STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Homes	305 8th Ave NE Minot, ND 58703

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on review of State Survey Agency reports, record review, review of facility policy, and staff interview, the facility failed to report an incident of serious bodily injury for 1 of 1 sampled resident (Resident #1) who experienced serious injury after a fall from a lift to the State Survey Agency (SSA). Failure to report an event that resulted in serious bodily injury in the prescribed time frame does not comply with regulations established to protect residents. Findings include: Review of the facility policy titled Abuse, Neglect and Exploitation occurred on 07/31/24. This policy, revised August of 2023, stated, . Definitions: . Mistreatment: inappropriate treatment . of a resident . Adverse Event: an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. Serious bodily injury: an injury involving extreme physical pain, . requiring medical intervention such as surgery, hospitalization . All actual or alleged incidents of . Catastrophic events will be reported immediately to the supervisor, charge nurse, department manager, or manager on call. The supervisor notified is responsible to initiate protective approaches . The supervisor will then contact the Director of nursing and/or Director of Social Services to initiate the investigation process. The Director of Nursing and/or Director of Social Services will report . to the Administrator and/or their designee and the State Health Department. All alleged violations involving abuse, neglect . or mistreatment . 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 . Review of Resident #1's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated [DATE], identified the resident had severely impaired cognition. A nurse's note, dated 07/27/24 at 10:09 a.m., stated, GNA [sic] called this nurse and stated in the process of transferring the resident with the hoyer [full body mechanical] lift, the resident fell out of the sling falling onto the floor and hitting her head. This nurse observed resident on her left side lying over one of the legs of the hoyer lift sustaining two lacerations to her face. MD [medical doctor] . made aware and give new order to send resident to the ER [emergency room] . Resident picked up at 2035 [8:35] pm. During an interview on 07/30/24 at 10:30 a.m., an administrative nurse (#1) explained the fall occurred on 07/26/24 at approximately 7:00 p.m. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/30/24 at 11:44 a.m., a social service director (#3) indicated the house supervisor contacted her on 07/27/24 at 1:54 p.m. to ask about reporting the incident. She further stated the house supervisor submitted the initial report to the SSA. The SSA received the initial allegation report on 07/27/24 at 2:10 p.m., approximate 19 hours after the fall resulting in serious injury. The facility staff failed to report the incident of serious bodily injury to the facility administration and SSA within 2 hours.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being for 1 of 1 sampled resident (Resident #1) who had a fall from a mechanical lift with facial laceration. Failure to document the fall assessment timely, ensure post-fall follow up is performed and documented. Failure to perform and document neurological assessments following a fall with facial laceration has the potential to delay identification and treatment of further or worsening signs/symptoms of injury. Findings include: Review of the facility policy titled Injuries, Skin Tears And Falls occurred on 07/31/24. This policy, revised January 2023, stated, . Falls documentation will be completed and vitals will be documented . If the resident sustains a fall, an event will be completed . If there is a head injury . an initial neuro [neurological] check will be completed and further neuro checks will be scheduled. Neuro checks will be completed every 15 minutes x [times] 4, then every two hours x 12, for a total of 24 hours, unless otherwise ordered by provider. Review of the facility policy titled Neurological Assessment (post fall/head injury) occurred on 07/31/24. This policy, revised May 2021, stated, . Documentation of the neurological assessment must be completed under the observation 'Neurological Checks' in the . EHR [electronic health record]. Review of the Facility Reported Incidents Reporting Form occurred on 07/30/24. This form, dated 07/27/24, stated . Date of the allegation (incident) 07/26/24 . Time of the allegation 1900 [7:00 p.m.] . Was the Resident injured? Yes . Injury Type . Severe Injury Need for suture . Briefly describe the alleged incident and/or injury Two CNAs [certified nurse aides] were transferring resident by hoyer [full body mechanical lift] . Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, anxiety, osteoarthritis, and weakness. A quarterly Minimum Data Set (MDS), dated [DATE], indicated severe cognitive impairment. The care plan, reviewed 05/01/24, stated, . requires the use of a mechanical lift hoyer and 2 staff to transfer due to Dementia and degenerative disc disease . At risk for falls . Review of nursing progress notes identified the following: * 07/27/24 at 10:09 a.m., GNA [sic], called this nurse and stated in the process of transferring the resident with the hoyer lift, the resident fell out of the sling falling onto the floor and hitting her head. This nurse observed resident on her left side lying over one of the legs of the hoyer lift sustaining two lacerations to her face. Resident assessed and transfer [sic] to her bed. neuro checks initiated. MD [medical doctor] . made aware and give new order to send resident to the ER [emergency room] for evaluation. Call placed to 911. POA, [Power of Attorney] [name] made aware. Resident picked up at 2035 [8:35] pm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record showed documentation of the fall occurred 15 hours after the fall occurred and lacked a date and time of the incident. * 07/27/24 at 10:41 a.m., Call from ER, resident given 2 Tylenol for pain , CT [computerized tomography] scan to the head, negative, Baseline, no vocal . Resident returned to facility at 0110am [1:10 a.m.]. Skin glue to face laceration. Resident baseline. Documented nine and a half hours after resident returned from ER. Review of the Fall Event form, dated 07/27/24 at 9:29 a.m., showed one neurological check completed, with the resident complaint of headache, but failed to identify the date/time the neurological assessment completed. Resident #1's medical record lacked documentation of vital signs and neurological assessment at the time of the fall, lacked documentation of further neurological assessment post fall and/or orders to discontinue neurological assessments. During an interview on 07/30/24 at 2:45 p.m., an administrative nurse (#1) stated the house supervisor or supervisory nurse is expected to be notified of all falls and ensure all documentation is completed per policy, and he expected staff to document timely, correctly and perform neurological assessments after a fall with head injury for 24 hours unless discontinued by the provider. The administrative nurse (#1) confirmed the medical record lacked documentation of neurological assessments for Resident #1. During an interview on 07/31/24 at 7:00 a.m., a staff nurse (#7) indicated she completed three neurological assessments immediately following Resident #1's fall and one neurological assessment upon Resident #1's return from the ER but failed to document them in the EHR, and confirmed she failed to complete additional neurological assessments per policy.