STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245250	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	905 Elm Street Farmington, MN 55024

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interviews, the facility failed to provide safe transfers for 1 of 3 residents (R1) who required the use of a stand lift for transfers. This resulted in actual harm when a nursing assistant failed to use the right size sling, apply the waist buckle, and a loop on the sling came off of the stand. The resident fell, hit her head and sustained a mild concussion with stitches. The facility implemented corrective action prior to the investigation, so the deficiency was issued at Past Noncompliance. Findings include: R1's face sheet dated 12/8/25 indicated R1 had diagnoses of multiple sclerosis, age related osteoporosis without current pathological fracture, and depression. R1's annual Minimum Data Set (MDS) dated [DATE] assessment indicated she was cognitively intact and required substantial assistance with transfers and activities of daily living. R1's care plan intervention dated 9/19/24 directed staff R1 required the stand lift with assistance of one staff using a medium sized sling (sic-harness). R1's progress note dated 11/28/25 at 3:31 p.m., indicated nursing assistant (NA)-A put R1 on the toilet. R1 used the call light when she was finished. NA-A returned and provided perineal care while R1 was still in the stand lift. NA-A lifted the resident to standing position and began to back out of the bathroom. The left strap came out of the hook and R1 fell to the floor. R1 was in a large harness, NA-A did not have the waist strap buckled and did not have the calf strap buckled. Registered nurse (RN)-A attended to R1, there was a moderate amount of blood on the floor from a presumed laceration on the back of the head. RN-A called 911 because R1 was actively bleeding and was in a position that was difficult to get her up from. Root cause was the lift and harness were being improperly used. The intervention was the lift being taken out of commission and later inspected. NA-A was re-educated on using the stand lift. R1's progress note dated 11/29/25 at 5:10 a.m., indicated R1 returned from the hospital by ambulance. R1 had a head laceration with a dressing over it. R1's nurse practitioner progress note dated 12/2/25 indicated R1 had sutures placed in the hospital and had a diagnosis of a mild concussion. R1's care plan dated 12/8/25 indicated R1 required the Hoyer lift (brand of full mechanical lift) with the assistance of two staff, medium sling size. During an interview on 12/9/25 at 9:42 a.m., NA-A stated on 11/28/25 she was helping a coworker who was already busy when R1 needed to use the bathroom. NA-A used the stand lift to place R1 on the toilet, R1 used the call light to indicate she was finished. NA-A assisted with perineal care and pulling R1's pants back up. NA-A used the stand lift to stand her up, when they were passing the doorway of the bathroom, the loop on the one side of the harness slipped off the stand lift (NA-A did not verify which loop). R1 fell and hit her head. NA-A went to get help. After R1 left the facility to go to the hospital, she received immediate re-education. NA-A verified she did not use the waist strap and that was a violation of the policy. NA-A verified she had access to harness size information for all residents; it was located in the care plan. NA-A stated she took ownership of the incident and felt guilty. During an interview on 12/8/25 at 3:26 p.m., RN-A stated on 11/28/25 she responded to the fall immediately after being notified by NA-A and asked for help. RN-A placed a washcloth under R1's head since there was bleeding. RN-A noticed one side of the harness was hooked up and one side was not. RN-A called 911, notified the on-call manager and R1's emergency contact. RN-A provided re-education to NA-A during that shift on how to use the stand lift safely, including using the waist strap and the leg strap. RN-A verified management completed more education in the following days. R1's transfer status was changed to the Hoyer lift with the assistance of two staff. During an interview on 12/9/25 at 9:20 a.m., nurse manager (NM)-A indicated an awareness of the R1's fall from the lift on 11/28/25. NM-A stated NA-A used the wrong sling size and did not have the buckles clipped. There was a facility-wide stand lift training. When R1 returned from the hospital, she was re-assessed by physical therapy (PT) and was to be transferred by two staff on the stand lift. Later, when two staff were transferring her, they noticed the loop started to come up again. The staff stopped and the director of nursing (DON) and NM-A tried transferring her about 10 times and the loop kept popping up. R1 was re-assessed and was changed to be a Hoyer lift transfer with the assistance of two staff. All stand lifts in the facility were assessed, rubber clips replaced the metal clips to prevent the same issue from re-occurring. NM-A thought this issue only affected R1 because of her multiple sclerosis and her specific position she would stand in while being in the stand lift. During an interview on 12/9/25 at 10:15 a.m., representative from the stand lift company (REP-A) verified she came to the facility following the incident to provide facility-wide education on using the stand lift properly. REP-A stated there were no concerns with the facility using equipment incorrectly prior to this incident, staff maintain the