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	04/30/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify the physician of a change in condition related to orthostatic hypotension and failed to notify the physician following a hyperglycemic blood glucose reading greater than 400 mg/dL for two of two residents (R5 and R68) reviewed for notification of change. Findings include: R5's quarterly Minimum Data Set (MDS), dated [DATE], indicated R5 was admitted to the care facility on 10/14/24, had a Brief Interview for Mental Status (BIMS) score of 15 (indicating intact cognition), received an antipsychotic medication (which has a potential side effect of orthostatic hypotension), and required substantial to maximum assistance with activities of daily living (ADLs). Orthostatic hypotension is a condition in which a person's blood pressure drops significantly when they move from lying down or sitting to a standing position. It is typically defined as a decrease of more than 20 mmHg in systolic blood pressure (the top number) or more than 10 mmHg in diastolic blood pressure (the bottom number). This sudden drop can prevent adequate blood flow to the brain, causing symptoms such as dizziness, lightheadedness, or even fainting when the body is unable to adjust blood pressure quickly enough. R5 had a physician's order, dated 9/18/25, for orthostatic blood pressure monitoring due to antipsychotic use once a month to include blood pressure readings while lying, sitting, and standing. R5's vital signs record, dated 4/18/26, indicated an orthostatic blood pressure drop from 122/72 while lying, to 118/71 while sitting, and 101/62 while standing, demonstrating a systolic drop greater than 20 mmHg between laying and standing. R5's electronic medical record (EMR) lacked evidence the physician was notified of the orthostatic blood pressure drop identified on 4/18/26. During an interview on 4/29/26 at 1:16 p.m., registered nurse (RN)-D stated if there was a 20-point difference in blood pressure readings between lay, sit or stand, staff would notify the provider. During an interview on 4/30/26 at 8:05 a.m., nurse manager and registered nurse (RN-C) stated staff should notify the provider for a 20-point orthostatic drop and document the communication. RN-C reported she had not been notified and was unaware R5 was experiencing orthostatic drops. During a follow-up interview on 4/30/26 at 8:47 a.m., RN-C stated the provider had been notified of (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orthostatic blood pressure readings in December with no new orders; however, the 4/18/26 orthostatic drop had not been reported. RN-C indicated she would provide staff education and clarify expectations with the provider regarding notification parameters. During an interview on 4/30/26 at 8:10 a.m., R5 stated they experienced dizziness when sitting or standing too quickly and reported needing to move slowly to prevent symptoms. A facility policy titled Change in Condition, revised 7/29/25, indicated staff would notify the physician for multiple reasons including the possible need to discontinue or start a new treatment. R68 R68's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R68 had severely impaired cognition and required substantial to maximum assistance with activities of daily living (ADLs). R68's diagnoses included type 1 diabetes mellitus (a condition where the body's immune system attacks and destroys insulin-producing beta cells in the pancreas, resulting in little or no insulin production and leading to high blood sugar levels) with other diabetic neurological complications and other frontotemporal neurocognitive disorder (progressive brain disease that primarily affect that leads to changes in behaviors, personality, language and movement). R68 had a physician order dated 10/3/25, for accuchecks (blood sugar checks) 3 times a day with meals: must update provider if blood sugar is less than 90mg/dl or greater than 400mg/dl. If less than 70 mg/dl give glucose gel. R68's vital signs record dated 3/26/26, indicated a blood sugar of 498.0mg/dl and vital signs record dated 4/20/26, indicated a blood sugar of 449.0 mg/dl. R68's electronic medical record (EMR) showed no evidence of provider notification for blood sugar reading of 498.0mg/dl on 3/26/26, and blood sugar reading of 449.0mg/dl on 4/20/26. During an interview on 4/29/26 at 8:45 a.m., registered nurse (RN)-B stated if a resident's blood sugar reading was elevated and they had an order for the provider to be notified, staff would notify the provider and would document the notification in the EMR. During an interview on 4/29/26 at 9:08 a.m., nurse manager and registered nurse (RN)-A stated staff should notify the provider of blood sugar readings of 498.0mg/dl and 449.0mg/dl. RN-A completed a brief EMR review and was unable to locate notifications sent to provider for the two incidences of blood sugar readings greater than 400mg/dl. RN-A stated they would provide staff education on expectations for provider notification. A facility policy titled Change in Condition, revised 7/29/25, indicated staff would notify the physician for multiple reasons including the possible need to discontinue or start a new treatment.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a discharge return not anticipated (DRNA) Minimum Data Set (MDS) was completed and transmitted to the Centers for Medicare and Medicaid (CMS) for 1 of 1 residents (R23) reviewed for no MDS record in 120 days.Findings include:R23's Census listing dated 1/6/26, indicated R23 admitted to the nursing home on [DATE], and their status changed to STOP BILLING on 1/6/26.R23's progress note dated 1/6/26 at 11:05 a.m., indicated R23 discharged home with family and would have home health services.R23's MDS listing dated 12/16/25 was reviewed and included no record that the facility had transmitted the required DRNA MDS to CMS for the 1/6/26 discharge. During an interview on 4/30/26 at 8:12 a.m., the assistant director of nursing/MDS coordinator (ADON) stated that R23's discharge MDS had been missed. The ADON stated that sometimes he would wait a few days to submit the discharge MDS to ensure the resident was not readmitted . The ADON stated he might have done this and then forgotten to complete the assessment. The ADON stated that it looks like a discharge return not anticipated MDS should have been completed.The facility's MDS 3.0 Assessment policy dated 8/20/24, indicated that a discharge assessment should be completed within 14 days of discharge.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident's care plan was revised related to changes in ambulation status 1 of 1 resident (R42) reviewed for restorative nursing programs. Findings include: R42's quarterly Minimum Data Set, dated [DATE] indicated R42 had moderate cognitive impairment and required partial to substantial assist with activities of daily living. It also indicated walking was not attempted during the assessment period. R42 had a diagnosis of progressive neurologic condition and was not on a range of motion or walking program. R42's care plan titled risk for decline in ambulation initiated 8/7/25, and revised 11/15/25, indicated R42 would ambulate 10-20 feet 3 times per week using a gait belt and front wheeled walker with an assist of 2 staff and wheelchair to follow. A mobility care plan revised 1/28/26, indicated R42 was non-ambulatory and required range of motion exercises twice daily. R42's self-care deficit care plan revised 4/7/26 indicated transfer with 2 assist and sit to stand mobility. R42's Kardex indicated R42 was non-ambulatory, required range of motion exercises twice daily, and was an assist of to for transfers with the sit to stand lift. R42's kardex also indicated to encourage and assist ambulating 10-20 feet with a front wheeled walker, gait belt, and staff assist of 2 three times per week. A progress note dated 1/28/26, indicated R42 had gone back/forth with ambulating short distances and worked with therapy on multiple occasion. R42 reported she felt comfortable ambulating with therapy, but she doesn't trust her legs or knees enough to ambulate with staff. The progress note indicated R42 was educated and reassured that staff are fully trained in ambulation and therapy also verbally educated staff with R42 present, but resident still does not wish to ambulate with staff. The progress note indicated R42 would remain an assist of 1 with a sit to stand lift and would be non-ambulatory going forward per her preference. During an interview on 4/29/26 at 1:30 p.m., nursing assistant (NA)-A stated the floor staff were responsible for performing restorative nursing tasks. Tasks were listed in the general charting on the computer documentation screen. NA-A stated she had not worked with R42 for months but believed she was on a walking program. NA-a confirmed R42 had a range of motion program as well as an ambulation program. The ambulation program indicated walk 10-20 feet with assist of 2 and wheelchair to follow. Transfer with sit to stand and assist of 2. NA-A stated R42 sometimes struggled with straightening her legs in the sit to stand so she can't imagine [R42] walks. During in interview on 4/29/26 at 1:38 p.m., NA-B stated R42 did fairly well with ambulation for a while but started refusing sometime late December 2025/January 2026. During an interview on 4/29/26 at 4:13 p.m., the facility therapy director (TD) stated when residents finished with therapy, recommendations for restorative exercises were given to the restorative nurse to implement with the nursing staff. If a resident was not participating in the restorative program, nursing staff usually let them know during morning meetings so they could evaluate and adjust the program. The TD stated R42's restorative recommendations were ambulation of 10-20 feet with a friend wheeled walker and assist of 2 with a wheelchair to follow. The TD stated they were not made aware of any changes to R42's level of participation in the restorative exercises. During an interview on 4/30/26 at 8:41 a.m., the restorative nurse stated therapy wrote the restorative programs for residents and he implemented the programs. If a resident was not participating in the program as expected, he would speak to the therapy department to get recommendations. The restorative nurse stated he would expect to be notified if a resident was unable to perform the exercises or staff were unable to get them done, however the communication is not always the greatest. The restorative nurse confirmed R42 was on a restorative program previously however was not currently on one due to her refusal to participate. The restorative nurse stated he realized on 4/29/26, R42's restorative program was still an active task for completion and confirmed it should have been removed when R42's program was discontinued. The restorative nurse stated R42 has not been ambulating and felt staff just checked (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the task as completed without reading what it was. During a follow-up interview, the restorative nurse confirmed the nurse manager was responsible for updating the mobility care plan, however he was responsible for updating any restorative care plans. During an interview on 4/30/26 at 9:27 a.m., registered nurse (RN)-A stated R42 has a history of going back and forth with her participation in her ambulation program. R42 did well until the end of January 2026 when she started refusing again. R42 stated told RN-A she felt comfortable walking with therapy however did not feel safe with the nursing staff. RN-A stated they provided reassurance to R42 the staff were properly trained for ambulation including in person instruction in R42's presence. RN-A stated she personally offered to assist R42 with her ambulation program, however she continued to refuse so her ambulation program was discontinued at that time. R42 has had some recent weight gain causing increased pain in her knees so she is currently an assist of 2 with a sit to stand however remains non-ambulatory. RN-A stated she updated the mobility care plan however the restorative nurse was responsible for updating the restorative care plan. RN-A confirmed R42 still had an active restorative care plan indicating an ambulation program in place. During an interview on 4/20/26 at 10:14 a.m., The director of nursing confirmed she would expect any changes related to resident's care be reflected in the care plan. A policy titled Person Centered care Planning revised 4/20/23, indicated the facility will develop a comprehensive person-centered careplan with the resident and/or family representative for each resident consistent with the resident's rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the resident's comprehensive assessment. The policy also indicated careplans are updated on an ongoing basis as need based on changes that occur between care conferences.