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	08/08/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42397 45873 46964 Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 6 of 25 sampled residents (Residents #29, #33, #66, #68, #88, and #317). Failure to review and revise the care plan limited staff's ability to communicate needs and ensure continuity of care. Findings include: Review of facility policy titled Care Planning occurred on 08/08/24. This policy, revised February 2023, stated, . a written plan of care be developed and maintained for each resident in coordination with all services . involved in the care of the resident. Each nursing unit. is responsible for the reviewing and updating of the resident care plans. OBJECTIVES: A. To develop a concise. plan of care for each resident. E. To assure optimum levels of care for each resident are being provided. PROGRESS RECORD-documentation in appropriate area. as condition warrants. A. Each department has the responsibility that. the individual's plan is implemented and maintained. C. The progress and outcome. is recorded on the careplan. If an approach or plan proves unsatisfactory, it is deleted and the problem and new approach are typed in . CARE PLAN REVIEW-Monthly on all nurse units. a. On each shift the CNA's and Nurse review care plans. so that each resident's care plan is reviewed monthly adding or deleting problems, goals, and approaches. - Review of Resident #29's medical record occurred on all days of survey. Diagnoses included lymphedema (swelling caused by fluid), osteomyelitis (inflammation and swelling in the bone). A physician's order, dated 06/19/24, stated, PT [physical therapy] eval [evaluation] and tx [treatment] Lymphedema lower extremities. A physical therapy evaluation, completed on 07/02/24 stated, PT evaluation completed today and [Resident] is willing to try the Ready wraps [compression wrap to control swelling] vs [versus] the ace wraps. The foot portion of the ace wrap is rolling up and causing discomfort and then her foot is swelling. Resident #29's care plan lacked a problem, goals, and interventions to control lymphedema. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/07/24, an administrative staff member (#17) stated the facility typically does not address edema, because orders change so often. - Review of Resident #33's medical record occurred on all days of survey. Diagnoses included dysphagia (difficulty swallowing) following cerebrovascular disease (stroke), gastrostomy (tube feeding). The current care plan stated, [Resident] is at nutritional risk r/t [related to] need for enteral [tube feeding] nutrition due to severe oropharyngeal [middle of the throat] dysphagia and is unable to meet nutritional needs through oral intake. NPO [nothing by mouth] diet. Pleasure feedings of Pureed & Nectar thick liquids by spoon 2 times daily. Afternoon snack of ice cream and nectar thick liquids daily. A nutrition note, dated 06/11/24, stated, Encourage compliance to NPO recommendations due to resident's high risk of aspiration [ingestion of food/liquids into the lungs]. During an interview on 08/08/24 at 9:55 a.m., a staff nurse (#19) stated facility staff supervise Resident #33 at the nurse's station during afternoon snack due to a history of aspiration and failed swallowing exam. Resident #33's care plan lacked the intervention for supervision of oral feedings to avoid aspiration. - Review of Resident #66's medical record occurred on all days of survey. A nurse's note, dated 04/25/24 at 6:41 p.m., stated, Skin assessment done: Wounds noted on abdomen . sutures on right anterior knee . Review of Resident #66's Wound Observation Forms, dated 08/03/24, identified the following: * Surgical incision to abdomen measuring 13 cm (centimeters) x (by) 7 cm. * Surgical incision to right knee measuring 2 cm x 5 cm. The current care plan failed to address the surgical incisions. - Review of Resident #68's medical record occurred on all days of survey. A podiatry consult note, dated 07/16/24, stated, . There is an ulceration on the posterior left heel, which is a stage III decubitus ulceration of the left heel measuring 1.3 cm in diameter, 2 mm [millimeter] in depth . Review of Resident #68's Wound Observation Forms, dated 08/04/24, identified a left heel ulcer measured at 1 cm x 1 cm. The current care plan failed to address Resident #68's left heel pressure ulcer. - Observations of Resident #88 on 08/05/24 at 3:28 p.m. and 08/06/24 at 9:31 a.m. showed Resident #88 ambulated with a four wheeled walker and an Unna boot (zinc impregnated compression wrap) to right lower extremity and a Coflex (a flexible bandage) wrap to the left lower extremity. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #88's medical record occurred on all days of survey. The current care plan stated, . [Resident] has chronic edema in. lower extremities. calf ready wrap compression garments on LE's [lower extremities]. [Resident] is at risk [for] alterations in her skin R/T fragile skin and venous statis [sic] dermatitis to bilateral lower extremities. A physician's order, dated 07/31/24, stated, Start Unna Boot to Rt leg, Coflex wrap (two layers) to L [left] leg Once A Day on Sun, Wed, Fri [Sundays, Wednesdays, and Fridays]. The current care plan failed to address the Unna boot to the right extremity and the Coflex wrap to the left extremity. - Review of Resident #317's medical record occurred on all days of survey. Diagnoses included heart failure, and chronic kidney disease. Physician's orders included Furosemide (a medication to treat fluid retention). A hospital discharge note, dated 07/29/24, identified discharge diagnoses of acute kidney injury) and chronic kidney disease secondary to dehydration. Resident #317's current care plan lacked interventions for use of a diuretic and interventions to prevent dehydration.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 31725 Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide care in accordance with professional standards for 2 of 2 sampled residents (Resident #29 and #41). Failure to obtain physician's orders and notify the physician of refusal of treatments may result in adverse health effects. Findings include: Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, Nurses are expected to analyze procedures . ordered by the physician or primary care provider. If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. Findings include: Observation on 08/06/24 at 10:00 a.m., showed a nurse (#18) applied Ready wraps (compression wrap to control swelling) to Resident #29's legs. The resident refused to wear the sock liners under the ready wraps. A physical therapy (PT) note, dated, 7/15/2024 stated, . [Resident] is agreeable to try the thin sock liners under the Ready wraps. Therapist explained that her skin is too fragile to wear the Ready wraps without the liners and it could cause skin tears. Review of Resident #29's medical record showed the record lacked a physician's order for Ready wraps and notification to the provider of the resident's refusal to wear the protective liners. During an interview on 08/07/24 at 11:45 a.m., a PT staff member (#26) stated they expected Resident #29 to wear the liners under the ready wraps to protect the resident's skin and to be notified by nursing staff if the resident refuses. During an interview on 08/07/24 at 2:10 p.m., an administrative staff member (#10) confirmed she expected a recommendation from PT be sent to the physician for an order and the physician or therapy be notified if the resident refuses treatment, or part of the treatment. - Review of Resident #41's medical record occurred on all days of survey. Physician's orders included, Monitor lower (R) [right] leg hematoma - Measure Q [every] shift until resolved. Observation on the afternoon of 08/06/24 showed Resident #41 in a wheelchair with a dressing to her right lower leg. Observation of a dressing change occurred on 08/07/24 at 11:10 a.m. A nurse (#23) removed a dressing from Resident #41's right lower leg and applied a non-adhesive dressing and a protective wrap to the lower leg. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/24 at 3:04 p.m., an administrative nurse (#2) stated the facility failed to get an order for Resident #41's dressing change to the right leg. 45873

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide appropriate treatment and services to prevent the development of a pressure ulcer for 1 of 5 sampled residents (Resident #68) with pressure ulcers. Failure to implement interventions as ordered, and ensure adequate monitoring/assessment resulted in an avoidable facility acquired pressure ulcer. Findings include: Review of the facility policy titled Skin Management -[NAME] Homes occurred on 08/08/24. This policy revised, December 2022, stated, . Nursing will follow the skin care procedures outlined below to . 2. Maintain the integrity of the resident's skin through monitoring and timely interventional skin care management . 8. Braden Scale will be repeated upon resident changes in condition . The resident's care plan will be updated by the nurse to include goals for prevention and management of pressure injuries with appropriate interventions. The care plan will be reviewed . at change of condition . Appropriate pressure reduction/relief devices: 1. Turn and positioning system 2. Heel protectors, therapeutic boots, or items ordered by provider . Floor nurse will observe wound daily . If dressing is soiled or not intact at any point . the dressing will be replaced . Review of Resident #68's medical record occurred on all days of survey. Diagnoses included end stage renal disease, diabetes mellitus, peripheral vascular disease, a Stage 2 pressure ulcer on the left heel. An admission Minimum Data Set (MDS), dated [DATE], identified moderate to maximum assistance with activities of daily living, dependent for transfers, a Stage 1 pressure ulcer. The current care plan stated, . is at risk for skin break down and for developing a pressure ulcer due to impaired mobility, diabetes, ESRD [end stage renal disease], CHF [congestive heart failure] . will have intact skin, free of redness, blisters, or discoloration . Pressure Ulcer Care/Prevention: Pressure relieving mattress & [and] pressure relieving wheelchair cushion. Notify nurse of new or changes in skin breakdown, redness, blisters, bruises, discoloration. Turn and reposition every 2 to 4 hours and prn [as needed]. Float heels off mattress. refuses to wear prevalon boots [pressure reducing boots] . The care plan failed to include the left heel pressure ulcer. Review of nurse's notes identified the following: * 04/23/24 at 11:20 p.m., . Dressing changed on her toes on both feet, noticed a foul smell with greenish discharge on the old dressing, complained too that her left heel is sore, on assessment they are red, intact, blanchable, applied calmoseptine [skin protectant]. Updated [provider name] by fax about the wound and the left heel. * 05/30/24 at 9:58 a.m., Resident stated to PT [physical therapist], the CNA [certified nurse aide] says 'my left heel is black'. PT removed ace wrap and found that resident has what appears to be a deep tissue injury on the left heel. PT encouraged resident to wear prevalon boots day and night. Resident . she is not doing any standing or walking, and prevalon boots would be better. PT informed nurse of this . PT also suggested perhaps a mepilex [protective dressing] over the left heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	* 07/18/24 at 2:47 p.m., . she is to be NWB [non-weight bearing] on her L [left] foot for fear of wound and bone damage. [Resident] will be a hoyer [full-body mechanical] lift for transfers until her next follow up. Review of podiatry progress notes/consultation form identified the following: * 06/14/24 . This patient is high risk for other potential complications and infections. She needs to continue with offloading to protect her heels from decubitus (injury to skin and underlying tissue resulting from prolonged pressure on the skin) ulcerations. * 07/16/24 . She has decubitus ulceration on the left heel . She apparently is not doing [sic] enough pressure off her left foot . she will need to be protected at the nursing home otherwise she will lose her legs. * 07/16/24 podiatry consult form, . new decub (decubitus) stage 3 . KEEP on Prevalon boots BIL (bilateral) . Review of wound management documentation/Braden Skin Risk Assessments (scale to determine pressure ulcer risk)/Focused Skin Observations identified the following: * 05/05/24 . Focused observation skin - left heel red and sore . * 05/09/24 . Focused observation skin - left heel, red, sore . * 06/07/24 . Braden Skin Risk Score 15 at risk [of developing pressure ulcers]. * 07/16/24 . Wound Location Left heel . Length . 1.3 cm [centimeter] Width . 1.3 cm . * 07/29/24 . Wound Location Left heel . Length . 1 cm Width . 1 cm . * 08/04/24 . Wound Location Left heel . Length . 1 cm Width . 1 cm . Exudate Amount . light . Exudate color and consistency . serosanguinous (pale red to pink, thin and watery [drainage]) . A physician's order dated 07/16/24, stated, Prevalon Boots to bilateral feet @ [at] all times. Daily Betadine [skin disinfectant] and bandages to all wounds. Observations of Resident #68 showed the following: * 08/05/24 at 2:49 p.m., Seated in a recliner in her room with the foot rest elevated and wearing ankle socks, and the Prevalon boots in a chair across the room. * 08/06/24 at 7:56 a.m., Out of facility for dialysis, and the Prevalon boots in a chair in her room. * 08/06/24 at 2:00 p.m. and 4:47 p.m., Seated in a wheelchair in her room, feet on the foot pedals, ankle socks on, and not wearing Prevalon boots. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	* 08/07/24 at 7:53 a.m., Laying in bed, feet directly on the mattress, and the Prevalon boots in a chair across the room. The resident stated she wore Prevalon boots during the night but takes them off when she wakes up because I just can't function with them. * 08/07/24 at 8:11 a.m., Two certified nurse aides (CNAs) (#25 and #28) transferred the resident from bed to the wheelchair with a full-body mechanical lift. The resident wore no socks or shoes, no dressing to the left heel. The CNAs failed to apply the Prevalon boots to the resident's feet. The resident's bare feet with open wound to the left heel rested directly on the carpeted floor. The CNA (#25) stated the resident doesn't wear the Prevalon boots during the day. The CNA (#25) spoke to the nurse but failed to inform her of the absence of Resident #68's dressing to her left heel. * 08/07/24 at 11:11 a.m. and 2:22 p.m., Seated in the wheelchair in her room with her bare feet directly on the carpeted floor. * 08/07/24 at 2:22 p.m., The nurse (#24) applied a dressing to the ulcer but failed to apply Prevalon boots. During an interview on 08/07/24 at 1:54 p.m., an administrative nurse (#1) stated Resident #68 intermittently refused to wear the Prevalon boots, confirmed he expected staff to document patient refusals of care or treatments, to follow infection control measures during wound care, and to cover open wounds. The facility failed to follow through after the development of a pressure injury to Resident #68's left heel. The facility lacked regular assessments of the size and condition of the wound including care planning interventions to aid in healing. observation showed staff failed to implement the use of preventative devices and document the resident's refusal. Due to the resident's risk factors which can cause a delay in healing and this resident to develop a pressure injury and may cause future complications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 1. Based on observation, record review, review of facility investigation, and resident and staff interview the facility failed to provide adequate supervision to prevent accidents for 1 of 1 sampled resident (Resident #61) who required surgical intervention for an injury. Failure to provide adequate supervision during a transfer from the shower resulted in Resident #61 experiencing severe pain, a hematoma (collection of blood in a tissue) which required three hospitalization s and surgical intervention, cellulitis (infection of the skin), and increased anxiety and depression. Findings include: Review of the facility reported incident form occurred on 08/05/24. The form, dated 07/25/24, stated, . On 07/16/24 at 5:00 p.m. after [Resident #61's] shower was complete, [certified nurse aide name] [CNA] (#27) went to pull her out in the shower chair and [Resident #61's] left leg hit the shower wall . [Resident #61] immediately complained of pain to the area . Review of Resident #61's medical record occurred on all days of survey. Diagnoses include atrial fibrillation, anemia, long term use of anticoagulants, cellulitis of left lower limb, and contusion of left lower leg. A quarterly Minimum Data Set (MDS), dated [DATE], identified intact cognition, and dependent on staff for shower transfers. Observation on 08/05/24 at 11:33 a.m. showed Resident #61 resting in bed with a wound VAC (vacuum-assisted closure device) to her lower left leg. During an interview at this time, the resident indicated the wound vac is for the injury that occurred when the CNA transferred her from the shower room and hit her leg on the wall. The resident stated her leg immediately started hurting after it hit the wall, the pain continued to get worse. The resident indicated during the week between the injury and her final hospitalization her leg worsened, and it was horrendously painful. She stated she went to the hospital three times, underwent surgery to debride [remove damaged tissue] my leg, and resulted in the need for a the wound vac. She indicated being frustrated with the incident and results because she was progressing in her therapy prior to the injury and now is unable to stand. She stated her blood thinners had been stopped and now every time I feel a flutter or twinge in my, chest I worry about a heart attack or a stroke. Review of nurse's notes identified the following: * 07/16/24 at 5:00 p.m., . The attention of this nurse was called because according to her the resident is in severe pain due to a bump on her lateral lower leg, on assessment noticed a hematoma measuring about 4cm [centimeter] x [by] 4 cm in diameter. Asked what happened and she and the CNA relayed that she bumped her leg on the wall when they were wheeling her out of the shower room. Applied ice, elevated her leg, and gave PRN [as needed] Tyl;enol [sic] [pain relieving medication] 1000 mg [milligram]. After supper around 1800 [6:00 p.m.], she was crying and said she's still in a lot of pain, her hematoma became bigger with the surrounding area red. Paged [provider name] the on call and gave an order to sent [sic] her to the ER [emergency room]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	* 07/17/24 at 3:13 a.m., Received resident from EMT [emergency medical technician]; Alert and oriented complaining of Left leg pain; with new Doctor's order for pain. Left leg with ace wrap and swollen with hematoma noted. * 07/17/24 at 3:53 p.m., Resident complained of having pain on the left leg with ace wrap and swollen with hematoma, PRN tab Tramadol [narcotic pain medication] 50mg was given with good effect . * 07/18/24 at 11:34 a.m., I visited with [Resident #61] about the hematoma to her left lower leg. She explained to me that when she was in the shower chair on 7-16-24 the CNA pulled her sideways and her left lower leg hit the corner of the shower wall. [Resident #61] is not able to bend her legs completely. * 07/20/24 at 2:15 p.m., Resident insisted she go to the emergency room today for her left lower leg hematoma. She states was previously at the ER, however, states her condition has changed and hasn't been assessed. I did inform her I spoke with the on-call provider who declined to send the patient to the emergency and recommended that the patient take her pain medication. * 07/20/24 at 10:23 p.m., The NP [nurse practitioner] went to see the resident and measured the swollen left leg with hematoma and still intact at 10X12 cm; ordered to send the resident to E.R. for treatment and further evaluation. After 10 mins [minutes] resident was calling and that she is scarred [sic] that her left left [sic] is draining fluids and dried blood. Resident was sent to E.R. immediately. * 07/24/24 at 3:00 p.m., Resident was brought back to the facility by the ambulance, alert, oriented, responsive, and not in pain. Left leg still swollen and with purplish discoloration, wound kept open and with ace wrap from left ankle to left foot. * 07/26/24 at 1:53 p.m.,. OT [occupational therapist] expressed concern for hematoma to L [left] lower leg is now open and draining . After observing hematoma . contacted NP . * 07/26/24 at 3:19 p.m., . Pt [physical therapist] notified this nurse of open area to posterior Lt [left]leg, stated large amount eschar [dead tissue] to area, looked at wound, hematoma open with a large amount coagulated [clotted] dark blood escaping, call to NP [name], stated she would stop and look at area and speak with resident, remains on antibiotic without adverse reaction. * 07/26/24 at 8:08 p.m., NP [name] came to review the resident and ordered that Resident should be sent to ER for Evaluation of worsening left lower extremity hematoma with necrotic tissue. Resident was taken to ER by EMT at 7pm. * 07/31/24 at 3:30 p.m., Resident was brought back to this facility by ambulance . wound back [sic] intact draining bloody discharge . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*08/06/24 at 11:51 p.m., Writer visited with resident on Monday afternoon. She is worried about her bill . She owns a home and wants to be able to return to it. We had a good discussion about how she is holding up mentally. She was hoping to be home by now and now feels like she is starting over. [Resident #61] verbalized being depressed and having a lot on her mind that makes it hard to sleep, she stopped her blood thinner so now whenever she feels something strange, she worries it may be a stroke or heart attack. [Resident #61] said she does not want to die and has no plans to harm herself but feels like she is going to die in here. I asked [Resident #61] if she is interested in speaking to someone and she is, she has an order for a psych consult and is on the list to see the psychiatrist. Review of provider notes identified the following: * 07/16/24 at 9:09 p.m., . presents because of pain and swelling of her left lower leg. She was being brought out of the shower room in a wheelchair when the aide ran her leg into the door frame. She had immediate pain and it began swelling right away . There is a raised 7 x 6 cm x 2 cm raised ecchymotic [bruised] soft/fluctuant [unstable] area on the . left lower leg. she states that after the third dose of morphine [narcotic pain medication] she has finally get [sic] pain relief . * 07/20/24 at 5:00 p.m., . being seen today for evaluation of worsening swelling and pain to left lower extremity. Skin: Measured 12 cm x 10 cm . Surrounding skin appears to have swelling, mild erythema [redness], warmth, and tenderness. Assessment and plan 1. Worsening pain and swelling to LLE [left lower extremity] due to recent trauma. Large intact fluid filled blister with hematoma noted. There is concern for cellulitis - send to ER for evaluation and treatment. * 07/24/24 at 12:00 a.m., . HPI [history of present illness] presented back to the emergency room . with worsening pain swelling and acute drainage from the hematoma. In the emergency room she had a CT scan [computerized tomography] which showed enlarging hematoma measuring 16 cm x 25 cm x 4.7 cm. * 07/26/24 at 5:23 p.m., . evaluated at bedside today for concerns by nursing staff today for worsening left lower extremity hematoma and cellulitis. She was recently sent to the ER and admitted from 7/20/2024 to 7/24/2024 for acute traumatic enlarging left lower extremity hematoma, left lower extremity cellulitis, and acute blood loss anemia [not enough healthy red blood cells to carry oxygen]. She was treated with antibiotics and given blood transfusions. SKIN: large area of necrotic tissue to posterior [back] left lower extremity with large open area and covered with clotted blood. Hematoma measures 25.5 cm x 25 cm. Assessment and plan Hematoma with necrotic skin tissue - There is a concern for developing large necrotic tissue, and worsening cellulitis send to ER for evaluation and treatment. * 07/31/24 at 11:00 a.m., . presented to . hospital 07/26/24 due to large left lower extremity hematoma. Underwent debridement of wound, lower lateral left hematoma 20 cm x 20 cm on 07/28/24 . Wound vac to LLE . wound bed measures approximately 19 cm x 20 cm x 0.3 cm . positive cultures obtained in OR [operating room]. Placed on oral abx [antibiotics] . Review of the facility investigation contained a written statement from the CNA (#27), dated 07/22/24, and stated I, [CNA #27] was giving [Resident #61] a shower on 7/16/24. When we was [sic] finished I had pushed her sideways out the shower door due to her showering in a bari [bariatric] chair, which was a small area, and opening the door at the same time. As I was pushing her out the shower door I didn't realize she had put her leg out & her leg hit the corner of the wall. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility failed to ensure the CNA (#27) provided a safe transfer for Resident #61 from the shower room which resulted in an injury to the resident's lower leg and lead to a hematoma, increased pain, three hospitalization s, surgical debridement, and placement of a wound vac. 28398 2. Based on observation, record review, review of facility policy, review of manufacturer's instructions, and staff interview, the facility failed to ensure residents received adequate supervision/assistance to prevent accidents for 2 of 3 sampled residents (Resident #4) observed during a sit-to-stand lift transfer and (Resident #36) observed with bruises. Failure to use a mechanical lift properly and/or re-evaluate the suitability of a mechanical lift transfer, and monitor/ensure safe transfer methods placed Residents #4 and #36 at risk for injury. Findings include: Review of the EZ Way Smart Stand [type of sit-to-stand mechanical lift] 400, 500 & 800 lb [pound] Capacities Operator's Instructions, revised 09/29/23, pages 2-6, stated, . As patients do vary in size, shape, weight and temperament, these conditions must be taken in to [sic] consideration when deciding if the EZ Way Smart Stand is suitable for their needs. Patients should be able to bear some weight, have upper body strength and be able to follow simple commands. Attach harness 1) Position the harness around the upper body of the patient so the sides of the harness are between the patient's torso and arm, resting 2-3 inches below the underarm. 2) For the safety of the patient, securely fasten the safety strap around the patient's torso. 3) Secure the buckle and pull the strap to tighten. Raise the patient . As the patient is being raised, simultaneously tighten the safety strap buckled around their torso. Stop lifting when the patient is in a standing position. Review of the facility policy titled Transporting Resident For Care Outside The Facility occurred on 08/08/24. This policy, revised February 2023, stated . If there is no family available for transport [NAME] Home will provide a transporter [employee that accompanies residents]. Arrangements can be made with [name of transport company for transportation by bus or van with wheelchair lift. If [transport company] is not available, contact Plan Operations and complete a work order . Notify nursing staff on the Unit of transport. Documentation in Nurses' Notes includes the date, time, who is accompanying the resident, the time of their return and any changes noted upon return. The facility failed to provide a policy for transportation via ambulance van. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, muscle weakness, and repeated falls. The quarterly Minimum Data Set (MDS), dated [DATE], identified moderate cognitive impairment, verbal and other behaviors, functional limitation in range of motion to bilateral lower extremities, dependent with chair-to-bed-to-chair transfers and toilet transfers. The care plan, revised 11/17/23, stated, . Toileting: . Staff assist of 2 and PAL [Portable Aquatic Lift - type of sit-to-stand mechanical lift] to transfer to toilet. Transferring: Assist of 2 and PAL . Resident #4's nurses' notes stated the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	* 01/19/24 at 1:24 p.m., [Resident #4] seen 1/18/24 for re-evaluation for RNP [restorative nursing program]. [Resident #4] requires training with standing and transfers. She is transferring with PAL and 2 staff. Upper body exercises continue as tolerated as well as XBOX [type of workout game]. * 02/26/24 at 1:21 p.m., [Resident #4] was discontinued from the RNP. She will continue to transfer via PAL and 2 staff. Observation on 08/05/24 at 4:56 p.m. showed two certified nurse aides (CNAs) (#6 and #7) transferred Resident #4 with an EZ Way sit-to-stand mechanical lift from the bed to her wheelchair, to the bathroom toilet, and back to her wheelchair. The resident yelled loudly as the CNAs assisted her to sit at the edge of the bed, then placed the lift harness, safety strap, and shin strap, and instructed the resident to hold the handles. As the CNAs (#6 and #7) lifted Resident #4 to a semi-standing position, she yelled loudly as the safety strap slid up her torso, and the CNAs lowered her back to the bed to adjust the safety strap. As the CNAs raised Resident #4 from the bed and encouraged her to stand up straight, her right arm/elbow rose to a nearly horizontal position. The resident whined, moaned, and/or yelled throughout the transfer to the toilet and again while the CNAs raised her from the toilet, provided perineal cares, and changed her brief. Resident #4's right shoulder, upper arm, and elbow rose above a horizontal position and the left arm/elbow nearly to a horizontal position as the CNAs transferred her from the bathroom to her wheelchair. The CNAs (#6 and #7) instructed the resident throughout the transfer to stand up straight as she sagged against the harness and safety strap, with the harness pushing up into her axilla. One CNA (#7) stated Resident #4 is declining with how she stands in the stand lift. Observation on 08/06/24 at 09:08 a.m. showed two CNAs (#8 and #9) transferred Resident #4 from her wheelchair to the bathroom toilet, back to her wheelchair and then to bed. The CNAs placed the EZ Way harness, safety strap (loosely around her torso), and shin strap, then cued the resident to hold the lift handles and stand up straight as she sagged against the harness which pulled up on her axilla. As the CNAs (#8 and #9) raised Resident #4 with the lift, her right arm/elbow moved up and away from her body in a horizontal position, throughout the transfer. Observation on 08/07/24 at 4:41 p.m. showed two CNAs (#6 and #7) applied the EZ Way stand harness, safety strap, and shin strap, while the resident frequently hollered oh boy, ouwwhh. The CNAs cued Resident #4 to hold the lift handles and placed her feet on the foot plate. A CNA (#6) tightened the safety strap as they raised the resident up, and the resident hollered [Explicit word], ouwwhh, do you have to have that so damn tight? Resident #4 failed to bear weight as the CNAs transferred her into the bathroom. During the transfer, the resident's right arm/elbow rose to a horizontal position and her left arm/elbow close to a horizontal position. As the CNAs (#6 and #7) lowered Resident #4 on the toilet, she hollered loudly ouch, that hurts indicating her breast. A CNA (#6) removed the safety strap which had pulled up under her breast. Upon standing the resident from the toilet to provide perineal cares, the CNAs attached the safety strap loosely with the resident's right upper arm/elbow in a horizontal position and the left arm/elbow nearly horizontal. The CNAs failed to tighten the safety strap during the transfer. The CNAs watched the resident's elbows which stuck out and upward, as they exited the bathroom to prevent the resident's elbows from hitting the door frame. When asked about elbow position during transfers, the CNA (#6) stated, I would want my arms down at my sides. A CNA (#7) stated she believed the resident used the stand lift about six months and doesn't feel like she bears her weight in the lift. When asked, a CNA (#6) stated staff should tell the nurse if concerns noted with a transfer, and the nurse would have physical therapy evaluate the use of the lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/08/24 at 12:01 p.m., a staff nurse (#20) agreed a resident's arms should not be in a horizontal position during a sit-to-stand mechanical lift transfer. Staff failed to provide safe transfers with the mechanical sit-to-stand lift. The facility failed to monitor Resident #4's upper/lower body strength and appropriate use of the stand lift and failed to periodically monitor and re-evaluate the suitability of the stand lift to meet Resident #4's needs and ensure safe transfers. 45873 - Review of Resident #36's medical record occurred on all days of survey. Diagnoses included muscle weakness and difficulty walking. The current care plan stated, . [Resident] is not able to do his own ADL's or activities of daily living due to weakness . Power wheelchair for locomotion. [Resident] is at risk for bleeding and bruising related to blood thinner medication. [Resident] is at risk for falls due to weakness. Edited: 08/05/2024 When going out for an appointment, communicate with transport to only use lift system and not ramp when getting in/out the van. During an interview on 08/05/24 at 12:46 p.m., when asked about the large bruises on right arm, Resident #36 stated, I was coming back from a doctor's appointment and the transportation van had a ramp instead of a lift. The ramp was too steep, and my power wheelchair doesn't have brakes. I started going down too fast, and I tipped over and fell out. The resident indicated bruises on his legs and knees. Review of Resident #36's progress notes showed the following: *07/29/24 at 1:55 p.m. Resident states he was coming down the ramp in his electric scooter, off of the bus after returning from his appointment. Resident states the entire wheelchair tipped over and fell off the ramp. Resident states he hit his head, his right elbow, has a small abrasion, and his right outer calf has a large hematoma. Provider and care giver were notified. *07/29/24 at 11:29 p.m. Resident has bruise on the right elbow due to fall. No new bruise observed, no complain of pain, alert and oriented. *07/30/24 at 8:11 a.m. [Resident] requested PRN [as needed] Tylenol last night for c/o [complaints of] being sore and his right hamstring and leg were hurting him from the fall. He also requested some ice to put on his hamstring. He showed staff all his bruises on his right elbow and sore areas. He slept all night and this morning after 0630 [6:30 a.m.] he said that he was 'very sore' this morning and he was slower because of it. He told staff all about what happened and about using a ramp to get off the bus and how he had no brakes with his electric wheelchair and everything that happened after that. *7/30/24 at 9:36 a.m. Resident alert, no changes noted in mentation. Hematoma [swollen bruise] to R [right] leg appears stable, but tender to the touch. Bruising to R arm also stable. All skin areas are intact. *07/31/24 at 11:58 p.m. Continues on fall monitoring r/t [related to] recent fall with multicolored bruising to right upper arm / elbow and right outer shin. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*08/05/24 at 8:14 a.m. Falls committee meeting on 7/30/24. Recommendation: communicate with transport to only use lift system and not ramp when getting in/out [sic] the van. Care plan has been reviewed. No other concerns/issues raised. During an interview on 08/07/24 at 10:00 a.m., two administrative staff mambers (#1 and #11) confirmed Resident #36 fell out of his wheelchair when exiting a transport van, the transport company completed an incident report, and the facility did not complete an incident report or investigation. The facility failed to evaluate the transfer requirements and safety needs of Resident #36 during van transportation.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 45873 Based on observation, record review, review of professional reference, and staff interview, the facility failed to restore, if possible, oral eating skills for 1 of 1 sampled resident (Resident #33) with a gastrostomy tube (tube inserted into the stomach for feeding) and orders for oral intake. Failure to clarify orders and evaluate oral intake may have the potential to result in adverse events, such as aspiration pneumonia. Findings include: Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 1185, stated, The four levels of semi-solid or solid foods are pureed, mechanically altered, mechanically soft, and regular. In consultation with the dietitian, occupational therapist, swallowing specialist, speech-language pathologist, and primary care provider, these levels can be used to determine a consistent approach to a particular client's dysphagia. Review of Resident #33's medical record occurred on all days of survey and showed diagnoses of dysphagia (difficulty swallowing) following other cerebrovascular disease (stroke), and gastrostomy status. The current care plan identified the following: . [Resident] presents with severe oropharyngeal [middle part of the throat] dysphagia secondary to multiple medical complexities. [Resident] can have ice cream 2x [two times] per day up in his wheelchair if he would like it. [Resident] is at nutritional risk r/t [related to] need for enteral [tube feeding] nutrition due to severe oropharyngeal dysphagia and is unable to meet nutritional needs through oral intake. NPO [nothing by mouth] diet. Pleasure feedings of Pureed & [and] Nectar thick liquids by spoon 2 times daily. Afternoon snack of ice cream and nectar thick liquids daily. A physician's orders dated 06/10/22 identified Diet: Regular, pureed Special Instructions: pleasure meal 2x/day [two times per day] consisting of pureed item & 1 glass of nectar thickened liquids [NTL] (lunch) by spoon and 09/21/22, Order NPO [nothing by mouth], Mildly Thick (Nectar), Pureed. Special Instructions: afternoon snack of ice cream & nectar thick liquids no meals at this time. Pleasure feedings 2x/day of pureed and nectar thick by spoon. A physician's note, dated 05/28/24, stated, . Today [Resident] is seen lying in his room and states he has been well. He continues to eat snacks orally in bed. ASSESSMENT AND PLAN: Protein calorie malnutrition, improving, continues on tube feedings, discussed avoiding feeds by mouth to prevent aspiration. A Nutrition Support Assessment, completed by a licensed registered dietitian on 06/11/24, identified the following: *Diet Order - Include supplements and snacks *NPO, pleasure feeds of pureed solids and nectar thick liquids by spoon twice daily *Resident is NPO and receives 100% of his nutritional needs via enteral feeding (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*[Resident] will take pleasure feedings twice daily of pureed solids and nectar thick liquids by spoon. *Nutritional Intervention-Continue with current tube feeding regimen. *Encourage compliance to NPO recommendations due to resident's high risk of aspiration. A Speech Therapy (ST) Treatment and Evaluation note dated, 06/15/22, stated, . Treatment diagnosis: Pneumonitis due to inhalation of food and vomit (03/08/2022) . ST Patient Discharge Instructions: Discharge planned for this patient. Recommendations discussed with patient and caregivers include recommendations for consumption of items for pleasure x2- ice cream and NTL by spoon. The record lacked an updated speech therapy evaluation since 06/15/22. During an interview on 08/08/24 at 9:55 a.m., a staff nurse (#19) verified staff supervised Resident #33 at the nurse's station during afternoon snack due to a history of aspiration and failed swallowing exam. The facility failed to clarify conflicting oral intake orders and obtain a speech therapy/swallowing evaluation for two years.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45873 Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure appropriate infection control practices for 1 of 1 resident (Resident #54) receiving oxygen via a tracheostomy. Failure to maintain cleanliness of respiratory supplies by ensuring appropriate storage could result in adverse effects for the resident. Finding include: Review of professional reference Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 1294-1295, stated, Administering Oxygen by Cannula, Face Mask, or Face Tent .Perform hand hygiene and observe other appropriate infection prevention procedures. Review of professional reference [NAME], [NAME], M.B.B.S, MD. Risks and Complications of Tracheostomy. The John Hopkins University 2024. https://www.hopkinsmedicine. org/health/treatment-tests-and-therapies/tracheostomy. Accessed 13 August 2024, stated Risks and Complications of Tracheostomy . A clean tracheostomy site, good tracheostomy tube care . should minimize the chances of complications. Review of Resident #54's medical record occurred on all days of survey and showed diagnoses of paralysis of vocal cords and larynx (voice box), acute respiratory failure with hypoxia (lack of oxygen), and tracheostomy (artificial opening into the windpipe) status. Physician's orders included oxygen at 4L (liters) through trach shield with humidification. The current care plan stated [Resident] has a tracheostomy that could cause further infectious problems. Contact precautions. Use good hand washing, gown and glove while providing cares in residents room .[Resident] requires oxygen therapy R/T [related to] trach placement and chronic respiratory failure. oxygen per trach collar mask . - Observation on 08/06/24 at 1:25 p.m. showed Resident #54's oxygen humidifier connected to the concentrator, resting on the floor along with the tracheostomy collar mask oxygen tubing. The certified nurse aide (CNA) (#8) took the oxygen tubing off the floor and connected it to the resident's tracheostomy collar mask. When asked if the oxygen tubing was on the floor, the CNA (#8) stated, Yes. We've tried to put it in different places, hanging it on the bed rail or bedside table but it would never stay and always fell down. During an interview on 08/08/24 at 12:15 p.m. an administrative member (#1) confirmed he expected oxygen supplies in the resident's room to be stored in a bag and off the floor. The facility failed to follow appropriate infection control practices for administration of oxygen via a tracheostomy.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42397 Based on record review and staff interview, the facility failed to ensure the resident's medication regimen remained free of unnecessary medications for 3 of 5 sampled residents (Resident #21, #66, and #68) reviewed for antipsychotic medications. Failure to establish a baseline by assessing for abnormal involuntary movements before starting an antipsychotic and to monitor periodically while on the medication may result in the resident experiencing adverse consequences related to the antipsychotic medication. Findings include: - Review of Resident #21's medical record occurred on August 5-7, 2024. Physician's orders included risperidone (antipsychotic medication) daily, initiated in August 2023. The medical record identified an Abnormal Involuntary Movement Scale (AIMS) assessment completed on 12/13/23. After a request for documentation of further assessments, an administrative nurse (#1) stated on the morning of 08/07/24 the unit manager completed an AIMS on 08/06/24 per the nurse's (#1) request. Resident #21's record lacked an AIMS assessment every six months. - Review of Resident #66's medical record occurred on all days of survey. The physician's orders identified the resident received olanzapine (antipsychotic medication), initiated on 06/04/24. Resident #66's record identified an AIMS assessment completed 08/07/24, approximately two months after the start of the medication. - Review of Resident #68's medical record occurred on all days of survey. The physician's orders identified the resident received chlorpromazine (antipsychotic medication) three times daily, initiated on 05/07/24. The record lacked an AIMS assessment completed at the start of the medication. During an interview on 08/07/24 at 1:46 p.m., an administrative nurse (#1) stated, We have no policy for AIMS assessments. The nurse (#1) stated he expected staff to complete a baseline AIMS when a resident started on an antipsychotic medication and then every six months.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45873 Based on observation and staff interview, the facility failed to store food in a sanitary manner in 1 of 1 main kitchen. Failure to maintain freezing systems has the potential to affect food quality/preparation and may result in the spread of foodborne illness to residents, staff, and visitors. Findings include: Observation of the main kitchen on 08/05/24 at 11:20 a.m. with a nutrition assistant (#13) and showed the following: Walk in freezer: *Noted frost build up on shelves and packages. Three fans covered with frost. One fan with a drip tray beneath it and the presence of icicles. Two separate fans showed icicles with no drip tray beneath it and ice/frost build up on three unopened boxes of crinkle cut carrots directly below the fans. Per the dietary assistant, she thought parts were ordered for a needed repair. During an interview and observation of the main kitchen on 08/07/24 at 9:05 a.m., with an administrative dietary staff member (#12), the walk-in freezer continued to have frost buildup and no drip trays under the second and third fans. The dietary staff member (#12) confirmed a part for the condenser is still needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 31725 Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 6 of 25 sampled residents (Resident #11, #41 #68, #69, #80, and #317) and one supplemental resident (Resident #60) observed during cares and one supplemental resident (Resident #43) with a foley catheter. Failure to practice infection control standards related to use of enhanced barrier precautions (EBP), personal protective equipment (PPE), and hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Handwashing/Hand Hygiene occurred on 08/07/24. This policy dated May 2022, stated, . When is Hand Hygiene (Alcohol Hand Sanitizer) necessary? . Immediately after glove removal . Review of the facility policy titled Enhanced Barrier Precautions occurred on 08/07/24. This undated policy stated, . Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities . those that have indwelling devices such as; foley catheter, feeding tube, central line, tracheotomy or open wound that requires a dressing. - Observation on 08/05/24 at 2:47 p.m. showed two certified nurse aides (CNAs) (#21 and #22) transferred Resident #60 to the toilet. A CNA (#22) completed perineal cares after a bowel movement. The CNA removed her gloves and, without performing hand hygiene, applied clean gloves, applied the resident's brief, pulled up her pants and transferred the resident to her chair with a stand lift. The CNA (#22) put the lift sling away, moved the resident's overbed table, and positioned the resident's call light. The CNA (#22) failed to perform hand hygiene after removing soiled gloves and before applying clean gloves. - Review of Resident #80's medical record occurred on all days of survey. Diagnoses included history of MDRO (multidrug resistant organism) infection and pressure ulcers of the coccyx and gluteal (buttocks) fold. Observation on 08/06/24 on 10:19 a.m. showed Resident #80 in bed and EBP in place. A nurse (#24) donned a gown and gloves and entered the room to perform catheter cares and a dressing change to the coccyx and gluteal fold. Observation showed the nurse (#24) did the following: * Flushed the resident's catheter, removed gloves, and applied new gloves without performing hand hygiene. * Completed the dressing change, changing gloves without performing hand hygiene multiple times throughout, applied medicated cream directly to the wound with a gloved finger, spreading blood from her gloved hand to packaging of gauze and laying the soiled packaging on the resident's bedside table. (continued on next page)

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	08/08/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* Emptied the resident's colostomy bag, and set the graduate containing stool on the resident's bedside table, which held the resident's personal items including a water glass. The nurse (#24) failed to perform hand hygiene between glove changes, after emptying the colostomy bag and before touching other surfaces, and placed objects contaminated with bodily fluids on Resident #80's bedside table and failed to disinfect the table. - Observation on 08/06/24 at 10:58 a.m. showed a CNA (#3) completed perineal cares for Resident #11 after an incontinent bowel movement. During the cares, the CNA (#3) failed to remove her soiled gloves before opening the cabinet to get more supplies. After the cares the CNA (#3) removed her gloves, lowered the bed, placed the call light, collected the garbage, and left the room without performing hand hygiene. - Observation on 08/06/24 at 4:15 p.m. showed a staff nurse (#6) changed Resident #69's duoderm (protective dressing) on her buttocks. The nurse (#6) donned gloves and removed both dressings, cleansed the rectal area with a perineal wipe, and applied two new duoderm dressings. The nurse (#6) failed to remove her gloves and perform hand hygiene after removing the old dressing, cleansing the rectal area, and applying the new dressing. - Review of Resident #68's medical record occurred on all days of survey. Diagnosis included MDRO infection and Stage III ulcer of the left heel. Observation on 08/07/24 at 2:22 p.m. showed Resident #68 seated in a wheelchair in her room with no socks, shoes or covering to the left heel ulcer, and EBP in place. The nurse (#24) performed a dressing change to the resident's bilateral feet. Observation showed the nurse did the following: * Entered the resident room, lifted the resident left foot with her bare hand and placed it on the resident's bed. * Entered and exited the resident's room without properly wearing gown/gloves to obtain supplies from the medication cart. * Changed gloves without hand hygiene several times during the course of the dressing change. The nurse (#24) failed to wear PPE when performing tasks for a resident with EBP and perform hand hygiene between glove changes. During an interview on 08/07/24 at 5:09 p.m., two administrative nurses (#1 and #11) stated they expected staff to perform hand hygiene after removing gloves and before applying new gloves and to wear appropriate PPE when performing close contact tasks for residents with EBP. - Observation on 08/05/24 at 12:15 p.m. showed Resident #41 without EBP in place. Observation later in the afternoon showed EBP in place. During an interview at this time a staff nurse (#4) stated Resident #41's hematoma (a mass of clotted blood) started to drain today and staff placed her in EBP. Record review for Resident #41 occurred on all days of survey. Nursing progress notes stated the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* 07/31/24 at 4:35 p.m. Hematoma measures 4X4 [four by four centimeters]. Draining a little bit. * 08/03/24 at 11:03 p.m. Hematoma measuring 3.5 X 4 [centimeters] bloody drainage . Review of Resident #41's treatment administration record (TAR) identified drainage from the hematoma on 08/04/24 day shift and evening shift. The facility failed to place Resident #41 on EBP when the hematoma started to drain. - Observation on 08/05/24 at 4:38 p.m. showed Resident #43 with a foley catheter and no EBP in place. During an interview at this time, an administrative nurse (#2) confirmed Resident #43 has a foley catheter and staff failed to take appropriate precautions by using EBP. - Observation on 08/06/24 at 8:05 a.m. showed Resident #317 with an PICC (type of intravenous line for administering medication) and EBP in place. Observation showed the resident in bed and two CNAs (#14 and #15) provided morning cares and dressed the resident. When questioned when staff are required to wear PPE, a CNA (#15) stated, We weren't sure if we needed to. During an interview on 08/07/24 at 10:00 a.m., an administrative nurse (#1) stated she expected staff to wear the appropriate PPE when a resident is on EBP. 42397 45873