order must be obtained and observed for all medications. . . . Read the medication label and compare with the HER [sic] [electronic health record	F0759	Resident #65 will be included in observations of nurses instilling the correct number of eye drops in residents' eyes as per provider order. Resident #96 will be included in charting reviews of administration times of IV antibiotics to ensure compliance of the administration time, either one hour prior to or no later than one hour after the scheduled time. All residents receiving eye drops have the potential to be affected. A resident must receive the correct number of eye drops as stated on the provider order. A failure to instill the correct number of eye drops has the potential to delay healing or treatment of an eye disorder. All residents receiving IV antibiotics have the potential to be affected. A resident must have the dose administered per facility policy (either one hour prior or no later than one hour after the administration time) A failure to follow facility policy regarding timing could result in reducing the effectiveness of the antibiotic in the bloodstream and cause the infection to persist longer than it should. All nurses will be re-educated on the 5 R's-right drug, right route, right resident, right time, right dose. Nurses will also be re-educated on eye drop installation and following provider orders. The facility policy on administration times will also be reviewed. Education will be done through meetings and read and signs. This will be completed by 9/18/25. QA audits will be completed by DON and ADON or designee on all units ensuring that eye drops are administered to residents as ordered. Five audits per unit will be completed weekly for 4 weeks, or until	09/27/2025

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F0759 SS = D	Continued from page 26 (EHR)] ensuring the five rights: a. Right drug . . . Right dose . . . Right route . . . Right time . . . Right resident. . . . " Review of Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education Inc., New Jersey, page 835, stated, "Process of Administering Medications . . . Medications prescribed more frequently than daily, but no more frequently than every 4 hours . . . [Administer] Within 1 hour before or after the scheduled time. . . ." -Observation on 08/11/25 at 4:32 p.m. showed a nurse (#15) administered one drop of Refresh eye drops to both of Resident #65's eyes. The Refresh label stated two drops left eye twice daily. After returning to the medication cart, the nurse confirmed the order stated two drops to left eye twice daily. Review of Resident #65's physician's order verified two drops to left eye until redness resolves then discontinue. -Review of Resident #96's medical record occurred on all days of survey and showed a physician's order for Cefepime 2 Gram (an antibiotic medication) every 12 hours for 14 days for bacteremia/sepsis. Review of Resident #96's electronic medication administration record (EMAR) showed scheduled administration times for the Cefepime at 9:00 a.m. and 9:00 p.m. Observation on 08/12/25 at 10:49 a.m. showed a nurse (#2) administered the Cefepime. This exceeded the one-hour after the scheduled time of 9:00 a.m. by 49 minutes. During an interview on 08/13/25 at 2:00 p.m., an administrative nurse (#1) stated he expected staff to administer medication within an hour prior to the scheduled time to an hour after the scheduled time.	F0759	Continued from page 26 compliance is achieved. Then 5 audits per month, per unit will be completed for 3 months or until compliance is achieved. Audits will then continue at 5 per unit quarterly or until compliance is obtained. All audits will include resident #65. QA audits will be completed by DON and ADON or designee will be done weekly on all units ensuring any resident receiving IV antibiotics for correct administration times. Five audits per unit will be completed weekly for 4 weeks, or until compliance is achieved. Then 5 audits per month, per unit will be completed for 3 months or until compliance is achieved. Audits will then continue at 5 per unit quarterly or until compliance is obtained. All audits will include resident #96. All Audits will begin on 9/18/25. Audits will be reported to the QA Committee during scheduled meetings.	09/27/2025
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the	F0761	For resident #12, the label on the insulin pen has been updated to reflect the order change for the insulin. This was completed on 8/14/2025. Resident #12 will be included in audits for matching orders and labels on insulin pens. All residents receiving insulin are at risk for hypoglycemia or hyperglycemia if insulin is not administered as ordered and have the potential to be affected.	09/27/2025

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F0761 SS = D	Continued from page 27 expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure accurate medication labeling for 1 of 8 residents (Resident #12) observed during medication administration and failed to discard expired medications in 3 of 7 medication storage areas (3 North East cart and cupboard and 3 South refrigerator) reviewed. Failure to ensure medication labels reflect the current physician orders may result in inaccurate dosages and failure to discard expired medications may result in decreased effectiveness of the prescribed medication. Findings include: -Review of the facility policy titled "Medication Administration and Crushing Medications" occurred on 08/14/25. This policy, revised January 2021, stated, ". . . administer medications as ordered by a provider. . . . Read the medication label and compare with the HER [sic] [electronic health record (EHR)] ensuring the five rights . . . Right dose . . ." Observation on 08/14/25 at 8:36 a.m. showed a nurse (#11) removed Resident #12's Novolog insulin pen from the medication cart. The label on the insulin pen and on a box with additional insulin pens identified 20 units before meals and at bedtime. The current physician's order identified 25 units before	F0761	Continued from page 27 All residents receiving medications must receive a medication that is not outdated. Failure to discard outdated medications could result in a resident receiving a medication that has a decreased effectiveness and may be unsafe. All residents receiving medications have the potential to be affected. All nurses will be educated on the process to follow when receiving an order change on an insulin pen. If a new order is received with a dosage change for an existing insulin pen, the nurse must fax the new order to the pharmacy and call them to notify of the change needing a new label. The pharmacy courier will come pick up the insulin pen to take back to get a new label by a pharmacist. The pharmacy courier will then deliver the insulin pen back to the facility when completed. This process change will be educated by read and signs to all nurses on 9/26/25. All nurses and medication aides are to be educated to check each medication, prior to use, for an expiration date and discarded if expired. All nursing units will have medication storage areas, including med carts and fridges, checked monthly for outdated medications. This will be completed by an assigned nurse or medication aide. Education will be done through meetings and read and signs. This will be completed by 9/18/25. QA audits will be completed weekly will be completed by DON and ADON or designee on all nursing units to ensure insulin pens labels and provider orders match. Five audits per unit will be completed weekly for 4 weeks, or until compliance is achieved. Then 5 audits per month, per unit will be completed for 3 months or until compliance is achieved. Audits will then continue at 5 per unit quarterly or until compliance is obtained. All audits will include resident #12. QA audits will be completed weekly will be completed by DON and ADON or designee on all nursing units to ensure no expired medications are present. Each nursing unit will be checked weekly for 4 weeks, or until compliance is achieved. Then each nursing unit will be checked monthly for 3 months or until compliance is achieved. Audits will then continue for each nursing unit per quarter or until compliance is obtained. All Audits will begin on 9/18/25. Audits will be reported to the QA Committee during	09/27/2025

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F0761 SS = D	Continued from page 28 meals and before bedtime. When asked, a nurse manager (#3) and the nurse (#11) stated Resident #12 received a recent order change and both confirmed the label on the insulin pen and box failed to reflect the change. -Review of the facility policy titled "Supplies - Outdated - Trinity Homes" occurred on 08/14/25. This policy, revised January 2023, stated, "OUTDATED SUPPLIES 1. All supplies will be checked once a month. 2. Supplies that are outdated will be discarded. . . ." Observations of medication storage showed the following: -08/12/25 at 5:15 p.m., a tube of Muscle Rub topical cream with an expiration date of 08/2024 located in the medication cart on 3 North East. -08/14/25 at 11:38 a.m., one box of Acetaminophen 650 milligrams (mg) suppositories with an expiration date of 12/2024, and one box of Bisacodyl 10mg suppositories with an expiration date of 07/2025 located in the medication refrigerator on 3 South. -08/14/25 at 11:45 a.m., one bottle of aspirin 325mg with an expiration date of 05/2025 located in the medication cupboard on 3 North East. During an interview on 08/14/25 at 1:50 p.m., supervisory staff members (#1, #10, and #13) agreed staff should remove expired medications from the storage areas.	F0761	Continued from page 28 scheduled meetings.	09/27/2025
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F0812	Expired pan of corned beef, Ensure and Prosource was immediately disposed of and nutrition services staff performed a search through all stored food and supplements to identify any other expired products. None were found. All residents consuming food or supplements have the potential to be affected. The residents are at risk of a food borne illness or a decrease in the quality of an item if they are served a product past the expiration date. All nutrition services staff were re-educated on the proper handling, storage, and discarding of food and supplements past the expiration date. The First In, First Out system was reviewed and emphasized in reference to stocking foods and supplements. The use of the daily check list was reviewed as this	09/27/2025

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F0812 SS = D	Continued from page 29 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to discard expired food and supplements in 2 of 6 food storage areas (Main kitchen and 4 North kitchenette) observed. Failure to discard expired food/supplements has the potential to affect the quality of the item served to residents related to safety and nutrition. Findings include: Review of the facility policy titled "Dietary Policy/Procedure" occurred on 08/14/25. This undated policy stated, ". . . PURPOSE: To assure that foods served are wholesome and not out dated. . . . All foods rotated by date and stored properly. . . ." Observations showed the following: -08/11/25 at 1:15 p.m., main kitchen: the large walk-in freezer contained a partially uncovered pan of corned beef dated March 2024. -08/13/25 (morning), 4 North kitchenette: an opened container of Prosource (dietary supplement) expired October 2024. -08/13/25 at 3:00 p.m., main kitchen: approximately 42 boxed containers of Ensure Clear (dietary supplement) with expiration dates from April 2025 through August 1, 2025. During an interview on 08/14/25 at 9:00 a.m., a dietary supervisor (#16) verified the facility lacked a consistent process to monitor for expired foods/supplements, and staff should discard the	F0812	Continued from page 29 contains checking expiration dates on all food products. This checklist must be turned into the supervisor upon completion each day. Education was completed through staff meetings and read and sign on 9/3/2025. Audits will be completed in food storage areas (kitchen, walk-in refrigerators, reach-in refrigerators, and dry storage) 3 times a week for 4 weeks, then 4 audits monthly until compliance is achieved, then 3 audits quarterly for 2 quarters. The Director of Nutrition Services and supervisors will be responsible for completion of QA audits. All Audits will begin on 9/8/25. Audits will be reported to the QA Committee during scheduled meetings.	09/27/2025

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F0812 SS = D	Continued from page 30 expired food/supplements.	F0812		09/27/2025