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	08/14/2025

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

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 1. Based on observation, record review, and resident and staff interviews, the facility failed to properly utilize assistive devices necessary to prevent accidents for 1 of 5 residents (Resident #29) observed for transfers. Failure to utilize a gait belt during transfers placed the resident at risk of injury. Findings include: Review of Resident #29's medical record occurred on all days of survey. The current care plan stated, . Transfers: Pivot transfer to and from bed with gaitbelt and assist of 1 [staff]. Non-weight bearing to right leg. -Observation on 08/11/25 at 2:57 p.m. showed Resident #29 seated on a motorized scooter. When asked how staff assisted with transfers between the scooter and other surfaces, Resident #29 stated, They grab the back of my pants and swing me over. Observation on 08/12/25 at 11:35 a.m. showed Resident #29 rested in bed. Two certified nurse aides (CNAs) (#8 and #9) entered the resident's room and assisted the resident to sit on the edge of the bed. The CNA (#8) grabbed the resident by the back of the pants and lifted/slid the resident to the electric scooter. The CNA (#8) failed to apply and use a gait belt to transfer Resident #29. During an interview on the afternoon of 08/13/25, an administrative nurse (#1) confirmed he expected staff to utilize a gait belt when transferring Resident #29. 2. Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to ensure residents remain free from accident hazards for 1 of 1 sampled resident (Resident #10) reviewed for smoking. Failure to provide an environment free from accident hazards by limiting access to cigarette lighters placed all residents, staff, and visitors at risk for injury from fire. Findings include: Review of the facility policy titled Smoke Free Facility occurred on 08/14/25. This policy, dated October 2022, stated, . It is policy of this facility to provide a safe and healthy environment for residents. If a resident does not abide by the smoking policy, care plan revisions shall be documented and implemented to promote safety. Smoking material found in plain view in the resident room will be removed immediately . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's admission packet occurred on all days of survey and stated, . SMOKE FREE FACILITY-RESIDENT POLICY . Residents will not be allowed to keep lighters or cigarettes in their rooms or on [NAME] Property. Smoking materials found in resident rooms will be removed immediately and no smoking policy will be reviewed. Review of Resident #10's medical record occurred on all days of survey. The care plan stated, . [resident's name] smokes tobacco when not on [NAME] property. [Resident's name] has signed a contract with [NAME] Homes, agreeing to this arrangement due to [NAME] Homes being a non-smoking facility. [Resident's name] will abide by the contract that she has signed . Inform nurse or Social Services of any problems or concerns. The contract, dated 04/21/21 and signed by the resident, stated, . [Resident's name] is aware the [NAME] Homes is a non-smoking facility and has agreed she will not smoke on any part of [NAME]'s property. [Resident's name] has agreed to carry her cell phone and contact staff or 911 for help if/when needed. The intention of this agreement is to keep [Resident #10's name] safe, as well as the residents, staff, and visitors . Observation on 08/12/25 at 11:37 a.m. showed Resident #10 seated in a power wheelchair in her room preparing to go outside and smoke. The resident placed a see-through netted pouch around her neck containing a visible pack of cigarettes. Prior to leaving her room, the resident asked a certified nurse aide (CNA) (#18) to hand her a personal cell phone and placed the phone into the pouch. The surveyor and Resident #10 exited the building and the resident drove to the end of the sidewalk in front of the building (more than 20 feet away). The resident removed the cigarettes and a lighter from the pouch and lit a cigarette. When finished, the resident placed the cigarettes, lighter, and cell phone back into the pouch, entered the building, kept the smoking materials with her, and drove her wheelchair back to her room. During an interview on 08/13/25 at 2:33 p.m., a nurse manager (#1) stated residents are not allowed to have cigarettes and lighters in their rooms but they don't always give them back. The facility failed to remove visible smoking materials from Resident #10 per facility policy and failed to implement methods and expectations for residents safe and secure storage of lighters/smoking materials. 3. Based on medical record review, review of facility policy, and staff interview, the facility failed to provide appropriate supervision to prevent an elopement for 1 of 1 sampled resident (Resident #1) who left the facility without notifying staff. Failure to monitor residents with decreased safety awareness resulted in Resident #1 exiting the facility and may have placed the resident in dangerous situations. Findings include: Review of the facility policy titled Code Purple – Missing Resident occurred on occurred on 08/14/25. This policy, revised July 2024, stated, . If a resident is not located in their room or in the dining room on a unit, the floor nurse on that unit must do the following: Search immediate area of the nursing unit . Additional searching of area surrounding [the facility] . Review of Resident #1's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated [DATE], identified as cognitively intact. The current care plan stated, . [Resident #1] was recently admitted to [the] hospital due to a fall in the home that resulted in multiple subacute pelvic fractures . impaired gait, impaired anticipatory and reactionary balance, and (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	decreased safety awareness . Resident unsafe to return home at this time . A progress note, dated 08/02/25 at 4:23 p.m., stated, This writer was alerted by another resident that [Resident #1] had left the nursing home to go to [the] [name] convenience store [located two blocks from the facility]. This writer went to look for [the] resident and found her sitting in her wheelchair by the kerbside [sic] and she stated she was tired. [The] Resident was having a difficult time navigating the uneven terrain, and she also stated that the nursing home looked like a school to her. [The] Resident stated that she had gone to [convenience store name] to purchase a candy bar but was unable to get back due to 'being tired.' This writer pushed [the] resident back to her room. [The] Resident's family . was updated. Weekend Manager, Social services and DON [Director of Nursing] were also updated. During an interview on 08/13/25 at 5:20 p.m., two administrative nurses (#1 and #13) confirmed staff failed to complete an incident report following Resident #1's elopement. 4. Based on review of the facility reported incident (FRI) report, record review, review of facility policy, and staff interview, the facility failed to provide appropriate supervision/assistance to prevent accidents for 1 of 14 sampled residents (Resident #3) who fell from her wheelchair during transport. Failure to utilize foot pedals during transport resulted in Resident #3's sustaining an injury to her forehead. This is considered past non-compliance based on review of the corrective actions the facility implemented following the incident. Findings include: Review of the power point presentation handout related to falls occurred on 08/14/25. The handout stated, . Wheelchair Leg Rests: Make sure foot pedals are in place with the resident's feet up on them prior to pushing them in the wheelchair. DO NOT PUSH A RESIDENT IN A WHEELCHAIR WITHOUT LEGRESTS ON. Leg rests may be removed and placed in the bag on the back of the wheelchair if the resident is independent with propelling their own wheelchair . Review of Resident #3's medical record occurred on all days of survey. The current care plan stated, . [Resident #3] is not able to perform own ADL's [Activities of Daily Living] due to behaviors and decreased mobility . Mobility . 1 staff to push chair behind. Rock-n-go for mobility and comfort. Ensure foot pedals are in use while staff is pushing chair . [Resident #3] is at risk for falls and fall related injuries . Falls Prevention . Ensure that the foot pedals of the resident's rock n go are on when transporting the resident . Review of the FRI report, submitted to the state agency on 02/19/25, stated, . [Certified nurse aide's (CNA's) [name] was pushing [Resident #3] to her room in her wheelchair and [Resident #3] fell forward out of the chair. [Resident #3] is always very agitated, restless, and last evening had been leaning over in her chair messing with her leg wraps and also continuously trying to stand up. [CNA's name] was telling her she needed to lean back in her chair, and she fell out forward. She did receive a bump on her head, was sent to the ER [emergency room], and returned with no further injury. The progress notes identified the following:* 02/18/25 at 11:15 p.m., Resident was drowsy at start of shift. approx [approximately] 1600 [4:00 p.m.] she started to become fidgety and obsessed with bending over in wheelchair fussing with the velcro on her foot wraps. She became more agitated and restless and the concern for her safety was growing. She continued to fidget and attempt to get out of chair. Finding it impossible to keep her in the recliner, she was placed back in wheelchair with 1:1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation. was being wheeled to the shower room to . toilet her. The CNA had just reminded resident to sit up and not lean forward. At that moment the resident fell face first onto [the] floor. (2100 [9:00 p.m.]) She remained as per her normal orientation. She had a small scratch on right cheek which was cleaned and did not bleed anymore. she had a large goose egg sized swelling to her right forehead. Resident was assessed and no other apparent injuries. we attempted to place an icepack on her forehead and assess VS [vital signs]. (2115 [9:15 p.m.]) Supervisor, provider and daughter were notified. Orders to transfer to ER [emergency room] for assessment were received and family agreed. Ambulance was called (2130 [9:30 p.m.]) and arrived at (2145 [9:45 p.m.]) for transport. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions to ensure the deficient practice does not recur by:* Completing an investigation on 02/18/25, including an interview with the CNA who transported Resident #3,* Determining the CNA transported Resident #3 without placing foot pedals on her wheelchair, resulting in a fall from her wheelchair, injury, and placed all residents at risk for falls with/without injury.* Immediately re-educating the CNA following the incident and re-educating all staff on the importance of utilizing foot pedals during resident transport.* Completing quality assurance audits to ensure resident safety during transport.

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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. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 11 sampled residents (Resident #12, #29 and #59) and 1 supplemental resident (Resident #126) observed for cares and/or medication administration. Failure to practice infection control standards related to enhanced barrier precautions (EBP), glove use, hand hygiene, and disinfecting of shared equipment has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Copy of Enhanced Barrier precautions occurred on 08/14/25. This policy, dated September 2024, stated, . Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [Multi-Drug Resistant Organism] as well as those that have . open wound that requires a dressing. high-contact activities . dressing . transferring . Review of the facility policy titled Blood glucose/Hypoglycemia occurred on 08/14/25. This policy, dated, December 2022, stated, . Glucometers will be cleaned and disinfected after each use using a Super Sani Cloth Germicidal wipe . Review of the facility policy titled Medications-Administration Of Sub-Q [subcutaneous-under the skin] occurred on 08/14/25. This policy, dated November 2023, stated, ADMINISTRATION OF SUBCUATNEOUS MEDICATIONS . Perform hand hygiene and apply clean gloves. Select appropriate injection site . inject needle . withdraw needle . remove gloves and perform hand hygiene. ENHANCED BARRIER PRECAUTIONS Review of Resident #29's medical record occurred on all days of survey. A history and physical note, dated 04/10/25, stated, . positive wound culture. Showed MRSA [Methicillin-resistant Staphylococcus aureus - an MDRO] . MRSA infection of chronic ulcer . The current care plan stated, . has a chronic open area to her right lower leg . enhanced barrier precautions in place per guidelines . Observation on 08/12/25 at 11:35 a.m. showed Resident #29's room with an EBP sign and a personal protective equipment (PPE) storage unit on the door. A certified nurse aid (CNA) (#9) applied a gown and gloves, and a CNA (#8) applied gloves and entered the room. The CNA (#8) applied the resident's shoes and pants, both CNAs assisted Resident #29 to sit on the edge of the bed, and the CNA (#8) transferred the resident to the scooter. The CNAs (#8 and #9) removed their soiled PPE, performed hand hygiene and exited the room. The CNA (#8) failed to apply a gown prior to dressing and transferring Resident #29. During an interview on 08/13/25 at 3:15 p.m., an administrative nurse (#10) confirmed she expected staff to wear the appropriate PPE to provide care for residents in EBP. MEDICATION ADMINISTRATION/GLUCOMETER USE Observations on 08/14/25 showed the following: -7:56 a.m. and 8:12 a.m., A nurse (#12) administered insulin to Residents #59 and #126 without wearing gloves. The nurse (#12) confirmed he failed to wear gloves during the insulin administrations. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8:30 a.m., A nurse (#11) checked Resident #12's blood sugar level using a shared glucometer and then placed the glucometer into a docking station without sanitizing it. When asked if there were more blood sugar checks to complete, the nurse (#11) stated, one more. The surveyor requested the nurse disinfect the glucometer with a Sani-cloth.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and resident, resident representative, and staff interviews, the facility failed to ensure the right to participate in the development and implementation of a person-centered plan of care for 2 of 31 sampled residents (Resident #6 and #118). Failure to ensure residents or their representative received notice of care planning conferences and/or interviewed the resident or their representative regarding care concerns/needs if they chose not to attend the conferences, limited their right to make decisions/provide input related to the resident's care, treatment, and services.Findings include: Review of the facility policy titled Care Planning occurred on 08/14/25. This policy, dated April 2025, stated, . It is the policy of [NAME] Nursing Care Facility that a written plan of care be developed and maintained for each resident in coordination with all services and individuals involved in the care of the resident. Family members, support persons with the permission of the resident, and/or resident will be invited to attend the care planning conference.-Review of Resident #6's medical record occurred on all days of survey and identified care planning conferences held on 03/05/25 and 05/25/25. During an interview on 08/12/25 at 8:55 a.m., Resident #6 expressed unawareness of the care planning conference and never attended the conferences. The record lacked evidence Resident #6 received notice of the care conferences held on 03/05/24 and 05/25/25 care conferences and/or staff interviewed the resident regarding care concerns or needs. During an interview on 08/13/25 at 11:45 a.m., an administrative staff member (#17) confirmed the medical record lacked evidence staff invited Resident #6 to the care planning conferences or interviewed the resident regarding care concerns and needs.-Review of Resident #118's medical record occurred on all days of survey and identified a care planning conference held on 06/25/25. During an interview on 08/12/25 at 1:55 p.m., Resident #118's personal representative stated she did not receive notification from the facility regarding the care planning conference. The record lacked evidence the resident's representative received notice of the care planning conference.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review, review of facility policy, and staff interview, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment for 1 of 31 sampled residents (Resident #84) reviewed for advance directives. Failure to ensure the resident's medical record reflected the most current resident wishes may result in unwanted treatment. Findings include:Review of the facility policy titled Code Status occurred on 08/14/25. This policy, revised October 2021, stated, . Nursing services will verify order between providers orders and/or resident's decision and that the code order in the electronic health record matches whatever the resident/residents representative has signed .Review of Resident #84's medical record occurred on all days of survey and identified a physician's order, dated 02/18/25, indicating a full code status. The resident identification ribbon in the electronic health record (EHR) also showed a full code status. On 08/12/25 at 5:25 p.m., a management staff member (#17) presented the surveyor a code status form dated 08/12/25 indicating Do Not Resuscitate (DNR) signed by the resident's Power of Attorney (POA). The staff member (#17) stated Resident #84 returned from the hospital today (08/12/25) and the code status changed. Resident #84's medical record showed facility staff failed to change the full code status to DNR in the EHR until 08/13/25 at 8:30 a.m. During an interview on the morning of 08/13/25, an administrative staff member (#1) confirmed staff failed to change the code status to DNR.

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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** Based on record review, review of facility policy, and staff interview, the facility failed to ensure all alleged violations involving possible abuse/neglect were reported immediately to officials including the State Survey Agency (SSA) for 1 of 1 sampled resident (Resident #1) who eloped from the facility. Failure to immediately report alleged violations to the SSA placed Resident #1 and other residents at risk for possible neglect and/or injury.Review of the facility policy titled Abuse, Neglect and Exploitation occurred on 08/14/25. This policy, revised August 2023, stated, . Neglect: Means the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress . The Director of Nursing and/or Director of Social Services will report the alleged . neglect . to the Administration and/or their designee and the State Health Department. An initial Allegation of Abuse Reporting form will be completed through the State Health Dept [Department] website . within 24 hours. The results of all investigations are reported to the Administrator or his designated representative and the State Health Department within five working days of the alleged incident .Review of Resident #1's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated [DATE], identified cognitively intact. The current care plan stated, . [Resident #1] was recently admitted to [the] hospital due to a fall in the home that resulted in multiple subacute pelvic fractures . impaired gait, impaired anticipatory and reactionary balance, and decreased safety awareness . Resident unsafe to return home at this time . A progress note, dated 08/02/25 at 4:23 p.m., stated, This writer was alerted by another resident that [Resident #1] had left the nursing home to go to [name of store] convenience store [located two blocks from the facility]. This writer went to look for resident and found her sitting in her wheelchair by the kerbside [sic] and she stated she was tired. Resident was having a difficult time navigating the uneven terrain, and she also stated that the nursing home looked like a school to her. Resident stated that she had gone to [convenience store name] to purchase a candy bar but was unable to get back due to ?being tired.' This writer pushed resident back to her room. Resident's family . was updated. Weekend Manager, Social services and DON [Director of Nursing] were also updated. During an interview on 08/13/25 at 5:20 p.m., two administrative nurses (#1 and #13) confirmed staff failed to complete an incident report following Resident #1's elopement. The medical record failed to reflect facility staff reported Resident #1's elopement to the State Health Department.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and staff interview, the facility failed to thoroughly investigate alleged violations of neglect for 1 of 1 sampled resident (Resident #1) who eloped from the facility. Failure to thoroughly investigate Resident #1's elopement, implement corrective actions, and evaluate the effectiveness of those actions, placed Resident #1 and other residents at risk for possible neglect and/or injury.Review of the facility policy titled Abuse, Neglect and Exploitation occurred on 08/14/25. This policy, revised August 2023, stated, . Neglect: Means the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress . The supervisor will then contact the Director of Nursing and/or Director of Social Services to initiate the investigation process. All staff with knowledge of the alleged incident will be required to make a written, signed, and dated statement. All residents involved in the allegation will be interviewed and a statement will be written up. The care plan will be updated accordingly to reflect any new interventions or changes.Review of Resident #1's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated [DATE], identified cognitively intact. The current care plan stated, . [Resident #1] was recently admitted to hospital due to a fall in the home that resulted in multiple subacute pelvic fractures . impaired gait, impaired anticipatory and reactionary balance, and decreased safety awareness . Resident unsafe to return home at this time . A progress note, dated 08/02/25 at 4:23 p.m., stated, This writer was alerted by another resident that [Resident #1] had left the nursing home to go to [name of store] convenience store [located two blocks from the facility]. This writer went to look for resident and found her sitting in her wheelchair by the kerbside [sic] and she stated she was tired. Resident was having a difficult time navigating the uneven terrain, and she also stated that the nursing home looked like a school to her. Resident stated that she had gone to [convenience store name] to purchase a candy bar but was unable to get back due to ?being tired.' This writer pushed resident back to her room. Resident's family . was updated. Weekend Manager, Social services and DON [Director of Nursing] were also updated. During an interview on 08/13/25 at 5:20 p.m., two administrative nurses (#1 and #13) confirmed staff failed to complete an incident report following Resident #1's elopement. Facility staff failed to complete an incident report after locating Resident #1, including:* Identifying how long Resident #1 was missing from the facility prior to locating her, the weather conditions/appropriateness of her clothing, etc.,* Documenting the results of the physical assessment,* Assessing Resident #1's safety awareness after being told she self-propelled her wheelchair two blocks from the facility, had difficulty navigating the uneven terrain, and thought the facility looked like a school, * re-educating Resident #1's on the procedure for leaving the facility, i.e.: sign-out book.

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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. Based on record review, review of professional reference, review of facility policy, and staff interview, the facility failed to follow professional standards of practice regarding physician's orders for 1 of 1 sampled resident (Resident #30) with orders for a physical therapy/occupational therapy (PT/OT) evaluation. Failure to transcribe and obtain a PT/OT evaluation placed Resident #30 at risk for delayed treatment. 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.Review of the facility policy titled Provider Orders occurred on 08/14/25. This policy, dated September 2022, stated, . PHYSICIANS ORDERS . all orders must be on the chart of the resident . Observed, sign, date and time, in red, beneath the providers written orders on Provider order sheets. enter order into the electronic health record. Review of Resident #30's medical record occurred on all days of survey. Diagnoses included arthritis, weakness, and difficulty walking. A provider's progress note, dated 05/07/25, stated, . chronic ambulatory dysfunction . wheelchair bound . currently a Hoyer [mechanical lift] transfer . An undated physician's order, scanned into the medical record, stated, PT/OT evaluate transfer/maneuver electric wheelchair safely. The physician's order lacked evidence facility staff acknowledged the order. The record lacked documentation of a PT/OT evaluation for electric wheelchair use. Observations on all days of survey showed an electric wheelchair Resident #30's room. During an interview on 08/11/25 3:14 p.m., Resident #30 identified she would like to receive some therapy and to use her electric wheelchair. During an interview on 08/13/25 at 8:15 a.m., a therapy manager (#6) confirmed therapy staff had not received notification of an evaluation order for Resident #30. During an interview on 08/13/25 at 11:00 a.m., an administrative nurse (#7) confirmed the provider wrote the order, failed to date it, and facility staff failed to carry out the order.

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	355074	A. Building B. Wing	08/14/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and resident and staff interview, the facility failed to ensure residents received the necessary services to maintain personal hygiene for 2 of 23 sampled residents (Resident #4 and #104) dependent on staff for personal hygiene. Failure to provide assistance with hair, oral, and nail care may result in poor hygiene and decreased self-esteem and quality of life. Findings include: The facility failed to provide a policy for activities of daily living. -Observation on 08/11/25 at 4:29 p.m. showed Resident #4's hair uncombed. The resident stated, I only get my hair combed about once a week and teeth brushed occasionally. Review of Resident #4's medical record occurred on all days of survey. The care plan stated, . [Resident #4's name] is not able to perform her own ADL's [activities of daily living] related to weakness and right femur fracture. Grooming/Personal Hygiene: staff assistance of one for assistance at bedside. Encourage [Resident #4's name] to . comb hair Oral hygiene: partials/own teeth. Oral cares bid [twice a day] . Encourage [Resident #4's name] to brush own teeth after set up . Review of Resident #4's personal hygiene task record from 07/14/25 to 08/09/25 identified the facility staff failed to assist the resident with personal hygiene (combing hair and brushing teeth) five times. -Observation on 08/11/2025 at 2:56 p.m. showed Resident #104's great toenails to both feet approximately three-fourths inches in length with jagged edges. Review of Resident #104's medical record occurred on all days of survey. The care plan stated, . Hand and foot nail care to be done by CNA [certified nurse aid] . During an interview on 08/14/25 at 1:17 p.m. an administrative staff nurse (#1) stated he expected the CNAs to assist dependent residents with all ADLs including combing hair and brushing teeth twice a day.

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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. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 1 of 6 sampled resident (Resident #6) observed during dressing changes. Failure to complete dressing changes as physician ordered placed the resident at risk for delayed wound healing. Findings include:Review of the facility policy titled Skin Management occurred on 08/14/25. This policy, dated December 2022, stated, . Wound Care Guidelines . Floor nurse will observe wound daily . Wound care dressings will be dated and initialed. Floor nurse will document observed wounds . in the resident's EHR [electronic health record].Review of Resident #6's medical record occurred on all days of survey. A physician's order, dated 11/27/24, identified a dressing change to the resident's right leg once a day. Observation on 08/12/25 at 9:30 a.m. showed a nurse (#12) removed a dressing dated 08/10/25 from Resident #6's right leg. The nurse (#12) stated, I don't know what happened. They must have forgot to change the dressing yesterday.

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F 0686 Level of Harm - Minimal harm or potential for 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** Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment/services to prevent skin breakdown and pressure ulcers for 1 of 4 sampled residents (Resident #4) reviewed with pressure ulcers. Failure to consistently reposition residents for pressure relief may result in delayed healing of current pressure ulcers and/or the development of new pressure ulcers.Findings include:Review of the facility policy titled Skin Management occurred on 08/14/25. This policy, dated December 2022, stated, Once residents are identified at risk of skin breakdown, prevention guidelines will be implemented, including but not limited to: turn schedule .Follow individualized prevention protocols for each resident . Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present.Review of Resident #4's medical record occurred on all days of survey. Diagnosis included a pressure ulcer to the sacral region noted upon admission [DATE]) to the facility. Physician's orders stated, . 05/07/2025 Turn/reposition schedule every 2/3 [2-3 hours] hours . 05/15/25 Consult General Surgery . worsening coccyx pressure ulcer . 06/19/25 Wound Vac (a therapeutic technique that uses suction to promote wound healing) to sacral wound .Resident #4's care plan, stated . Bed mobility: staff assist of 1 for re-positioning . has a pressure ulcer to coccyx. turn [NAME] [sic] 2-3 hours . resident bedbound due to stage IV sacral wound . A Minimum Data Set, dated [DATE], identified Resident #4 dependent upon facility staff to roll left and right.Resident #4's medical record showed the resident's wound was debrided by a surgeon on 06/19/25, and included the following nursing progress note, dated 06/19/25 at 11:14 a.m., stated, . Resident to MD [medical doctor] appointment at surgeon's office. Per note from [nurse practitioner's name], resident will now receive wound vac orders: white foam to tunnel and exposed bone . measures 10x10x2 [10 centimeters (cm) length by 10 cm width by 2 cm depth] with a 4cm tunnel at 5 oclock, [sic] 5% bone exposed, 10% yellow slough and 85% red wound bed. Review of the wound care documentation, dated 08/07/25, showed a stage IV (full thickness tissue loss, exposing underlying bone, muscle or tendon) pressure ulcer to Resident #4's sacral region and measured 11 centimeters (cm) by 10.5 cm width and 2 cm undermining.Resident #4's repositioning record, dated July 15 to August 13, 2025, identified the following:- Not repositioned: 1 day zero times- Repositioned once: 6 days - Repositioned twice: 14 days - Repositioned three times: 7 days - Repositioned four times: 1 day During an interview on 08/14/25 at 9:49 a.m., an administrative staff member (#7) confirmed Resident #4's turning and repositioning task failed to show staff repositioned the resident every 2-3 hours. The administrative staff member stated she expected facility staff to reposition the resident every two to three hours. During an interview on 08/14/25 at 1:17 p.m., an administrative staff member (#1) stated staff should reposition Resident #4 every 2-3 hours.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to provide appropriate services and assistance to maintain bowel continence for 1 of 2 sampled residents (Resident #4) observed during toileting/incontinence cares. Failure to provide alternate toileting methods may result in unnecessary incontinence, a loss of dignity, and avoidable skin issues. Findings include:Review of Resident #4's medical record occurred on all days of survey. Diagnosis included weakness, right femur fracture (occurred prior to admission) and pressure ulcer to sacral region. Physician orders, dated 07/25/25, stated, . Activity Level: Up with assist . partial weight bearing as tolerated for two weeks and then transition to weight bearing as tolerated. The care plan stated, . foley catheter R/T [related to] wound healing. Toileting: Frequently incontinent. brief changes assistance of 1 [staff]. Toileting to be done every 2 to 4 hours and prn [as needed]. The resident's quarterly Minimum Data Set (MDS), dated [DATE], identified cognitively intact, dependent on staff for toileting, no physical or verbal behaviors, and no rejection of care.Observation on 08/13/25 at 11:18 a.m. showed Resident #4 incontinent of bowel with stool noted on the wound dressing. The nurses (#23 and #24) provided perineal cares, changed the incontinent product, and changed the wound dressing. During an interview on 08/11/25 at 4:41 p.m., Resident #4 stated she wears an incontinent product and They just change me. I can't get out of bed with this fracture. During an interview on 08/14/25 at 8:00 a.m., a therapy staff member (#6), stated, We do not get her (Resident #4) out of bed because she requires the hoyer lift [mechanical lift] and we do not want to risk her coccyx wound getting worse from shearing. The staff member (#6) also stated, We have tried to stand her (Resident #4) at bedside and she is unable to. She just isn't there yet. We will try the sit to stand lift with two of us and see if she can do that. During an interview on 08/14/25 at 8:08 a.m., an administrative staff nurse (#7) stated Resident #4 does not get out of bed per her choice, and staff only check and change her. The administrative staff nurse confirmed facility staff have not attempted alternate toileting methods, such as the bed pan, bedside commode, etc. The medical record lacked evidence the facility staff educated Resident #4 on her current weight bearing status and offered alternate toileting methods, which may have resulted in avoidable incontinence, decreased dignity, and risk of further skin breakdown.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, review of facility policy, and staff, resident, and family interviews the facility failed to offer and/or assist with fluids for 3 of 8 residents (Resident #2, #13, and #14) who required staff assistance for fluid intake. Failure to provide fluids to dependent residents may result in dehydration, constipation, and urinary tract infections. Findings include: Review of the facility policy titled, Fluids and dehydration occurred on 08/14/25. This policy, revised May 2019, stated, . The information gathered from the nutritional assessment, along with current standards of practice, will be used to develop an individualized care plan that addresses the resident's specific . hydration concerns and preferences . Interventions to improve a resident's hydration status may include but not limited to the following . Offer the resident a variety of fluids during and between meals . Provide assistance with drinking . - During an interview on 08/11/25 at 2:39 p.m., Resident #2 stated, I don't know why they didn't bring me any water. Observation showed an empty glass of water sitting on the bedside table. A few minutes later, an unidentified certified nurse aide (CNA) entered the room and Resident #2 immediately asked the CNA for water. Review of Resident #2's medical record occurred on all days of survey. The physician's orders identified, . chart fluids q [every] shift . The current care plan stated, . At risk for dehydration r/t [related to] diuretic medication use, recent infection. Dehydration observation weekly as ordered . Offer and encourage fluids at and between meals. At risk for constipation R/T opioid medication use . Offer and encourage fluids at and between meals . - During an interview on 08/11/25 at 2:28 p.m., Resident #13's family member stated, They [staff] drop off water and don't offer or assist her. She is weak and can't even hold a cup. Review of Resident #13's medical record occurred on all days of survey. The current care plan stated, . At risk for constipation . Offer and encourage fluids at and between meals . At risk for dehydration . Dehydration observation weekly as ordered . Offer and encourage fluids at and between meals . Observations on 08/13/25 showed the following:* 1:20 p.m., Two CNAs (#19 and #20) assisted Resident #13 with cares and exited the room. The CNAs (#19 and #20) failed to offer the water located on the bedside table prior to exiting the room.* 5:00 p.m. A CNA (#21) assisted Resident #13's with cares and exited the room. The CNA (#21) failed to offer the water located on the bedside table prior to exiting the room. Review of Resident #14's medical record occurred on all days of survey. Diagnoses included vascular dementia. The care plan stated, . Offer and encourage fluids . [Resident #14's name] is not able to do her own ADL's [activities of daily living] . Potential for dehydration. History of UTI [urinary tract infection]. Resident needs total assistance with eating . Observation on 08/13/25 at 3:35 p.m. showed two certified nurse aides (CNAs) (#4 and #5) assisted Resident #14 with cares and transferred the resident to the wheelchair and exited the room. The CNAs failed to offer water located on the bedside table. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/14/25 at 1:17 p.m., an administrative staff member (#1) stated he expected staff to offer dependent residents water with cares. 039484

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 9 residents (Resident #65 and #96) observed during medication administration. Two medication errors occurred during staff administration of 27 medications, resulting in a 7% error rate. Failure to follow physicians' orders and administer medications in the correct dose and at the correct time may result in residents receiving an ineffective and/or inaccurate dose and experiencing adverse reactions.Findings include: Review of the facility's policy titled Medication Administration and Crushing Medications occurred on 8/14/25. This policy, approved October 2024, stated, . OBJECTIVE: 1. To administer medications as ordered by a provider . Provider's Order must be obtained and observed for all medications. Read the medication label and compare with the HER [sic] [electronic health record (EHR)] ensuring the five rights: a. Right drug . Right dose . Right route . Right time . Right resident. Review of Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice, 11th ed., Pearson Education Inc., New Jersey, page 835, stated, Process of Administering Medications . Medications prescribed more frequently than daily, but no more frequently than every 4 hours . [Administer] Within 1 hour before or after the scheduled time. -Observation on 08/11/25 at 4:32 p.m. showed a nurse (#15) administered one drop of Refresh eye drops to both of Resident #65's eyes. The Refresh label stated two drops left eye twice daily. After returning to the medication cart, the nurse confirmed the order stated two drops to left eye twice daily. Review of Resident #65's physician's order verified two drops to left eye until redness resolves then discontinue. -Review of Resident #96's medical record occurred on all days of survey and showed a physician's order for Cefepime 2 Gram (an antibiotic medication) every 12 hours for 14 days for bacteremia/sepsis. Review of Resident #96's electronic medication administration record (EMAR) showed scheduled administration times for the Cefepime at 9:00 a.m. and 9:00 p.m. Observation on 08/12/25 at 10:49 a.m. showed a nurse (#2) administered the Cefepime. This exceeded the one-hour after the scheduled time of 9:00 a.m. by 49 minutes. During an interview on 08/13/25 at 2:00 p.m., an administrative nurse (#1) stated he expected staff to administer medication within an hour prior to the scheduled time to an hour after the scheduled time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, and staff interview, the facility failed to ensure accurate medication labeling for 1 of 8 residents (Resident #12) observed during medication administration and failed to discard expired medications in 3 of 7 medication storage areas (3 North East cart and cupboard and 3 South refrigerator) reviewed. Failure to ensure medication labels reflect the current physician orders may result in inaccurate dosages and failure to discard expired medications may result in decreased effectiveness of the prescribed medication.Findings include: -Review of the facility policy titled Medication Administration and Crushing Medications occurred on 08/14/25. This policy, revised January 2021, stated, . administer medications as ordered by a provider. Read the medication label and compare with the HER [sic] [electronic health record (EHR)] ensuring the five rights . Right dose . Observation on 08/14/25 at 8:36 a.m. showed a nurse (#11) removed Resident #12's Novolog insulin pen from the medication cart. The label on the insulin pen and on a box with additional insulin pens identified 20 units before meals and at bedtime. The current physician's order identified 25 units before meals and before bedtime. When asked, a nurse manager (#3) and the nurse (#11) stated Resident #12 received a recent order change and both confirmed the label on the insulin pen and box failed to reflect the change. -Review of the facility policy titled Supplies - Outdated - [NAME] Homes occurred on 08/14/25. This policy, revised January 2023, stated, OUTDATED SUPPLIES 1. All supplies will be checked once a month. 2. Supplies that are outdated will be discarded. Observations of medication storage showed the following: -08/12/25 at 5:15 p.m., a tube of Muscle Rub topical cream with an expiration date of 08/2024 located in the medication cart on 3 North East. -08/14/25 at 11:38 a.m., one box of Acetaminophen 650 milligrams (mg) suppositories with an expiration date of 12/2024, and one box of Bisacodyl 10mg suppositories with an expiration date of 07/2025 located in the medication refrigerator on 3 South. -08/14/25 at 11:45 a.m., one bottle of aspirin 325mg with an expiration date of 05/2025 located in the medication cupboard on 3 North East. During an interview on 08/14/25 at 1:50 p.m., supervisory staff members (#1, #10, and #13) agreed staff should remove expired medications from the storage areas.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility policy, and staff interview, the facility failed to discard expired food and supplements in 2 of 6 food storage areas (Main kitchen and 4 North kitchenette) observed. Failure to discard expired food/supplements has the potential to affect the quality of the item served to residents related to safety and nutrition.Findings include: Review of the facility policy titled Dietary Policy/Procedure occurred on 08/14/25. This undated policy stated, . PURPOSE: To assure that foods served are wholesome and not out dated. All foods rotated by date and stored properly. Observations showed the following: -08/11/25 at 1:15 p.m., main kitchen: the large walk-in freezer contained a partially uncovered pan of corned beef dated March 2024. -08/13/25 (morning), 4 North kitchenette: an opened container of Prosource (dietary supplement) expired October 2024. -08/13/25 at 3:00 p.m., main kitchen: approximately 42 boxed containers of Ensure Clear (dietary supplement) with expiration dates from April 2025 through August 1, 2025. During an interview on 08/14/25 at 9:00 a.m., a dietary supervisor (#16) verified the facility lacked a consistent process to monitor for expired foods/supplements, and staff should discard the expired food/supplements.