DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 5, 2026

Administrator
Trinity Care Center
905 ELM STREET
FARMINGTON, MN 55024

RE: CCN:245250

Cycle Start Date: April 30, 2026

Dear Administrator:

On April 30, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 30, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 30, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department’s informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 4/28/26 - 4/30/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		05/05/2026
F0000	INITIAL COMMENTS On 4/28/26 - 4/30/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H00977105C (iQIES #2747447). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/05/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F0580	F0580 SS=D Residents R5 and R68 were reviewed. The provider was notified regarding the identified orthostatic blood pressure readings and elevated blood glucose readings greater than 400 mg/dL. Documentation was completed in the electronic medical record.	06/12/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 1 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by:	F0580	Continued from page 1 Nursing staff were educated on facility policy, Change in Condition, which outlines expectations and documentation requirements for when to notify a physician. To identify other residents who may have been affected by the same deficient practice, the Director of Nursing (DON) or designee completed an audit of residents with physician notification parameters related to orthostatic blood pressures, blood glucose levels, and other change in condition orders to ensure provider notifications were completed and documented appropriately. To prevent recurrence, the facility re-educated nursing staff regarding the Change in Condition policy, including physician notification requirements, documentation expectations, and escalation of significant clinical findings. The facility also implemented a review process during clinical meetings to address identified changes in condition and ensure appropriate follow-up and provider communication occurs timely. The DON or designee will audit: · 5 residents weekly for 4 weeks, then · 5 residents monthly for 2 months to ensure physician notifications are completed and documented according to physician orders and facility policy. Audit results will be reviewed through the facility's QAPI process, for additional recommendations and interventions, as needed. Completion Date: June 12, 2026	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 2 Based on interview and document review, the facility failed to notify the physician of a change in condition related to orthostatic hypotension and failed to notify the physician following a hyperglycemic blood glucose reading greater than 400 mg/dL for two of two residents (R5 and R68) reviewed for notification of change. Findings include: R5's quarterly Minimum Data Set (MDS), dated 4/7/26, indicated R5 was admitted to the care facility on 10/14/24, had a Brief Interview for Mental Status (BIMS) score of 15 (indicating intact cognition), received an antipsychotic medication (which has a potential side effect of orthostatic hypotension), and required substantial to maximum assistance with activities of daily living (ADLs). Orthostatic hypotension is a condition in which a person's blood pressure drops significantly when they move from lying down or sitting to a standing position. It is typically defined as a decrease of more than 20 mmHg in systolic blood pressure (the top number) or more than 10 mmHg in diastolic blood pressure (the bottom number). This sudden drop can prevent adequate blood flow to the brain, causing symptoms such as dizziness, lightheadedness, or even fainting when the body is unable to adjust blood pressure quickly enough. R5 had a physician's order, dated 9/18/25, for orthostatic blood pressure monitoring due to antipsychotic use once a month to include blood pressure readings while lying, sitting, and standing. R5's vital signs record, dated 4/18/26, indicated an orthostatic blood pressure drop from 122/72 while lying, to 118/71 while sitting, and 101/62 while standing, demonstrating a systolic drop greater than 20 mmHg between laying and standing. R5's electronic medical record (EMR) lacked evidence the physician was notified of the orthostatic blood pressure drop identified on 4/18/26. During an interview on 4/29/26 at 1:16 p.m., registered nurse (RN)-D stated if there was a 20-point difference in blood pressure readings between lay, sit or stand, staff would notify the provider. During an interview on 4/30/26 at 8:05 a.m., nurse manager and registered nurse (RN-C) stated staff	F0580		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 3 should notify the provider for a 20-point orthostatic drop and document the communication. RN-C reported she had not been notified and was unaware R5 was experiencing orthostatic drops. During a follow-up interview on 4/30/26 at 8:47 a.m., RN-C stated the provider had been notified of orthostatic blood pressure readings in December with no new orders; however, the 4/18/26 orthostatic drop had not been reported. RN-C indicated she would provide staff education and clarify expectations with the provider regarding notification parameters. During an interview on 4/30/26 at 8:10 a.m., R5 stated they experienced dizziness when sitting or standing too quickly and reported needing to move slowly to prevent symptoms. A facility policy titled Change in Condition, revised 7/29/25, indicated staff would notify the physician for multiple reasons including the possible need to discontinue or start a new treatment. R68 R68's quarterly Minimum Data Set (MDS) assessment dated 04/6/26, indicated R68 had severely impaired cognition and required substantial to maximum assistance with activities of daily living (ADLs). R68's diagnoses included type 1 diabetes mellitus (a condition where the body's immune system attacks and destroys insulin-producing beta cells in the pancreas, resulting in little or no insulin production and leading to high blood sugar levels) with other diabetic neurological complications and other frontotemporal neurocognitive disorder (progressive brain disease that primarily affect that leads to changes in behaviors, personality, language and movement). R68 had a physician order dated 10/3/25, for accuchecks (blood sugar checks) 3 times a day with meals: must update provider if blood sugar is less than 90mg/dl or greater than 400mg/dl. If less than 70 mg/dl give glucose gel. R68's vital signs record dated 3/26/26, indicated a blood sugar of 498.0mg/dl and vital signs record dated 4/20/26, indicated a blood sugar of 449.0 mg/dl.	F0580		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 4 R68's electronic medical record (EMR) showed no evidence of provider notification for blood sugar reading of 498.0mg/dl on 3/26/26, and blood sugar reading of 449.0mg/dl on 4/20/26. During an interview on 4/29/26 at 8:45 a.m., registered nurse (RN)-B stated if a resident's blood sugar reading was elevated and they had an order for the provider to be notified, staff would notify the provider and would document the notification in the EMR. During an interview on 4/29/26 at 9:08 a.m., nurse manager and registered nurse (RN)-A stated staff should notify the provider of blood sugar readings of 498.0mg/dl and 449.0mg/dl. RN-A completed a brief EMR review and was unable to locate notifications sent to provider for the two incidences of blood sugar readings greater than 400mg/dl. RN-A stated they would provide staff education on expectations for provider notification. A facility policy titled Change in Condition, revised 7/29/25, indicated staff would notify the physician for multiple reasons including the possible need to discontinue or start a new treatment.	F0580		06/12/2026
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a	F0640	F0640 SS=D Resident R23's Discharge Return Not Anticipated (DRNA), Minimum Data Set (MDS) assessment, was completed and transmitted to CMS. The MDS coordinator and nursing leadership were educated regarding discharge assessment timing and transmission requirements utilizing the MDS 3.0 Assessment policy. To identify other residents potentially affected by the same deficient practice, the MDS coordinator and/or designee audited discharged residents from the previous 90 days to ensure required discharge assessments were completed and transmitted timely to CMS. To prevent recurrence, the facility implemented a discharge MDS tracking process to ensure all required discharge assessments are completed and transmitted within required timeframes. The DON, MDS Coordinator, or designee will audit this tracking for:	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0640 SS = D	Continued from page 5 facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a discharge return not anticipated (DRNA) Minimum Data Set (MDS) was completed and transmitted to the Centers for Medicare and Medicaid (CMS) for 1 of 1 residents (R23) reviewed for no MDS record in 120 days. Findings include: R23's Census listing dated 1/6/26, indicated R23 admitted to the nursing home on 12/9/25, and their status changed to "STOP BILLING" on 1/6/26. R23's progress note dated 1/6/26 at 11:05 a.m.,	F0640	Continued from page 5 all discharged residents weekly for 4 weeks, then monthly for 2 months to ensure discharge assessments are completed and transmitted timely. Audit results will be reviewed through the facility's QAPI process, for additional recommendations and interventions, as needed. Completion Date: June 12, 2026	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0640 SS = D	Continued from page 6 indicated R23 discharged home with family and would have home health services. R23's MDS listing dated 12/16/25 was reviewed and included no record that the facility had transmitted the required DRNA MDS to CMS for the 1/6/26 discharge. During an interview on 4/30/26 at 8:12 a.m., the assistant director of nursing/MDS coordinator (ADON) stated that R23's discharge MDS had been missed. The ADON stated that sometimes he would wait a few days to submit the discharge MDS to ensure the resident was not readmitted. The ADON stated he might have done this and then forgotten to complete the assessment. The ADON stated that it looks like a discharge return not anticipated MDS should have been completed. The facility's MDS 3.0 Assessment policy dated 8/20/24, indicated that a discharge assessment should be completed within 14 days of discharge.	F0640		06/12/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F0657	F0657 SS=D Resident R42's care plan was reviewed and updated to accurately reflect and match the resident's current ambulation and transfer status. To identify other residents potentially affected by the same deficient practice, the facility completed an audit of residents receiving restorative nursing services to ensure all care plans accurately reflected current resident status' and interventions. To prevent recurrence, education on policy, Restorative Nursing Program was provided to nursing staff regarding expectations for timely communication and updating of restorative programs, Kardex information, and care plans following changes in resident condition, participation, or functional status. The facility initiated a Restorative Nursing program Meeting weekly for review. The DON or designee will audit: 5 restorative nursing residents weekly for 4 weeks, then 5 restorative nursing residents monthly for 2 months	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0657 SS = D	Continued from page 7 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident's care plan was revised related to changes in ambulation status 1 of 1 resident (R42) reviewed for restorative nursing programs. Findings include: R42's quarterly Minimum Data Set dated 4/14/26 indicated R42 had moderate cognitive impairment and required partial to substantial assist with activities of daily living. It also indicated walking was not attempted during the assessment period. R42 had a diagnosis of progressive neurologic condition and was not on a range of motion or walking program. R42's care plan titled "risk for decline in ambulation" initiated 8/7/25, and revised 11/15/25, indicated R42 would ambulate 10-20 feet 3 times per week using a gait belt and front wheeled walker with an assist of 2 staff and wheelchair to follow. A mobility care plan revised 1/28/26, indicated R42 was non-ambulatory and required range of motion exercises twice daily. R42's self-care deficit care plan revised 4/7/26 indicated transfer with 2 assist and sit to stand mobility. R42's Kardex indicated R42 was non-ambulatory, required range of motion exercises twice daily, and was an assist of to for transfers with the sit to stand lift. R42's kardex also indicated to encourage and assist ambulating 10-20 feet with a front wheeled walker, gait belt, and staff assist of 2 three times per week. A progress note dated 1/28/26, indicated R42 had "gone back/forth with ambulating short distances and worked with therapy on multiple occasion. R42 reported she felt comfortable ambulating with therapy, but she doesn't trust her legs or knees enough to ambulate with staff." The progress note indicated R42 was educated and reassured that staff are fully trained in ambulation and therapy also verbally educated staff with R42 present, but	F0657	Continued from page 7 to ensure restorative programming, Kardex documentation, and care plans accurately reflect current resident status and interventions. Audit results will be reviewed through the facility's QAPI process, for additional recommendations and interventions, as needed. Completion Date: June 12, 2026	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0657 SS = D	Continued from page 8 resident still does not wish to ambulate with staff. The progress note indicated R42 would remain an assist of 1 with a sit to stand lift and would be “non-ambulatory going forward per her preference”. During an interview on 4/29/26 at 1:30 p.m., nursing assistant (NA)-A stated the floor staff were responsible for performing restorative nursing tasks. Tasks were listed in the “general charting” on the computer documentation screen. NA-A stated she had not worked with R42 for months but believed she was on a walking program. NA-a confirmed R42 had a range of motion program as well as an ambulation program. The ambulation program indicated “walk 10-20 feet with assist of 2 and wheelchair to follow. Transfer with sit to stand and assist of 2.” NA-A stated R42 sometimes struggled with straightening her legs in the sit to stand so she “can’t imagine [R42] walks.” During in interview on 4/29/26 at 1:38 p.m., NA-B stated R42 did “fairly well” with ambulation for a while but started refusing sometime late December 2025/January 2026. During an interview on 4/29/26 at 4:13 p.m., the facility therapy director (TD) stated when residents finished with therapy, recommendations for restorative exercises were given to the restorative nurse to implement with the nursing staff. If a resident was not participating in the restorative program, nursing staff usually let them know during morning meetings so they could evaluate and adjust the program. The TD stated R42’s restorative recommendations were ambulation of 10-20 feet with a friend wheeled walker and assist of 2 with a wheelchair to follow. The TD stated they were not made aware of any changes to R42’s level of participation in the restorative exercises. During an interview on 4/30/26 at 8:41 a.m., the restorative nurse stated therapy wrote the restorative programs for residents and he implemented the programs. If a resident was not participating in the program as expected, he would speak to the therapy department to get recommendations. The restorative nurse stated he would expect to be notified if a resident was unable to perform the exercises or staff were unable to get them done, however the “communication is not always the greatest.” The restorative nurse confirmed R42 was on a restorative program previously however was not currently on	F0657		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0657 SS = D	Continued from page 9 one due to her refusal to participate. The restorative nurse stated he realized on 4/29/26, R42's restorative program was still an active task for completion and confirmed it should have been removed when R42's program was discontinued. The restorative nurse stated R42 has not been ambulating and felt staff "just checked the task as completed without reading what it was." During a follow-up interview, the restorative nurse confirmed the nurse manager was responsible for updating the mobility care plan, however he was responsible for updating any restorative care plans. During an interview on 4/30/26 at 9:27 a.m., registered nurse (RN)-A stated R42 has a history of going back and forth with her participation in her ambulation program. R42 did well until the end of January 2026 when she started refusing again. R42 stated told RN-A she felt comfortable walking with therapy however did not feel safe with the nursing staff. RN-A stated they provided reassurance to R42 the staff were properly trained for ambulation including in person instruction in R42's presence. RN-A stated she personally offered to assist R42 with her ambulation program, however she continued to refuse so her ambulation program was discontinued at that time. R42 has had some recent weight gain causing increased pain in her knees so she is currently an assist of 2 with a sit to stand however remains non-ambulatory. RN-A stated she updated the mobility care plan however the restorative nurse was responsible for updating the restorative care plan. RN-A confirmed R42 still had an active restorative care plan indicating an ambulation program in place. During an interview on 4/20/26 at 10:14 a.m., The director of nursing confirmed she would expect any changes related to resident's care be reflected in the care plan. A policy titled "Person Centered care Planning" revised 4/20/23, indicated the facility will "develop a comprehensive person-centered careplan with the resident and/or family representative for each resident consistent with the resident's rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the resident's comprehensive assessment." The policy also indicated careplans are updated on an ongoing basis as need based on changes that occur between care conferences.	F0657		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245250	A. BUILDING **01 - MAIN BUILD...** B. WING	**05/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on May 1, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Trinity Care Center, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		05/05/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Building Info: TRINITY CARE CENTER – BLDG 01 is a 1-story building with partial basement under the 2007 addition. The building was constructed at 4 different times. The original building was constructed in 1967 and was determined to be of Type II (222) construction. In 1972, addition was constructed to the South Wing that was determined to be of Type II (222) construction. In 1995, another addition was constructed to the West Wing that was determined to be of Type II (111) construction. The 2008 addition is a 1-story building with a partial basement. and was determined to be of Type II(222) construction. Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The facility is fully protected throughout by an	K0000		05/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	Continued from page 2 automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 66 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		05/05/2026
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect the cooking ventilation system in accordance with the NFPA 96. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 05/1/2026, at 11:55 AM, observations and staff interview revealed that the kitchen hood filters were not properly sealed leaving a 1/4" gap between the	K0324	K0324 SS=F As a remedy and with approval from the State Fire Marshal, the facility purchased and installed a stainless-steel strip to reduce the ¼-inch gaps between the kitchen hood filters to ⅛-inch or less in accordance with NFPA 96. The Maintenance Director verified proper installation and compliance following completion of the repair. To prevent recurrence, the kitchen hood system will be added to the facility's routine environmental and life safety inspection rounds. Any identified concerns will be corrected promptly. The Maintenance Director or designee will monitor ongoing compliance through monthly environmental rounds and documentation review. Completion Date: May 15, 2026	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0324 SS = F Bldg. 01	Continued from page 3 filters.. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0324		05/15/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, and NFPA 110 (2010 edition) section 8.3.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K0918	K0918 SS=F The facility purchased a conductance tester to ensure generator batteries are tested in accordance with NFPA 99 and 110 requirements. Monthly battery conductance testing will be completed in conjunction with the required monthly generator load test. To ensure ongoing compliance, this testing requirement has been added to the facility's TELS preventive maintenance program and monthly maintenance checklist. The Maintenance Director or designee will be responsible for completing, documenting, and reviewing monthly testing to ensure continued compliance. Completion Date: May 15, 2026	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0918 SS = F Bldg. 01	Continued from page 4 On 5/1/2026, at 11:10 AM, it was revealed by a review of available documentation, the facility was not testing the batteries for the Emergency Generators for specific gravity or conductance. Facility was using the LCD screen reading for this. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0918		05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245250	A. BUILDING **03 - TRINITY CC** B. WING	**05/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 03	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on May 1, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Trinity Care Center, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		05/05/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING **03 - TRINITY CC** B. WING	(X3) DATE SURVEY COMPLETED **05/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 03	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Building Info: Trinity Care Cross Roads addition (Building 4)is a 20 bed unit that is connected to an existing building. This unit is separated with a 2 hour firewall, connected to the existing sprinkler system and fire alarm system for full coverage. This unit is Type II (000) construction. The facility has a capacity of 70 beds and had a census of 66 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		05/05/2026
K0918 SS = F Bldg. 03	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K0918	K0918 SS=F The facility purchased a conductance tester to ensure generator batteries are tested in accordance with NFPA 99 and 110 requirements. Monthly battery	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING **03 - TRINITY CC** B. WING	(X3) DATE SURVEY COMPLETED **05/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0918 SS = F Bldg. 03	Continued from page 2 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, and NFPA 110 (2010 edition) section 8.3.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 5/1/2026, at 11:10 AM, it was revealed by a review of available documentation, the facility was not testing the batteries for the Emergency Generators for specific gravity or conductance. Facility was using the LCD screen reading for this An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0918	Continued from page 2 conductance testing will be completed in conjunction with the required monthly generator load test. To ensure ongoing compliance, this testing requirement has been added to the facility's TELS preventive maintenance program and monthly maintenance checklist. The Maintenance Director or designee will be responsible for completing, documenting, and reviewing monthly testing to ensure continued compliance. Completion Date: May 15, 2026	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245250	A. BUILDING **04 - Building 4** B. WING	**05/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 04	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on May 1, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Trinity Care Center, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		05/05/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING **04 - Building 4** B. WING	(X3) DATE SURVEY COMPLETED **05/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 04	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Building Info: TRINITY CARE CENTER – BLDG 03 is a 1-story building with partial basement. The facility was constructed in 2018 and was determined to be of Type II (000) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 66 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		05/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING **04 - Building 4** B. WING	(X3) DATE SURVEY COMPLETED **05/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0918 SS = F Bldg. 04	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, and NFPA 110 (2010 edition) section 8.3.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 5/1/2026, at 11:10 AM, it was revealed by a review of available documentation, the facility was not testing the batteries for the Emergency Generators for specific gravity or conductance. Facility was using the LCD screen reading for this	K0918	K0918 SS=F The facility purchased a conductance tester to ensure generator batteries are tested in accordance with NFPA 99 and 110 requirements. Monthly battery conductance testing will be completed in conjunction with the required monthly generator load test. To ensure ongoing compliance, this testing requirement has been added to the facility's TELS preventive maintenance program and monthly maintenance checklist. The Maintenance Director or designee will be responsible for completing, documenting, and reviewing monthly testing to ensure continued compliance. Completion Date: May 15, 2026	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING **04 - Building 4** B. WING	(X3) DATE SURVEY COMPLETED **05/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	**905 ELM STREET , FARMINGTON, Minnesota, 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0918 SS = F Bldg. 04	Continued from page 3 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0918		05/15/2026

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 18, 2026

Administrator
Trinity Care Center
905 ELM STREET
FARMINGTON, MN 55024

RE: CCN: 245250
Cycle Start Date: April 30, 2026

Dear Administrator:

On June 16, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us