

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/24/2024
NAME OF PROVIDER OR SUPPLIER  Trinity Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495</b></p> <p>Based on observation, interview, and document review, the facility failed to provide a dependent resident, who received no fluids by mouth, oral care to promote comfort and hygiene for 1 of 3 residents (R19) reviewed for activities of daily living (ADLs).</p> <p>Findings include:</p> <p>R19's quarterly Minimum Data Set (MDS), dated [DATE], indicated R19 had severe cognitive impairment and was dependent on staff for all ADLs including oral care. The MDS further indicated R19 required a gastrostomy tube (g-tube; feeding tube) for nutrition.</p> <p>R19's care plan dated 7/22/22, indicated R19 was NPO (nothing by mouth) TF (tube feeding) and required assistance with oral care for optimal oral health hygiene. The care plan directed the nursing assistants to ensure R19 was sitting upright at a 90-degree angle, wet toothbrush and use a small pea sized amount of toothpaste and brush teeth if R19 unable to do so himself and use a pink toothette to swab mouth and remove toothpaste when finished.</p> <p>R19's Observations by Resident, dated 7/1/24 - 7/23/24, indicated R19 received oral care seven times during the dates listed on 7/5/24 x 2, 7/13/24, 7/14/24, 7/19/24 x 2, and 7/21/24 x 2.</p> <p>During an interview on 07/22/24 at 2:25 p.m., R19's family member (FM) stated oral care was not being done by the nursing assistants. FM stated oral care should be done twice a day and since R19 was not able to take any food or fluids by mouth speech therapy had provided education to the nursing staff on how to safely perform oral cares, but it was still not being completed.</p> <p>During a follow up interview on 7/24/24 at 7:28 a.m., FM stated she spent 12 hours every day with R19, coming in at 6 a.m. everyday and has not seen facility staff do oral at all this week, stating R19 almost always sleeps with his mouth open and was sure it gets dry stating, I would like to see then do oral care.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation and interview on 7/24/24 at 7:57 a.m., nursing assistant (NA)-C and NA-D were providing morning cares to R19. Registered nurse (RN)-D was also present providing medications to R19 via G-tube. NA-C and NA-D provided peri-care with a clean brief and repositioned R19 in bed. RN-D assessed R19's skin, lung sounds, and bowel sounds and applied A&amp;D ointment to R19's skin on his buttocks. No oral care was performed by NA-C, NA-D, or RN-D. NA-D stated this was the typical morning routine and cares that were provided to R19. RN-D confirmed that was a typical morning routine and consisted of the cares and assessments provided to R19 each morning.</p> <p>During an interview on 7/24/24 at 10:01 nurse manager and registered nurse (RN)-C stated the expectation was for oral cares to be done with R19 BID, stating speech therapy did education with staff on how to properly do oral care and it absolutely needed to get done.</p> <p>An facility policy titled Oral Hygiene, revised 5/25/23, indicated, all residents will receive oral care as assessed to be appropriate and defined by the care plan. The purpose was to promote cleanliness and prevent oral infection.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495</b></p> <p>Based on observation, interview and document review the facility failed to monitor bruising and scabbing on a resident's left shin who was also on a blood thinner for 1 of 1 resident (R42) reviewed for non-pressure skin alterations.</p> <p>Findings include:</p> <p>R42's quarterly Minimum Data Set (MDS), dated [DATE], indicated R42 had severe cognitive impairment, required substantial to maximum assistance with activities of daily living (ADLs) and had received an anticoagulant during the seven day look back period. The MDS further indicated R42 had diagnoses of dementia, Parkinson's disease, depression, and psychotic disorder.</p> <p>R42's Current Orders, printed 7/25/24, indicated R42 had an order for Eliquis (a blood thinning medication used to prevent blood clots) 5 milligrams (mg) daily. The orders however lacked an order to monitor the skin alterations (bruising and scabbing) to R42's left shin.</p> <p>R42's care plan, printed 7/24/24, instructed staff to monitor R42 for potential side effects of Eliquis use to include excessive bleeding and bruising, diarrhea or constipation, indigestion, dizziness, headaches, rashes, itching skin, hair loss, jaundice. The care plan further indicated R42 was at risk for skin breakdown related to atrial fibrillation (irregular heart rhythm), Parkinson's, edema (swelling related to excess fluid) and incontinence with interventions for the nurses to inspect R42's skin weekly and the nursing assistants to inspect R42's skin daily for bruises and edema.</p> <p>R42's last three Weekly General Observation - Skin Conditions, dated 7/6/24, 7/13/24, and 7/20/24, indicated skin checked, no problems found.</p> <p>R42's electronic medical record (EMR) lacked any wounds that were currently being monitored under the Wound Monitoring section of the EMR.</p> <p>During observation and interview on 7/22/24 at 3:19 p.m., R42 was observed asleep in bed with his legs exposed, multiple bruising and scabbing were noted on his left shin. R42's family member (FM-2) stated she had noticed the bruising and scabbing to R42's shin on Sunday (7/21/24).</p> <p>During an interview on 7/24/24 at 8:11 a.m., nursing assistant (NA)-D stated she has noticed the bruising and scabbing on his left shin, stating R42 bruises easily and had bruising and scabbing on his shins for a long time confirming she has told the nurses about it.</p> <p>During an interview 7/24/24 at 8:55 a.m., licensed practical nurse (LPN)-B stated she had noticed the bruising and scabbing on R42's left shin, stating he often runs his shins into things while in his wheelchair and that he also picks at his skin.</p> <p>During a follow up interview on 7/24/24 at 10:01 a.m., RN-C stated she assessed R42's legs and would be starting treatment and monitoring to his left shin.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/24/24 at 10:01 a.m., nurse manager and registered nurse (RN)-C indicated it was the expectation that any new or acute skin alterations would be addressed on an incident report which would then notify her for follow up, confirming she was not aware of any skin alterations with R42. She stated it would be important to monitor any skin alterations to monitor for any changes, improvements, or worsening.</p> <p>A facility policy on non-pressure skin concerns was requested and not received.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495</b></p> <p>Based on observation, interview and document review the facility failed to provide routine range of motion for 1 of 1 resident (R19) reviewed for ROM who was dependent on staff for all activities of daily living (ADLs).</p> <p>Findings include:</p> <p>R19's quarterly Minimum Data Set, dated [DATE], indicated R19 had severe cognitive impairment and was dependent on staff for all ADLs.</p> <p>R19's care plan, dated 7/22/22, indicated R19 should receive ROM daily with dressing.</p> <p>R19's Observations by Resident, dated 7/1/24 - 7/23/24, lacked any documentation of the nursing assistants providing ROM to R19.</p> <p>During an interview on 7/22/24 at 2:28 p.m., R19's family member (FM) stated R19 had stiff and contracted legs and was still working with therapy but was also supposed to receive daily ROM to his legs. FM stated she has not seen nursing staff do any ROM with R19.</p> <p>During a follow up interview on 7/24/24 at 7:28 a.m., FM stated she spent 12 hours every day with R19, arriving at 6a.m. every morning and confirmed she had not seen nursing staff do any ROM with R19 this week.</p> <p>During observation and interview on 7/24/24 at 7:58 a.m., nursing assistant (NA)-C and NA-D entered R19's room to provide morning cares to include peri care, a brief change and repositioning. R19 was observed to have stiff bilateral legs that were difficult to maneuver while providing cares. R19's bilateral legs also appeared to not be able to fully straighten. RN-D was also present providing medications and to assess R19's skin, lung sounds and bowel sounds. No ROM was performed by NA-C, NA-D, or RN-D. NA-D stated this was the typical morning routine and cares that were provided to R19. RN-D confirmed that was a typical morning routine and consisted of the cares and assessments provided to R19 each morning.</p> <p>During observation and interview on 7/24/24 at 11:11 a.m., (NA)-C and NA-D were entering R19's room to get R19 dressed and up in his wheelchair. R19 was dressed in pants, socks and shoes and a hospital gown was kept on as a top per daughter preference. R19 was transferred to his wheelchair via a full body mechanical lift. NA-C and NA-D left R19's room without providing ROM.</p> <p>During an interview on 7/24/24 at 10:45 a.m., registered nurse and restorative nurse (RN)-E stated nursing staff were instructed to and should be providing R19 ROM to his arms and legs while getting R19 dressed. RN-E confirmed they should also be documenting this under Observations by Resident after completion.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy titled Range of Motion, revised 11/8/13, indicated the restorative ROM program was to provide residents with the assistance required to maintain and improve joint mobility and promote a greater sense of wellbeing. The policy indicated when a resident had ROM care planned, a general guide was to repeat the exercise 10 times per joint.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49034</p> <p>Based on observation, interview, and document review, the facility failed to ensure proper cleaning of a non-invasive ventilation machine to reduce the risk of complications (i.e., respiratory infection) for 1 of 1 residents (R48) observed for continuous positive airway pressure (CPAP) machine use.</p> <p>Findings include:</p> <p>The ResMed AirFit F20 Full Face Mask User Guide dated 12/20, indicated the mask should be disassembled, rinsed, cleaned with a soft brush until dirt was removed, cleaned with warm water and a mild detergent, rinsed and air dried daily or after each use. The guide indicated the headgear should be cleaned with warm water and mild detergent and then rinsed and air-dried weekly.</p> <p>The ResMed AirSense 10 User Guide dated 2/21, indicated the non-invasive ventilation machine should be cleaned weekly including washing the water tub and air tubing with warm water and mild detergent and wiping the machine's exterior with a dry cloth. The guide recommended regular cleaning of the tubing, water tub, and mask for optimal therapy and prevention of the growth of germs.</p> <p>R48's annual Minimum Data Set (MDS) dated [DATE], indicated R48 had intact cognition and required maximal assistance with upper body dressing, personal hygiene, and bed mobility. The MDS indicated that R48 utilized a non-invasive ventilation machine.</p> <p>R48's diagnoses list dated 6/5/23, indicated R48 was diagnosed with obstructive sleep apnea (sleep-related breathing disorder), hypertension (high blood pressure), and COVID-19 (7/13/24).</p> <p>R48's Current Order summary dated 6/9/23, indicated staff were to assist R48 with applying her CPAP at night and removing it every morning. The order indicated staff were to ensure the machine had distilled water up to the fill line of the humidification chamber before CPAP placement but did not include daily cleaning of the CPAP. The summary included an order for weekly cleaning of the headgear, chin strap, mask, and tubing.</p> <p>R48's Medication Administration Record (MAR) Summary dated 7/1/24 through 7/24/24, indicated weekly CPAP cleaning of the headgear, chin strap, mask, and tubing had occurred but did not include daily cleaning. The summary indicated the CPAP had been applied and removed daily during the period.</p> <p>During an interview and observation on 7/22/24 at 1:31 p.m., R48 stated staff did not clean the CPAP machine very often, and it had looked like it needed to be cleaned for a while. R48's ResMed AirSense 10 with an attached ResMed AirFit F20 Full Face Mask was observed on R48's bedside table with a white substance partially covering the inside of the mask and a buildup of dust and a white substance on the outside of the machine.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 7/23/24 at 11:32 a.m., R48's CPAP machine with an attached mask was observed on R48's bedside table with a white substance partially covering the inside of the mask and a buildup of dust and a white substance on the outside of the machine. Registered nurse (RN)-D stated the mask appeared dirty and needed to be cleaned and had not been cleaned today. RN-D stated that R48 had scheduled weekly cleanings of the CPAP machine on Sundays but did not have scheduled daily cleanings. RN-D stated she would sometimes wipe down the mask in the morning but did not detach the mask from the machine or use soap to clean it, other than for the weekly cleanings.</p> <p>During an interview on 7/24/24 at 11:23 a.m., RN-C, the nurse manager, stated R48's CPAP machine should be wiped down every day and the order was now updated to reflect this. RN-C stated having a buildup of grime on the CPAP mask was disgusting and nursing staff should have been cleaning this. RN-C stated nursing staff should not need an order to know to wipe down a CPAP machine, it should be basic nursing sense.</p> <p>The facility Cleaning/Disinfection Resident Care Equipment policy dated 1/25/22, indicated respiratory therapy equipment was a semi-critical item and should remain free from all microorganisms.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49339</p> <p>Based on observation and interview and policy review, the facility failed to ensure medications were securely stored safely in 2 of 6 medication carts observed.</p> <p>Findings include:</p> <p>During observation and interview on 7/22/24 at 1:37 p.m., an unattended and unlocked medication cart was observed outside a nursing station of the long-term care unit named, The Cottages. The unattended and unlocked medication cart was adjacent to the courtyard/dining room with several residents present. Registered nurse (RN)-A verified the medication cart was unlocked and stated, I am responsible for the unlocked medication cart. RN-A stated unattended medication carts should always be locked to protect medications from unauthorized staff, residents, and visitors.</p> <p>During observation and interview on 7/24/24 at 8:30 a.m., an unattended and unlocked medication cart was observed outside a nursing station of a unit named, The Chateau. The unlocked and unattended medication cart was adjacent to the courtyard/dining room with several residents present. Trained medication aid (TMA)-A approached the medication cart and verified they were responsible for the medication cart. TMA-A verified the medication was unlocked and unattended by staff. TMA-A indicated the medication cart should be locked to prevent a medication error and so people can't get in it.</p> <p>On 7/24/24 at 11:24 a.m., director of nursing (DON) stated, I expect that if they (medication carts) are unattended, they are locked. This ensures they can't be accessed by unlicensed personal or residents.</p> <p>A facility policy titled Medication Administration, dated 8/7/23, was provided. The document indicated the medication cart is stored in designated area(s) and locked when not in use. The nurse or TMA retains the medication cart key on his/her person while on duty.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656</b></p> <p>Based on observation, interview and document review, the facility failed to ensure personal protective equipment (PPE) practices were implemented by staff during a COVID-19 outbreak at the facility. This had the potential to affect all residents residing in one unit (Chateau Unit) of the facility.</p> <p>Findings include:</p> <p>Review of CDC guidance updated, 3/14/24 , Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic indicated when a facility is in COVID-19 outbreak status Source control is recommended more broadly as described in CDC ' s Core IPC Practices in the following circumstances: By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days)</p> <p>During survey entrance on 7/22/24 at 12:45 p.m., a large whiteboard was placed at facility main entrance with a stand up sanitizing unit, and two boxes of surgical masks. The whiteboard indicated, Attention, effective 7/5/24 COVID OUTBREAK *Masking Required for everyone, Thank you.</p> <p>R10's annual Minimum Data Set (MDS) dated [DATE], indicated R10 had severely impaired cognitive skills, required substantial/maximal assistance with eating, oral hygiene, upper body dressing, and personal hygiene. Also, R10 was dependent for bathing and toileting. R10 diagnoses include Alzheimer's, dementia, aphasia (inability to comprehend or communicate), hemiplegia (paralysis on one side of the body), and anxiety.</p> <p>During observation and interview with infection control preventionist (IP) on 7/23/24 at 7:38 a.m., IP was observed stocking a PPE cart outside R10's room on the long-term care unit named, Chateau. R10's door had signage which indicated, Droplet Precautions. IP stated R10 tested positive for COVID-19 on 7/22/24 and verified the facility was in a COVID outbreak and all staff were required to wear surgical masks at all times unless entering a COVID positive room, which then required a N95 mask, PPE gown, gloves, and eye protection.</p> <p>During observation on 7/24/24 at 7:45 a.m., trained medication aide (TMA)-A was observed with a surgical mask below the nose and above mouth stood at medication cart outside nursing station adjacent to the Chateau dining room obtaining medications. Several residents were seated at the adjacent dining room tables.</p> <p>During observation on the Chateau unit on 7/24/24:</p> <ul style="list-style-type: none"> <li>- at 8:45 a.m., TMA-A was observed standing at a medication cart outside the Chateau nursing station adjacent to the dining room with her face mask below the nose and chin obtaining medications.</li> <li>- at 8:47 a.m., TMA-A pulled the face mask up to cover her mouth but not her nose.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-at 8:50 a.m., TMA-A was observed administering medications to a resident at the dining room table with her face mask below her nose.</p> <p>-at 8:58 a.m., TMA-A was observed walking down the Chateau hallway with a cup of medications in her hand. TMA-A had her face mask down below her chin exposing both nose and mouth.</p> <p>-at 9:22 a.m., TMA-A was observed standing at a medication cart outside nursing station adjacent to the Chateau dining room with her face mask below her nose and chin obtaining medications. Three people were sitting in the dining room. Two staff members were sitting in nursing station and one housekeeper, and a maintenance staff member walked past.</p> <p>-at 10:37 a.m., TMA-A was observed exiting the staff break room and walked down a hallway and past the whiteboard posted at the entrance of the facility which announced the COVID outbreak and requirement of all staff to wear a mask. TMA-A was wearing her face mask below her nose and mouth.</p> <p>-at 11:08 a.m., TMA-A was observed pushing a cart with lunch trays from the kitchen past the central dining room of residents and the entire transitional care unit (TCU) of the facility to the Chateau unit dining room. TMA-A was wearing face mask below her chin exposing nose and mouth.</p> <p>During observation and interview with nursing assistant (NA)-A on 7/23/24 at 12:15 p.m., NA-A was working on the Chateau unit and was observed wearing a surgical mask and stated, [staff] gotta wear it because of COVID outbreak. We have to wear it all times to prevent spreading infection to others and catching it too.</p> <p>During observation and interview with NA-B on 7/23/24 at 12:23 p.m., NA-B was working on the Chateau unit and was observed wearing surgical mask and stated, [staff] wear mask at all times to prevent spread of infection. Should be above mouth and cover the nose at all times.</p> <p>During interview on 7/24/24 at 9:30 a.m., housekeeper (H)-A stated all staff are required to wear a surgical mask due to the facility being in COVID outbreak status and, [staff] must have them when out in the resident areas.</p> <p>During interview on 7/24/24 at 9:32 a.m., H-B stated, right now we [facility] are under COVID outbreak. [We are to] wear the mask at all times in resident areas. [It is] important to protect residents and ourselves and family and visitors as well.</p> <p>During interview on 7/24/24 at 9:34 a.m., with licensed practical nurse (LPN)-B, LPN-B stated, We have to wear it all times to prevent infection spread.</p> <p>During interview on 7/24/24 at 10:12 a.m., with registered nurse (RN)-C, RN-C stated, Staff have to wear them [surgical masks] at all times.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/24/2024
NAME OF PROVIDER OR SUPPLIER  Trinity Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During observation and interview with TMA-A on 7/24/24 at 11:10 a.m., TMA-A was standing at medication cart located outside nursing station and adjacent to the Chateau dining room. TMA-A stated teh facility was in a COVID outbreak and it was important for staff to wear surgical mask over the mouth and nose, to prevent [the] spread [of] infection. TMA-A verified R10 on the Chateau unit tested positive for Covid on 7/22/24. TMA-A also verified she failed to wear the face mask appropriately during multiple surveyor observations, due to sweating and [sic]can't breathe. TMA-A stated all of the residents of the facility were vulnerable to infection.</p> <p>During interview with the director of nursing (DON) on 7/24/24 at 11:15 a.m., DON verified the facility was in a COVID outbreak and stated the expectation of all staff was to wear masks appropriately, at all times.</p> <p>Facility policy titled Coronavirus Prevention, Screening, and Identification reviewed 10/11/2023 identified, A breach of PPE can result in the spread of infectious pathogens. Breach of PPE can include but is not limited to:</p> <p>i. Inappropriate use of facial mask.</p> <p>49339</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49034</p> <p>Based on interview and document review, the facility failed to ensure that recommended pneumococcal vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided to reduce the risk of severe disease for 5 of 5 residents (R6, R8, R19, R45, R48) reviewed for immunizations.</p> <p>Findings include:</p> <p>A CDC Pneumococcal Vaccine Timing for Adults chart dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained for adults [AGE] years and older. The chart indicated when a resident had received the Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and the pneumococcal polysaccharide vaccine 23 (PPSV23) at greater than [AGE] years, the resident and provider may choose to administer the Pneumococcal 20-valent Conjugate Vaccine (PCV20).</p> <p>R6's annual Minimum Data Set (MDS) dated [DATE], indicated R6 was [AGE] years old at the time of assessment, had severely impaired cognition, and was diagnosed with kidney disease, dementia, and heart failure.</p> <p>R6's Resident Vaccinations record dated 7/23/24, indicated R6 had received the PPSV23 on 2/10/04 (greater than [AGE] years old at administration) and the PCV13 on 5/4/15.</p> <p>A call was attempted on 7/24/24 at 8:48 a.m. to R6's resident representative (RR)-A with no answer.</p> <p>R8's quarterly MDS dated [DATE], indicated R8 was [AGE] years old at the time of assessment, had moderately impaired cognition, and was diagnosed with kidney disease, diabetes, and dementia.</p> <p>R8's Resident Vaccinations record dated 7/23/24, indicated R8 had received the PPSV23 on 11/9/12 ([AGE] years old at administration) and the PCV13 on 4/27/16.</p> <p>A call was attempted on 7/24/24 at 8:43 a.m. to R8's resident representative (RR)-D with no answer.</p> <p>R19's quarterly MDS dated [DATE], indicated R19 was [AGE] years old at the time of assessment, had severely impaired cognition, and was diagnosed with diabetes and dementia.</p> <p>R19's Resident Vaccinations record dated 7/23/24, indicated R19 had received the PPSV23 on 1/1/07 (greater than [AGE] years old at administration) and the PCV13 on 12/23/16.</p> <p>During an interview on 7/24/24 at 8:23 a.m., RR-B stated that no one from the facility had offered an additional pneumococcal vaccination for R19 before survey entrance but if they had, they would have wanted it.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Trinity Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  905 Elm Street Farmington, MN 55024	
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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R45's annual MDS dated [DATE], indicated R8 was [AGE] years old at the time of assessment, had severely impaired cognition, and was diagnosed with diabetes and dementia.</p> <p>R45's Resident Vaccinations record dated 7/23/24, indicated R45 had received the PPSV23 on 11/12/03 ([AGE] years old at administration) and the PCV13 on 3/2/15.</p> <p>During an interview on 7/24/24 at 8:09 a.m., RR-C stated she did not recall anyone from the facility offering an additional pneumococcal vaccination for R45 before survey entrance but if they had, they would have wanted it.</p> <p>R48's annual MDS dated [DATE], indicated R48 was [AGE] years old at the time of assessment, had intact cognition, and was diagnosed with a heart dysrhythmia and hypertension.</p> <p>R48's immunization record dated 3/9/21, indicated R48 had received the PPSV23 on 9/1/10 ([AGE] years old at administration) and the PCV13 on 1/15/15.</p> <p>During an interview on 7/24/24 at 10:29 a.m., R48 stated she had not been offered an additional pneumococcal vaccination before survey entrance, but if they had, she would have said yes.</p> <p>R6's, R8's, R19's, R45's, and R48's medical records were reviewed and did not indicate the PCV20 was offered or administered prior to survey entrance.</p> <p>During an interview on 7/24/24 at 10:26 a.m., the infection preventionist (IP) stated that the registered nurse (RN)-C, the nurse manager oversaw tracking and offering pneumococcal vaccinations and RN-C was the best source of information regarding this.</p> <p>During an interview on 7/24/24 at 10:40 a.m., RN-C stated all five residents (R6, R8, R19, R45, R48) were eligible for a PCV20 dose but it had not been offered before survey entrance. RN-C stated the facility had difficulty getting a standing house order from their medical director and it had led to delays in offering and administering this vaccination.</p> <p>The facility Resident Immunization policy dated 9/29/23, indicated pneumococcal vaccines would be offered to residents according to the current CDC guidance.</p>		