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	05/20/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of a facility reported incident, policy review, and staff interview, the facility failed to ensure residents remained free from abuse for 2 of 2 sampled residents (Resident #1 and #2) with impaired cognition who displayed sexual behaviors towards each other. Failure to protect residents from sexual abuse may result in fear, anxiety, mental anguish, and physical injury. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident. Findings include: The surveyor determined a deficient practice existed on 05/18/25. The facility implemented corrective action immediately, completed corrective action on 05/19/25, and continues with staff education and monitoring. Review of the facility policy titled Abuse, Neglect and Exploitation occurred on 05/20/25. This policy, revised August 2023, stated, . Sexual abuse is defined as non-consensual sexual contact of any type with a resident. Sexual Abuse-all residents have the right to initiate a relationship with another individual . The determination of capacity to consent to a sexual relationship will be reviewed by a team that will include the provider and social worker at a minimum . If capacity for consent is not evident, the team will update the plan for the resident(s) to prevent any sexual abuse. Review of a facility reported incident, dated 05/18/25, indicated a certified nurse aide (CNA) (#1) entered Resident #2's room and observed Resident #1 laying on Resident #2's bed with her shirt pulled up and Resident #2 touching her breasts. The report stated, . [Resident #2's name] was not hurting her . and she [Resident #1] was not showing any signs up [sic] being upset. It was stopped and both residents were removed from the room. Both have very poor short-term memories and are on the secured unit. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Review of Resident #1's medical record occurred on 05/20/25. Diagnoses included Alzheimer's disease and dementia with agitation. The care plan stated, . Her behaviors can be very unpredictable, and she has a hx [history] of becoming very angry and abusive. She also has a hx of wandering at home and has also been wandering since she was admitted looking for a way out and going into other resident's rooms . Will also remove her clothes and come walking down the hall and an episode of being found in a male resident's room with her shirt pulled up, exposing her breasts. Monitor her when she is ambulating around the unit. Offer female CNA's to intervene as men seem to agitate her worse. Assist her to her room and assist her to put her clothes back on when needed. Monitor her whereabouts and remove her from other residents' rooms. Resident #1's progress notes included the following: * 05/18/25 at 7:45 p.m., Resident was found in another resident's room. She was laying in the bed with her shirt pulled up. She was letting the male resident feel her breasts. She has a history of being combative if it's something she does not want to do. She was redirected out of the room and brought to the dining room. No further contact between the two were made. * 05/19/25 at 11:49 a.m., Social Services visited with [Resident #1's] son [name] this morning about the incident that happened last evening with a male resident on the unit. It appears to be an isolated incident, as it is the first time there have been any kind of relations between the two of them. Staff will be monitoring both residents very close to avoid any future physical interactions between the two of them. - Observation on 05/20/25 at 10:52 a.m. showed Resident #2 asleep on his bed with a stop sign hung across his open door. Review of Resident #2's medical record occurred on 05/20/25. Diagnoses included Alzheimer's disease and dementia. A quarterly MDS, dated [DATE], identified severe cognitive impairment. The care plan stated, . has made inappropriate comments to female staff. Occasional episodes of cursing/screaming at CNA, rejection of cares and false beliefs. Episode of touching a female residents' breasts. Let [Resident #2] know when comments are not appropriate. Leave and return later, try another caregiver. Remove any female residents from [Resident #2]'s room as needed and explain he cannot have any sexual relations with any of the female residents. Review of Resident #2's progress noted included the following: * 05/18/2025, [Recorded as Late Entry on 05/19/2025 10:44 AM] 19:45 [7:45 p.m.] Resident was found in his room. There was a female resident laying on his bed with her shirt pulled up. He was feeling her breasts. He was redirected out of his room. He was brought to the nurses' station. He has not made contact with the other resident again. During an interview on 05/20/25 at 11:05 a.m., a nurse manager (#2) stated Resident #1 will hit and kick if she doesn't want to do something and showed no distress upon discovery with Resident #2. She stated the staff monitored Resident #1 and #2 closely after the incident and observed no signs of distress. The nurse stated neither resident has mentioned this incident since it happened, staff don't believe the residents remember the incident as both have very short-term memories, and there has never been an incident like this before with either of these two residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sexual contact is nonconsensual if a resident appears to want the contact to occur but lacks the cognitive ability to consent. Therefore, the facility failed to ensure Residents #1 and #2, both lacking the cognitive ability to consent, remained free from sexual abuse, defined as non-consensual sexual contact of any type. Based on the following information, non-compliance at F600 is considered past non-compliance. The facility implemented corrective actions to ensure the deficient practice does not recur by: * completed an investigation following the incident * implemented measures immediately after the incident to separate the two residents * required staff to be located in/observing the hallway as much as possible * increased rounding checks on all residents from every hour to every half hour * educated the staff on duty on 05/18/25 and at the start of each shift thereafter, regarding the incident and monitoring the residents' location closely * added WATCH HALLS TO MAKE SURE RESIDENTS ARE NOT WANDERING INTO OTHER RESIDENTS' ROOMS to the CNA care cards * updated the residents' care plans * staff meeting on 05/20/25 to further educate staff regarding vulnerable adults, reporting requirements, monitoring the hallway, and 30-minute rounding on all residents.