DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3Y32

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00365

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245315**

2.STATE VENDOR OR MEDICAID NO.
(L2) **541743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRIMONT HEALTH CARE CENTER**
(L4) **303 BROADWAY AVENUE SOUTH**
(L5) **TRIMONT, MN** (L6) **56176**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/12/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **31** (L18)

13.Total Certified Beds **31** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	31			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 07/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 09/08/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
06/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/29/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5315

On May 22, 2017 a survey was completed at this facility. Conditions in the facility constituted Immediate Jeopardy. The most serious deficiencies were issued at a S/S level of L (441).

The IJ began on May 5, 2017, was identified by survey staff on May 19, 2017 at 2:30 p.m. and was removed on May 21, 2017, at 12:30 p.m.

As a result of the survey findings, state monitoring was imposed effective June 13, 2017. In addition, we recommended to the CMS RO the following remedy for imposition and CMS concurred:

- Civil money penalty for deficiency cited at F441

On July 12, 2017 the Minnesota Department of Health and on July 5, 2017 the Minnesota Department of Public Safety conducted PCR's and found the facility to be in substantial compliance effective June 26, 2017.

As a result of the findings, the Department discontinued the Category 1 remedy of state monitoring effective June 26, 2017.

In addition, we recommended the following action to the CMS RO and CMS concurred:

- Civil money penalty for deficiency cited at F441.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245315 July 26, 2017

Ms. Patrice Goette, Administrator
Trimont Health Care Center
303 Broadway Avenue South
Trimont, MN 56176

Dear Ms. Goette:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 26, 2017 the above facility is certified for:

31 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 26, 2017

Ms. Patrice Goette, Administrator
Trimont Health Care Center
303 Broadway Avenue South
Trimont, MN 56176

RE: Project Number S5315026

Dear Ms. Goette:

On June 8, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective June 13, 2017. (42 CFR 488.422)

Also, on June 8, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at K441. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on May 22, 2017. The most serious deficiency was found to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required.

On July 12, 2017, the Minnesota Department of Health completed a Post Certification Revisit and on July 5, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 22, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 26, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 22, 2017, as of June 26, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 26, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalty for the deficiency cited at F441. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3Y32

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00365

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245315**

2. STATE VENDOR OR MEDICAID NO. (L2) **541743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRIMONT HEALTH CARE CENTER**
(L4) **303 BROADWAY AVENUE SOUTH**
(L5) **TRIMONT, MN** (L6) **56176**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/22/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **36** (L18)

13.Total Certified Beds **36** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date : 06/19/2017 (L19)
Susan Kalis, HFE NE II

18. STATE SURVEY AGENCY APPROVAL Date: 06/27/2017 (L20)
Kamala Fiske-Downing, Enforcement Specialist

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **06/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health on May 15, 16, 17, 18, 19, 21, & 22, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F441 related to the facility's failed response to implement effective infection control procedures for a resident diagnosed with Clostridium Difficile in order to prevent transmission of to others, which resulted in the high potential for harm or death. The IJ began on 5/5/17, was identified by survey staff on 5/19/17 at 2:30 p.m., and was removed on 5/21/17, at 12:30 p.m., after it could be verified the facility had implemented a removal plan. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint #H5315006 was completed. The complaint was unsubstantiated.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 157		6/21/17

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

Electronically Signed | 06/16/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	**303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176**

(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
F 157	Continued From page 1 consistent with his or her authority, the resident 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.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 157	Continued From page 2 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to notify the physician with ongoing detailed information and assessment data involving the treatment of infectious disease for 1 of 2 residents (R22) reviewed for notification of changes. In addition, the facility failed to ensure the physician was informed of a change in wound care dressing for 1 of 1 resident (R4) reviewed with a wound care dressing. Findings include: R22's face sheet dated 5/18/17, revealed she was admitted on 3/20/17 with diagnoses of gastrointestinal hemorrhage and inability to care for herself, mild cognitive impairment, high blood pressure, congestive heart failure (CHF) and atrial fibrillation (heart rhythm abnormality). Review of the medical record for R22 revealed she began experiencing loose stools on 4/30/17. On 5/3/17, a fax was sent to her primary physician (A) requesting a reply for medication and treatment orders. That same day, MD-A replied back to obtain a stool sample to check for pathogens and a basic metabolic panel (laboratory [lab] blood test). Stool and blood samples were obtained, and sent to the lab for analyses. Nursing progress note dated 5/5/16, indicated R22 was diagnosed with Clostridium difficile	F 157	Corrective action for R22 - physician visited on 5/18/2017 and rounded with charge nurse, reviewed resident chart and ordered comfort cares. The charge nurse faxed the physician on 5/22/2017 to update on R22's condition including lab values, vitals, edema status, loose stools and isolation status. On 5/23/2017 the charge nurse called to notify physician of condition change. On 5/25/2017 the physician was called and received telephone orders regarding medication changes, to cancel lab draw and evaluate for hospice and follow comfort orders. On 5/26/2017 the physician was notified of residents' death and received telephone order to release body to funeral home. Corrective action for R4 - on 5/18/2017 the charge nurse faxed and telephoned the physician to clarify physicians response regarding wound care nurse order. Received clarification and implemented physician order. No other residents were affected by this practice as evident by no resident condition changes needed to be reported to a physician during this time. On 5/25/2017 Physician Order policy and procedure was updated. A nursing department meeting was held on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 157	Continued From page 3 (C-diff) (highly infectious, intestinal bacteria). MD-A ordered Flagyl (antibiotic) and also Zithromax (antibiotic) for Shiga toxin--producing E. coli (highly infectious intestinal bacteria) that day. An emergency room progress note dated 5/6/17, indicated R22 was transported to the emergency room (ER) at the family's request for decreased level of consciousness (mental alertness) and low blood pressure. At that time, the ER evaluated her lab results. The on-call physician for MD-A was updated on her health status. Complete diagnoses at that time were Colitis C-diff, dehydration, and diarrhea. R22 was discharged back to the facility with instructions to follow up with the primary physician for continuity of care. Review of the nursing notes and physician fax correspondence, documented from 5/8/17 to 5/18/17 revealed the following entries: -On 5/8/17 R22 was alert to self only and had difficulty communicating her needs. She was not using her call light. Her speech was mumbled and difficult to understand. She had a large incontinent loose stool, orange in color and was experiencing a loose, non-productive cough. At 7:45 a.m., R22 developed a large 10 centimeter (cm) "rash like area on her left scapula." She denied pain. Nursing wrote they would continue to monitor. No mention of notification to the physician was documented at that time. At 12:43 p.m., notes documented showed "States she is feeling better, cont. [continue] to be weak, stayed in bed all shift, denies pain. Appetite is poor, refuses to eat, took juice only. Will answer to name. Told TMA [nurse aide] she will be dying today. VS [vital signs] 95.8 [Temperature], 94	F 157	5/26/2017 - the DON reviewed the need to communicate with resident physicians regarding changes in resident conditions timely and that information needs to be complete to provide the physician with a clear and accurate picture of the residents condition. A staff meeting is scheduled for 6/21/2017 - nursing staff will receive further education on Policy and Procedure regarding notification of physicians regarding resident condition changes. Audits are in place to be completed by the charge nurse or DON when physicians round at the facility to verify that the physicians feel they have received appropriate communication regarding their residents. An audit was completed on 5/30/2017 and 6/15/2017 during physician rounds. Also, letters were sent to non-rounding physicians on 6/2/2017 inquiring of any concerns they may have regarding communication of their residents healthcare conditions. All audits and responses to letters sent will be reviewed by the DON and discussed at Quarterly QA Meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 157	Continued From page 4	F 157		

[Pulse], 24 [Breathing Rate], 78/58 [Blood pressure], sats [Oxygen level in blood] 93% with 02 [Oxygen] at 3 LPM [liters per minute]. Fax sent to MD regarding low BP's."

-A faxed correspondence to MD-A, dated 5/8/17 revealed the only information from the above assessment that had been relayed to the physician on the fax was the low blood pressures recorded. There was no mention of R22's previously noted rash, current weakness, having been bed bound, her decreased appetite, thoughts of dying that day, low temperature, high breathing rate, or the need for oxygen therapy. The faxed note read: "Resident has been having low BP's throughout the weekend into today. She takes metoprolol (used for blood pressure and congestive heart failure) 25 mg daily. BP's ... May we have a perimeter guideline for administration of meds [medications]? May we hold if BP too low? Please advise." MD-A, given only that information, wrote an order back to decrease her metoprolol to 12.5 mg by mouth daily.

-On 5/9/17, at 7:41 a.m. staff documented R22 had a wakeful night and had been up out of bed every hour. "Found walking about with walker most of the time undressed." Had one medium incontinent BM, orange in color. She was noted to have a non- productive cough and was receiving oxygen at 2 LPM. Her sats were at 94%.

-On 5/9/17 at 10:30 a.m., R22's intake varied due to how she felt at meal times. Staff noted they were going to continue with current approaches.

-On 5/10/17, R22 continued to have the rash on her back. She had a reddened peri (private)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 157	Continued From page 5	F 157		

area, and had one large incontinent loose BM that shift. Peri care was provided by staff and a barrier cream applied to the resident's private areas.

-On 5/11/17, staff noted the resident was up and about her room with no complaints. However, shortness of breath with exertion was documented. She was also noted to have "large pockets of fluids raiding (sic) [radiating] throughout left arm and a bruise to antecubital fossa [inner arm] from IV insertion. Denies pain. Appears quite confused as well. BP 112/62 [milligrams of mercury (mm/mg)] today. Resident incontinent of loose BM x 1 today. Appetite continues to be poor, resting quietly at this time." There was no mention of MD-A being updated on the changing condition of R22, with the newly developed fluid pockets in her arm or the continued poor appetite.

-On 5/13/17, at 4:04 a.m., staff documented R22 had once more been wakeful that shift and very confused. She had one incontinent loose stool. At 10:23 a.m., staff documented R22 was continent of bowels but wore a brief related to (r/t) dribbling. Her appetite was described as fair. The nurse practitioner (NP) had been contacted related to the Lasix (diuretic) after a lab draw. That NP ordered Lasix at 20 mg every day and to be reviewed again on 5/16/17. There was no documentation the NP was ever made aware of any of the above previously unmentioned information at that time.

-On 5/14/17, MD-A was contacted at 11:30 a.m. about increased bilateral edema (swelling). He stated to discontinue the Lasix 20 mg daily and Restart the Lasix 80 mg daily and recheck lab

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 157	Continued From page 6	F 157		

values on 5/18/17. There was no mention the physician had been informed of anything other than the edema at that time.

-On 5/15/17 at 11:45 p.m. documentation read "This morning reported that resident isolation precaution was d/c [discontinued]." At 11:45 p.m., documentation showed isolation precautions resume r/t diarrhea continued. Large amount of blood in stool with blood clots. MD-A was notified by fax.

-On 5/15/16, a fax was sent to MD-A at 10:48 p.m.. Documentation of that fax showed "Status update: Resident continues with diarrhea. Also noted lg [large] assessment of blood rectal and blood clots. Isolation precautions continue. Resident denies pain or discomfort. Please advise. Thank you." The physician responded back on that same fax on 5/16/17 at 4:04 p.m. with "Check CBC [lab test] and provide comfort." There was no further assessment data included on the form of any vital signs or other pertinent data. Nursing staff had also not included details of R22's history upon her admission to the facility of a gastrointestinal bleed.

-On 5/16/17, at 10:41 a.m., staff documented R22 had no complaints but was noted to experience shortness of breath on exertion.. She again had another loose stool and was not able to hold it in and had an accident in her clothing. Her appetite continued to be poor. She was in protective isolation and needed help with her activities of daily living (ADLs). Her lower legs were "2+ edema filled." There was no mention in the documentation R22's continued poor appetite notification was given to the provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 157	Continued From page 7 During interview on 5/18/17, at 11:05 a.m. with MD-A regarding the care and treatment for R22 revealed when he was asked whether notified by staff of R22 continued illness and had been kept informed, he stated "No, I don't." He felt he wasn't updated if she was still on her medication, or if she had any symptoms prior [to her C-diff a Shigatoxin diagnosis] or if anything [regarding her care] had worsened. MD-A indicated he was not notified with enough information. R4 R4's face sheet dated 5/18/17 revealed diagnoses of hemiplegia and hemiparesis (paralysis on one half and one side of the body), epilepsy, stroke, and dermatitis. R4's treatment orders, dated 4/17 indicated he had a treatment order on 4/3/17 for a dressing change with an oil emulsion gauze wrap every day, for protection. That was applied to the front of his right leg. During observation on 5/15/17, at 6:00 p.m. it was noted that R4 had numerous scabbed areas to both lower legs which were loosely wrapped in gauze and bandages at that time. Review of R4's physician order dated 5/17/17, indicated the wound care nurse visited the facility and made a recommendation to change R4's dressing from an oil emulsion dressing to a dry dressing. During interview and review of R4's physician's orders on 5/18/2017, at 1:43 p.m. with licensed practical nurse (LPN)-A revealed R4 did have an oil emulsion dressing. LPN-A stated the wound care nurse just saw R4 recently and	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 157	Continued From page 8 recommended changing the course of treatment to a dry, protective dressing. When asked what dressing staff were using currently she stated they (nursing staff) are using a foam pad and kerlix per the wound care nurse's recommendations. She stated the doctor was in the facility on rounds on 5/17/17, and made a note of it on his orders. In reviewing the notes with LPN-A, she stated she assumed the physician would want to follow the wound nurses recommendation. However, documentation entered by the physician noted "No changes to treatment." LPN-A stated she was unsure if that documentation reference the other orders or all orders. LPN-A agreed nursing staff had initiated a change in R4's treatment without clarification from the physician and physician order. During interview on 5/18/17, at 1:50 p.m. with the administrator regarding R4's treatment order revealed she expected nurses to follow doctors orders and to clarify an order if they were unsure prior to initiating it. "They screwed up." Review of the facilities 9/29/08, RN Charge Nurse policy revealed nursing staff were to have the ability to administer treatments according to physician's orders as well as make recommendations to the physician when improvement is lacking and document all measures in the medical record.	F 157		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:	F 280		5/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 280	Continued From page 9 (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be-	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 280	Continued From page 10 (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. (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 record review the facility failed to revise the plan of care to include seizure and bleeding precautions for 1 of 5 residents (R4), reviewed for unnecessary medications.	F 280	Corrective action for R4 - on 5/22/2017 the residents care plan was updated by the MDS Coordinator to reflect bleeding and seizure precautions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 280	Continued From page 11 Findings include: R4's face sheet dated 5/18/17 revealed diagnoses of hemiplegia and hemiparesis (paralysis on one half and one side of the body), epilepsy, a history of stroke. R4's quarterly Minimum Data Set (MDS) assessment, dated 3/28/17, revealed a diagnosis of epilepsy, and use of an anticoagulant. R4's medication orders, dated 5/17 included warfarin (anticoagulant medication) and Depakote (anti-seizure medication). Review of R4's current care plan located in the electronic medical record (EMR), undated, had no preventative measures in place for safety related to his diagnosis of epilepsy or any mention of bleeding precautions needed related to his warfarin use. The plan of care identified R4 as a fall risk but lacked any precautions related to his epilepsy and/or increased risk of bleeding. During interview and care plan review on 5/19/17, at 1:43 p.m. the director of nursing (DON) revealed there were no measures identified on the care plan related to his warfarin treatment nor history of epilepsy. The DON indicated the MDS coordinator was the only designated staff who update and/or revise the care plan at any time; stating it was updated at the time of the resident's MDS assessments. The DON explained that other nursing staff do not regularly update the care plan. Review of the policy dated 7/5/16, Care Planning Process policy revealed the facility must develop	F 280	To identify other residents having the potential to be affected - the MDS Coordinator and DON on 5/22/2107 ran a report off of Matix to identify other residents with a seizure and/or hx of seizure diagnosis and reviewed medication lists for every resident taking anticoagulants - changes/updates completed as needed at that time. Care plans are currently reviewed with weekly charting by the charge nurse. At the nursing staff meeting held on 5/26/2017, the DON reviewed the process of care plan review and updating with the weekly charting. The MDS Coordinator and DON will complete weekly audits to verify that care plans are being reviewed/updated with the weekly charting. Audits will be discussed at the Quarterly QA Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 280	Continued From page 12 a comprehensive care plan for each resident's medical needs that are identified in the MDS assessment.	F 280		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered	F 309		5/26/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 309	Continued From page 13 care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor bruising for 1 of 3 residents (R20) reviewed for non-pressure related skin conditions. Findings include: Review of R20's diagnosis located on the face sheet in the medical record included: long term use of aspirin and dementia. On 5/17/17, at 7:16 a.m. R20 was observed to have several dark bluish bruises on the top of the right hand that were the size of a dime in diameter. The top of the left hand had a large bruise that covered most of her hand that was dark bluish in color. Both inner/outer lower arms also were observed to have a large bruise that was yellowish in color. The resident was unable to verbalize how she obtained the bruises due to her impaired cognition. Review of the quarterly Minimum Data Set (MDS) assessment dated 4/4/17, identified R20 as having severely impaired cognition and requiring supervision of 1 staff with mobility. Review of the current plan of care for R20 did not include the residents skin/bruising. Review of R20's current physician orders indicated R20 was receiving Aspirin 81 mg daily. Review of the bath sheet dated 5/15/17, identified R20 as having several bruises to the	F 309	Corrective action for R20 - on 5/17/2017 a skin sheet was completed - bruises were measured and documented - incident report completed and physician, family, administrator and DON notified and documented in the nurses notes. Follow up was completed on 5/27/2017, a skin assessment was completed due to resolved bruises. To identify other residents potentially being affected by this deficient practice - skin assessments are completed on resident bath days to identify skin issues. Any skin issues identified are documented, physicians notified, treatment provide per physician orders and follow-up completed per policy and procedure. On 5/26/2017 all licensed nurses were re-educated on policy and procedure skin assessments and completion of reports. Also on 5/26/2017 all nursing assistants were re-educated on their role of reporting skin issues that they observe. DON to review incident reports for appropriate interventions and care plan changes and discuss at daily stand up meetings with IDT. Incident reports are being audited by the Administrator for completion of report.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 309	Continued From page 14 tops of both hands. No measurements or description of the bruises had been documented. Review of the progress notes for R20 over the past 2 weeks did not include identified skin concerns/bruising. Interview with nursing assistant (NA)-A on 5/17/17, at 8:30 a.m. indicated R20 has several bruises on both hands and lower arms that was observed during the residents bath on 5/15/17. NA-A further included she reported R20's bruises to the charge nurse and documented them on the weekly bath sheet. Interview with licensed practical nurse (LPN)-A on 5/17/17, at 12:42 p.m. indicated she was unaware of R20's bruises on her hands and lower arms. LPN-A included R20 will occasionally obtain bruises to her hands/arms that come and go but could not confirm the causal factors. LPN-A confirmed a skin assessment had not been completed for the current bruises. Interview with NA-B on 5/18/17, at 9:30 a.m. indicated she was aware of R20's bruises to her hands and lower arms. NA-B further revealed R20 has had these bruises for the past week and thought the charge nurses were aware of the bruises. On 5/18/17, at 10:25 a.m. LPN-A was observed to measure R20's bruises. Eight dark bluish bruises on the top of the right hand measured 1.0 centimeters (cm) each in diameter. A large yellowish bruise on the outer lower right arm measured 5 inches in diameter. A large dark bluish bruise on the top of the left hand measured 5 inches in diameter and a large yellowish bruise	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 309	Continued From page 15 on the inner lower left arm that measured 5 inches in diameter. Interview with the director of nursing (DON) on 5/18/17, at 1:00 p.m. indicated the staff should have been monitoring R20's bruises when they were identified, and more importantly with multiple/large areas. The DON further included the facility policy should have been followed when the bruises were first identified. Review of the facility policy Bruises dated 8/30/07, included a procedure for identified bruises. 1) when a bruise is identified it will be reported to the charge nurse to evaluate the size and location. If the bruise is less than 3.0 cm the bruise will be charted in the nurses notes and re-evaluated as needed; 2) when the bruise is greater than 3.0 cm the charge nurse will initiate and investigation to the cause and an incident report and wound sheet will be completed to include monitoring of the size, shape, color and healing weekly; 3) staff will be educated regarding prevention and techniques for prevention of bruising.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 309	Continued From page 16	F 309		
F 431 SS=E	.... 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is	F 431		5/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 431	Continued From page 17 maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify on multi-dose eye drop medication bottles and insulin pens the date opened so the expiration date could be monitored for 5 of 5 residents (R2, R5, R15, R20, R34) reviewed on the only medication cart used in the facility. Findings include: On 5/16/17, at 12:00 p.m. the medication cart	F 431	Corrective action for residents identified - R2, R5, R15, R20 and R34 - all expired eye drop medication and insulin were discarded on 5/16/2017 and new medications ordered from pharmacy. To identify other residents having the potential to be affected, all medications were reviewed for correct dating/labeling and those medications not dated/labeled were discarded and new medications	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 431	Continued From page 18 was inspected with licensed practical nurse (LPN)-A and the following was noted: (1) The eye drop medication Latanoprost (anti-glaucoma) for R20 had a date filled of 10/14/16; however it lacked a date identifying when the bottle was opened. When interviewed at this time, LPN-A verified the bottle should have the date identified on the bottle when opened. Review of R20's medication administration record (MAR) noted R20 had been receiving this medication once daily. (2) The eye drop medications dorzolamide (anti-glaucoma) and Lumigan (anti-glaucoma) for R15 both had a date filled of 1/23/17; however they lacked a date identifying when the bottles were opened. During interview at this time, LPN-A verified the bottles should have the date when opened identified, and confirmed these bottles were being used for R15's medication adminsitration. (3) A Humulin N insulin pen for R2 was noted to have been filled on 4/2/17; however, the insulin pen had no date identified on the pen when it was opened. LPN-A verified the pen had been used during medication administration and disposed of it at this time indicating without a date open it should not be used. The manufacturer's instruction indicated storage of opened (in use) Humulin N insulin pens be stored at room temperature and used within 14 days. (4) The eye drop medication Systane (artificial tear) for R5 had a date filled of 7/18/16; however lacked a date identifying when the bottle was opened.	F 431	ordered from the pharmacy and delivered on 5/17/2017. At the nursing staff department meeting on 5/26/2017, education was provided by the DON regarding dating/labeling medications. Also implemented consulting pharmacist Opthalmic Expiration Date Guideline. A medication labeling policy and procedure was created on 5/30/2017 and provided to the nurses. Audits will be completed weekly by the charge nurse and reviewed by the DON and discussed at the Quarterly QA meeting. The first audit was completed on 5/25/2017 for eye drop medications and insulin pens.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 431	Continued From page 19 (5) The eye drop medication Refresh tears (artificial tear) for R34 was noted to have been filled on 1/18/17; however it too lacked a date identifying when the bottle was opened. During interview on 5/16/17, at 12:17 p.m. LPN-A stated "we've gotten lax with labeling date opens", and verified all insulin's and eye drops are to be labeled with date opened. During interview on 5/17/17, at 8:56 a.m. the director of nursing (DON) indicated facility staff followed guidance as posted on medication wall for medication expiration dates once opened. The DON verified the opened Latanoprost may only be stored at room temperature for 6 weeks and Humulin N pens must be discarded 2 weeks after first use as indicated on posted guidance. When interviewed on 5/17/17, at 1:12 p.m. the DON verified her expectation is all eye drops and insulin's are labeled with date opened as this was "nursing common sense" and confirmed all medications had been removed from cart. During interview on 5/18/17, at 2:15 p.m. the consultant pharmacist verified without a date open on eye drop bottles and insulin, the medications were past their shelf life and further confirmed multidose bottles and insulin should be dated when opened.	F 431		
F 441 SS=L	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 441		6/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 20 a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 21 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff utilized proper infection control practices to prevent and control the transmission of a highly infectious spore forming bacterium (Clostridium Difficile, otherwise known as C-diff) when caring for 1 of 1 resident (R22) who had a known case of this bacterium. This resulted in an Immediate Jeopardy (IJ) with the potential for serious harm, injury or death for the other 21 residents (R1, R2, R4, R5, R7, R8, R11, R14, R15, R16, R18, R20, R21, R23, R25, R31, R33, R34, R36, R37 & R38) who currently reside in the facility. The Immediate Jeopardy (IJ) began on 5/5/17, when R22 was diagnosed with C-diff was placed on contact precautions. The administrator and	F 441	Corrective action accomplished for all resident found to have been affected by the deficient practice - on 5/19/2017 the DON educated all staff on duty on donning proper PPE prior to entering R20 room (isolation room), discarding all disposable kitchen utensils or items into designated red biohazard garbage bag, removing disposable or washable PPE and discarding into designated red biohazard laundry bag and washing hands with soap and water for 15 seconds or greater prior to exiting resident room. All other employees from all departments were contacted via phone to be educated regarding the above procedures. All staff as they reported to work reported to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 22 director of nursing (DON) were notified of the IJ situation on 5/19/17, at 2:30 p.m. The IJ was removed on 5/21/17, at 12:30 p.m., but non-compliance remained at the lower scope and severity level of (F) widespread with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: R22's admission documents and Resident Face Sheet, indicated R22 had been admitted to the facility on 3/20/17 The Resident Face Sheet identified admitting diagnoses to include: gastrointestinal hemorrhage, inability to care for self, mild cognitive impairment, high blood pressure, congestive heart failure (CHF) and atrial fibrillation (heart rhythm abnormality). Further review of R22's medical record revealed she began experiencing loose stools on 4/30/17. On 5/3/17, a fax was sent to her primary physician (MD-A) requesting medication and treatment orders. MD-A had responded requesting a stool sample be obtained to check for pathogens. According to the record, stool and blood samples were obtained on 5/4/17 and sent for analysis. A nursing progress note dated 5/5/17, documented that R22 was diagnosed with C-diff and MD-A had ordered Flagyl (antibiotic) and Zithromax (also an antibiotic) for Shiga toxin-producing E. coli (highly infectious intestinal bacteria) on 5/5/17. According to the progress notes, R22 was transferred to the emergency room (ER) on 5/6/17, at 11:00 p.m. due to staff concern that R22 was becoming septic (a potential life-threatening systemic infection).	F 441	charge nurse for a demonstration of the proper technique of the above procedures. Each employee was instructed/educated on the appropriate infection control practices and signed off on a sheet indicating they received the information. In order to eliminate cross contamination, the isolated resident was provided complete bed baths in her room. The shower room was disinfected on 5/17/2017 with the appropriate disinfectant. Housekeeping went into the isolation room and cleaned with Diffense - a multipurpose, broad spectrum cleaner disinfectant with bleach. Designated equipment and cleaner to clean the isolation room was set up and staff were instructed on its use on 5/17/2017. In the dietary department, the kitchen area, the dishwasher and all dishes were disinfected with 1 cup bleach with 9 cups water (1:10). Disposable dishes and utensils were used in the isolation room and disposed of prior to exiting as of 5/17/2017. To clean the washer in the laundry department, our chemical rep came and made a new isolation chemical formula of bleach and liquid laundry plus and programed it into the machine. After the isolation items were washed another washer cycle ran empty with the solution. On 5/19/2017 disposable gowns were stocked in chemical cabinet for use with red bag laundry. Wash cycle was adjusted to a cycle that is recommended for c-diff. Red bag wash cycle was updated on wash cycle setting sheet. On 5/20/2017 laundry aides were educated on the updated red bag wash cycle and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 23 Documentation from the ER indicated their staff had evaluated lab results. There was no documentation indicating the facility had communicated to the ER the amount of fecal stooling R22 had been experiencing prior to the ER visit. The ER discharge diagnoses included: Colitis, C-diff, dehydration, and diarrhea. In addition notes indicated an on-call physician for MD-A was updated on R22's health status. Review of nursing notes revealed the following entries: 5/8/17-large incontinent loose stool, orange in color; 5/9-out of bed every hour, medium incontinent BM; 5/10-one large incontinent loose BM this shift; 5/11-large incontinent BM; 5/13-one large incontinent loose stool; 5/15-continues with diarrhea; and 5/16/17-again had another loose stool, was not able to hold it in and had an accident in her clothing. Review of R22's current (undated) care plan from the electronic medical record (EMR), revealed R22 required assist of one or two staff with toileting. The care plan did not include the current diagnoses of C-diff and/or Shiga, nor were interventions identified related to the care and management of these infections. The facility did not make a paper version of the care plan available during the survey. During the initial tour on 5/15/17 at 5:40 p.m., a sign was observed posted on R22's room indicating visitors were to check with the nurse before entering. In addition an isolation cart was noted in the hallway outside R22's room. At that time, RN-A stated R22 had recently been diagnosed with C-Diff and Shiga infections, but had been taken off isolation yesterday. RN-A	F 441	the updated setting sheet. Explained that a higher amount of bleach will be used in this cycle for our red bag laundry. Staff was instructed to wear disposable PPE when handling red bag laundry and that a supply of disposable gowns are in the chemical cabinet and also stocked in the basement storeroom. A red biohazard garbage bin is whereto dispose of the PPE when finished. On 5/19/2017 housekeeping isolation cleaning kit was updated with DIffense to clean and disinfect room 104. Instruction sheet was written and placed in the kit. Kit is stored in the housekeeping closet. On 5/20/2017 housekeeping staff were instructed on the use of Diffense and the 8 minute period. Timers have been placed on the housekeeping carts to use. Diffense is stocked in the basement storeroom. Housekeeping staff were instructed on how to mop an isolation room floor and what supplies to use, how to use PPE, where and how to dispose of it. Stressed to housekeeping staff that clean PPE is to be used when taking red bag garbage to shed for disposing and where to place the red bag garbage and hand hygiene. On 5/19/2017 dietary staff for the pm shift that evening were instructed to use disposable containers for all food and beverages going into the isolation room. The isolation room has a cart outside the room that dietary will deliver the meal and will notify nursing when the tray is ready to deliver for nursing to take into the room. Dietary staff were instructed on the use of Diffense chemical. Dishwasher sanitizer was set at 200ppm by maintenance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 24 said staff had not yet had the chance to remove the signage or the cart. During observation on 5/16/17, at 10:30 a.m. the isolation cart remained outside R22's room and the signage on the door was still present. LPN-B was interviewed at that time and stated R22 had been taken off isolation for a few hours, but because R22 had become symptomatic with diarrhea again when staff had resumed the isolation precautions. Documentation did not clarify the length of time the isolation had been discontinued. During a tour of the laundry room at 7:09 a.m. on 5/17/17, laundry aide (LA)-B was interviewed. LA-B stated R22's linens were transported to the laundry in a red plastic garbage bag. LA-B explained staff were supposed to apply PPE (personal protective equipment), remove the inner bag from the red bag, and place it in the washing machine designated for isolation linen. LA-B explained the isolation bag would disintegrate as it was washed using Formula 5 and Cycle 19 (a different Formula and Cycle that what was utilized to wash regular linens). LA- B stated she was unaware of the chemicals used or the required temperature of the water during the washing cycle for isolation precaution linens. LA-B said she'd been told the facility's wash water was "hot enough to kill anything." LA-B further stated she was unaware of R22's organism/diagnosis that required isolation precautions, and stated the maintenance supervisor could provide information related to the specifics of Formula 5 and Cycle 19 as she could not readily find the information for review. During observation on 5/17/17, at 8:04 a.m.	F 441	supervisor to properly disinfect for C-diff. On 5/20/2017 Dietary Manger instructed in the morning the dietary staff on the isolation precautions and returned again to instruct a different staff member on the evening shift prior to starting their duties. Isolation supply cart was explained to the dietary staff if they need to go into the isolation room and the appropriate use of PPE and hand hygiene. Measures put in place or will be developed and put in place by 6/21/2017 include the following: Audits were developed and the charge nurse completed them to ensure that appropriate infection control practices are taking place. These audits are reviewed by the DON and will be discussed at the next Quarterly QA meeting. Audits were also developed by the laundry supervisor and were completed daily for 7 days, then done once a week for one month and will now be completed monthly. These audits will also be discussed at the Quarterly QA meetings. A CDC Environmental Checklist for Monitoring Terminal Cleaning was completed of the isolation room on 5/29/2017 following the death of R20 on 5/26/2017. Infection control/isolation practices was reviewed with nursing personal at a meeting on 5/26/2017. A system of notification of infection control issues is being developed that includes having the charge nurse complete a Communication Report when they become aware of an infection control issue - such as the need for isolation - the charge nurse will post a Communication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 25 nursing assistant (NA)-D entered R22's room to deliver a breakfast tray. NA-D was not observed to wash her hands prior to donning PPE including a gown and gloves. After NA-D had delivered the tray to R22, she removed the PPE inside the resident's room and left the room without performing any handwashing. NA-D immediately proceeded across the hall to the nurse's station/medication room where she washed her hands at that sink. When questioned about handwashing at this time, NA-D explained she had never been instructed to wash her hands prior to leaving an isolation room. When questioned as to who would pick up R22's tray, NA-D replied that NA staff remove the trays as the kitchen staff did not like to enter R22's room. NA-D indicated that since she was unsure of the process for returning the trays to the kitchen she would refer to NA-B who was familiar with the process. During interview with NA-B on 5/17/17 at 8:10 a.m., NA-B stated she was familiar with R22's care. NA-B explained when R22 was finished eating, she would don PPE, pick up the tray from R22's room and transport the tray across the hall to the kitchen, opening the kitchen door and walking through the kitchen to set the tray on the dirty dish tray line. NA-B stated she would return from the kitchen to R22's room where she would remove the PPE and implement handwashing. NA-B acknowledged she had to open the kitchen door to enter, and exit, while wearing the gloves she had on in R22's room. During interview with housekeeper (H)-B on 5/17/17 at 8:15 a.m., regarding the cleaning of R22's room, H-B stated she used Steriphene II, a disinfectant/deodorant to spray on environmental	F 441	Card at the time clock which will state all staff are to report to the charge nurse prior to start of their duties - the charge nurse will review the communication report with the employee, which will include the date, resident name, resident room #, diagnosis/organism/infectious disease, type of precaution needed and location of disinfectant - the employee will sign an acknowledgement sheet stating they received the communication report. A list of leaners and their specific uses for infectious diseases will be posted where chemicals are stored at for easy reference for staff. Employee orientation process is being reviewed and revised to include more information on infection control practices, a checklist will be used and signed off on by the employee stating they received the information regarding infection control. Yearly Infection Control Inservicing will become semi-annual. A new Infection Control RN Coordinator has been hired that will work as a charge nurse 3 days per week and one full day each week doing infection control - the prior position didn't include any charge nurse hours - by adding this position to the nursing floor the nurse will have a better ability to be aware of changes with residents and staff regarding infection control issues. The DON will be improving the infection control surveillance program to track/monitor not only resident infections but also symptomatic infectious diseases of residents and employees. Maintenance will verify hot water temps from the main line to the laundry room on a monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 26 surfaces in the room, and a product called Vindicator for cleaning the floors. H-B stated she was unsure of the organism present in R22's room and that housekeeping staff were not normally informed of what organism was present to cause the isolation. H-B stated, "They don't tell us what they have, it's none of our [housekeeping] business." Then H-B explained she received annual mandatory infection control (IC) training but none specific to the cleaning products utilized, or training to use specific products for specific organisms. When questioned about how to clean when C-diff was present, H-B confirmed she was unsure of what product to use, or whether there was a product available in the facility that would effectively kill C-diff spores. After verifying the label information noted on the cleaning products she was using, H-B verified the product instructions did not list C-diff as an organism it was effective against. H-B was unable to indicate where she could locate information related to specific products used for cleaning a room contaminated with C-diff. H-B stated she'd thought the products they used for cleaning were "potent enough to kill anything." H-B stated she worked part-time, however felt she was very familiar with the facility's cleaning products. Upon review with H-B, there was no additional product available on the housekeeping cart, or in the housekeeping closet, that indicated an effectiveness at killing the C-diff organism. During interview with NA-A and NA-B on 5/17/17, at 8:30 a.m. it was revealed R22 received showers in the facility's only shower room. NA-A reiterated there was no specific system to clean the shower following use by R22. NA-A said when she was finished assisting R22 with her	F 441	basis and document findings. Nursing staff will be re-educated on how to complete care plan updating during weekly charting to reflect resident changes in conditions and new diagnosis's. Staff will be re-educated on process of calling in when ill at our all staff meeting on 6/21/2107. The following policy and procedures will be revised and/or developed by 6/21/2107 and reviewed with all staff on 6/21/2017: P & P for Calling when ill and logging and follow up for these call-ins; P & P regarding Infection Control Surveillance: P & P for Environmental Cleaning; P & P for Cleaning Shower/Bath Bay; P & P for communicating to emergency personal that are transporting/receiving a resident who is on isolation precautions; P & P regarding infection control in the laundry department when dealing with items from an isolation room; P & P for housekeeping department when cleaning an isolation room during and after a resident stay; P & P for dietary department in how to handle items that may come from the isolation room to the kitchen and P & P regarding integration of Infection Control Practices into the Quality Assurance Program. All above Policy and Procedures will be reviewed monthly for the following year and discussed at Quarterly QA meetings for effectiveness in providing a safe environment for the residents to live in and for employees to work in.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 27	F 441		

shower, she would notify housekeeping so they could clean the shower. NA-A stated housekeeping used a disinfectant spray [Steriphene II] to clean the shower.

Again, upon review of the manufacturer's labeling information with the NA staff, it was verified Steriphene II was not effective against C-diff.

The director of nursing (DON) stated during interview on 5/19/19, at 9:00 a.m. that R22 required staff assist R22 with personal cares during including toileting. The DON also verified the resident had some cognitive impairment and was alert to self only.

When interviewed at 12:25 p.m. on 5/19/17, licensed practical nurse (LPN)-A verified 20 of the facility's 21 residents routinely use the facility's one shower.

During interview with H-A on 5/19/17 at 12:29 p.m., H-A stated she'd begun employment at the facility in January 2017. H-A said the training she'd had upon hire related to proper infection control was limited. H-A said she'd been instructed to follow another housekeeper to observe while cleaning the environment and a short time later had been assigned to work independently, H-A stated she was aware that PPE use was required when a resident was placed on infection precautions. However, H-A stated she'd been unsure how to don PPE so had asked a bath aide (an NA) to help her. H-A further confirmed having received no training as to whether there were specific cleaning products effective for killing specific organisms, and she added that housekeeping staff utilized the same products and equipment, including mops and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 28	F 441		

toilet brushes, to clean any room.

During interview with NA-C on 5/19/17 at 2:33 p.m., NA-C stated R22 required extensive staff assistance with all toileting cares including assistance to the toilet every 2 hours, and assistance with hand hygiene. NA-C further stated R22 had cognitive impairment and at times attempted to remove her brief, which she may do even if she had incontinent stool on her clothing.

During observation and interview in the kitchen with cook (C)-C on 5/17/17, at 8:40 a.m., C-C verified staff brought R22's used food tray through the kitchen to the dirty dish tray line. C-C stated dietary staff wore aprons and gloves, and scraped any remaining food from R22's tray into the trash before washing the tray with other dishes. C-C verified staff wore the same aprons throughout the day while performing regular duties in the kitchen. C-C stated they utilized Red Sani RTU to clean the tray line where trays were delivered. Review of the Red Sani RTU label with C-C at that time, revealed it was not effective against C-diff spores.

When interviewed regarding IC practices on 5/17/17, at 8:45 a.m. the certified dietary manager (CDM) revealed she was unsure whether the Red Sani RTU was effective against C-Diff. During the interview, an undated clear spray bottle with a handwritten label that read "Bleach" on it was observed next to the Red San RTU sanitizer. When questioned about the bleach, the CDM responded she had no idea how long the spray bottle had been there as staff never used bleach to her knowledge as a disinfectant in the kitchen. In addition, the CDM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 29	F 441		

stated she was unaware an appropriate bleach solution would be effective against C-diff, was unsure how to dilute the bleach, and was unsure how long the bleach solution could be stored. The CDM further verified she had not provided directions for staff to follow regarding the use of bleach as a disinfectant. At that time, a review of the Dishwasher Temperature/Sanitizer log was done. The 5/17/17 log indicated bleach was logged daily at 50 parts per million (ppm). On 5/22/17, at 10:15 a.m. the MS reported to the surveyor that he'd contacted the dishwasher equipment manufacturer on 5/19/17, and had increased the level of the bleach solution from 50 to 200 ppm per their recommendation.

During interview on 5/17/17, at 9:00 a.m. the maintenance supervisor (MS) revealed he was unaware R22 was infected with C-diff. In addition, MS confirmed there were no chemicals in Formula 5 when set to Cycle 19 in the laundry cycle. He further confirmed the laundry personnel were unaware of the C-diff when handling R22's laundry and stated the laundry machine was set for Cycle 19 (used for isolation linens). He said during Cycle 19, the water temperature set by the equipment manufacturer should reach 110 degrees. However, he was unable to verify the water temperature from the main line to the laundry room and also confirmed he was unaware that specific cleaning products should be used by housekeeping staff to ensure effectiveness against C-diff. The MS stated he was responsible for ordering the chemicals used to disinfect and clean in the facility and when asked whether any environmental cleaning products contained bleach, he stated he had one spray bottle unopened on the shelf in the storage room in the basement. MS acknowledged they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 30	F 441		

had not ordered that product for a long time, and it was not currently being used. When observed, the product was labeled Diffense. Review of the Diffense label revealed it would be effective against C-diff if used appropriately.

During interview on 5/17/17, at 12:28 p.m. the infection control coordinator (ICC) stated the facility followed Centers for Disease Control (CDC) guidelines with respect to their infection control program.

During interview on 5/17/17, at 1:40 p.m. LPN- A stated nursing staff documented resident signs/symptom of infections in the progress notes in reach resident's electronic medical record (EMR) and it was the ICC's responsibility to track that data via the progress notes. LPN-A explained the ICC would ask staff a couple times per week to check resident infections as she was not a full-time employee.

When interviewed on 5/17/17, at 3:11 p.m. the infection control coordinator (ICC) revealed she had been in her role since October 2016 and that she spent approximately 8 hours per week in the facility, but was on-call 24 hrs/day/7 days/week. The ICC said her responsibilities included tracking, trending and surveillance related to infections and that the DON notifies her of isolation issues when she is absent. The ICC further explained she does not always get notified from staff if a resident experiences symptoms of an infection, buts checks progress notes and questions staff when at work. Documentation was lacking to indicate how symptoms of resident infections were tracked when the ICC was notified by nursing staff. The ICC explained she tracked infections related to (r/t) antibiotic use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 31	F 441		

and determined the effectiveness of the antibiotic treatment by reviewing the nursing progress notes. ICC stated the expectation was that nursing staff notify the physician, if altering care. Regarding R22, the ICC stated she was unaware whether R22 still experienced diarrhea but was aware R22 remained on contact precautions. The ICC also stated staff were expected to wash their hands prior to exiting R22's room and agreed it would not be an appropriate infection control practice for staff to wear their PPE outside R22's room, as cross contamination could occur. The ICC further stated she'd thought the "Red bottles [cleaning chemicals] contained C-diff killers." The ICC was unaware whether the chemicals used to clean the environment including the resident's room, the community shower, or surfaces in the kitchen, were effective against C-diff. When informed the products currently being utilized by staff were not effective against C-Diff, the ICC agreed the environmental areas were not being disinfected properly and stated there had been a lack of communication between departments.

Additionally, the ICC verified during the interview that she had not provided any IC education or training to staff since she'd begun her role in October 2016, because the DON was responsible to handle the education of staff. The ICC stated she would report surveillance of infections to the QA (quality assurance) meeting monthly and quarterly to review the known medically treated infections in the facility. QA committee reviewed the information and put interventions in place to prevent future occurrence of infection. Documentation was lacking in the IC program to identify the interventions implemented, recommendations made by the QA members and/or whether they were effective and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 32	F 441		

changes/additions needed. The last annual training was November 2016 and she was not a part of that training. When questioned about how outbreaks and cross-contamination were prevented and controlled using transmission-based precaution, the ICC stated the facility followed CDC guidelines. However, the ICC was unaware of any CDC precautions specific to C-diff.

During interview on 5/18/17, at 8:38 a.m. the DON stated infections evident in the facility were discussed at their daily standup meetings. The DON said staff in regular attendance included herself, the MDS (minimum data set) coordinator, the activities director, the CDM, the administrative assistant, and the administrator. The DON said it was the responsibility of the department heads to pass along pertinent information from the daily meetings to their employees.

Additionally, during review of the IC surveillance revealed there was no monitoring of employee symptoms of infection as part of the overall infection control program. When interviewed on 5/18/17, at 10:29 a.m. the administrator revealed employees who call in sick for work, are documented on a call-in log, but are not refrained from working until they are symptom free. The administrator stated employees were supposed to use their own judgment as to when to return to work because there was not a specific policy indicating when employees with active signs or symptoms of infection may return to work. In addition, she confirmed they did not have a method to monitor those employees.

The current employee handbook, page 28, paragraph 2, indicated directions for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 33	F 441		

employee to notify the facility 2 hours prior to the time scheduled to report to work. They were to keep the department head notified of his or her daily condition and advise them of an expected return to work date. The facility had no method in place to prohibit employees with symptomatic infectious diseases from contact with residents.

During interview with the DON and ICC on 5/19/17, beginning at 8:53 a.m., they verified the DON was hired in her position in January 2017, and the ICC had been hired in October/November 2016. The ICC reported she had received some infection control training in March 2017. During the interview, the following was discussed:

When discussing the lack of handwashing observed in R22's room, the ICC confirmed staff should have washed their hands prior to exiting the room, however stated if staff had washed their hands prior to donning gloves, there was no risk for contamination. The DON stated nursing staff were expected to wash with soap and water prior to exiting the room regardless, and agreed staff had not performed appropriate handwashing as described. The DON also agreed a potential for cross contamination had occurred when staff wore their PPE out of R22's room to take her tray to the kitchen. The DON acknowledged entering the kitchen, touching surfaces with contaminated gloves and crossing the hall to return to the resident's room were all potential areas for cross contamination. In addition, the DON agreed staff should be knowledgeable about the chemicals effective to prevent the spread of C-diff. and indicated she had informed the CDM, who also managed the housekeeping staff, of what organism was present in R22's room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 34	F 441		

The DON explained staff were made aware of the C-Diff and isolation precautions via a document in the computer; "Example: [R22] was infected with _____ she is not to come out." The DON stated the information was communicated to the nurses via the shift board and in the NA book. The DON was unsure whether the documentation was available for review and had assumed staff had been educated during the November 2016 training and/or upon hire. Neither the DON or ICC were aware whether the annual infection control training included dietary or housekeeping staff.

The IC training dated November 2016 was reviewed during the interview, and the following was noted: Infection Control Bingo was presented. It consisted of three categories. (1) Chain of infection-asked staff to name the links in the chain of infection; staff were to list three ways to break the chain of infection and a true/ false question related to the spread of influenza; (2) asked staff to name two products you can use to perform hand hygiene; when should you use alcohol based hand rubs?; and asked staff to demonstrate proper hand hygiene to a colleague and have them sign; (3) a true/false question of "Routine practices are to be used for all patients all the time"; asked "What does PPE stand for?"; and had staff put the following steps in order to remove PPE. This had been the only IC training provided. The DON verified she had not been hired yet at the time and the ICC had not been involved with the training. The DON also explained a policy and procedure book was available for all staff to reference if they had questions.

The DON verified the housekeeping staff clean the shower. The DON stated R22 was scheduled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 35	F 441		

for the last bath of the day and she had assumed an appropriate sporicidal chemical solution (to eliminate C-diff) was being used to disinfect the shower. The ICC confirmed she had never verified the laundry equipment was used according to the manufacturer's instructions to prevent any cross contamination. The DON further stated she expected the CDM to be familiar with appropriate cleaning supplies, including sporicidal cleaning products required, as she was in charge of the housekeeping staff.

Infection Control policies and procedures were reviewed with the DON and ICC, and noted (not all inclusive) the following:

(1) The 8/22/08, Infection Control Procedures Policy indicated staff were to implement isolation procedures with appropriate including washing hands before and after cares in the room. Dietary staff were to have worn appropriate items while handling, cleaning and distributing food, including washing dishes. The DON agreed staff had not followed that policy.

(2) The July 2014 Policies and Practices-Infection Control policy revealed the ICP was to establish guidelines for implementing precautions and providing guidelines for safe cleaning of reusable resident-care equipment. The QA (quality assurance) committee was to oversee the implementation of those policies and ensure they were implemented and followed. It was further noted all personnel were to have been trained on IC policies upon hire and periodically thereafter, including where and how to use procedures and equipment. The depth of training was to be appropriate to direct care and job responsibilities. The DON agreed this policy had not been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 36 followed and was previously aware staff needed additional IC training "Those are things I obviously knew." (3) The ICC provided an undated Kitchen policy, on 5/17/17 entitled, Frequently Asked Questions about Clostridium Difficile for Healthcare Providers from the CDC. The policy revealed staff were to use contact precautions with known or suspected C-diff and indicated alcohol would not kill C-diff. Further, the directions indicated staff were to dedicate or perform cleaning on shared equipment and use PPE, and were to continue those precautions until diarrhea had ceased at minimum. The policy further indicated staff were to implement an environmental and disinfection strategy, and were to utilize environmental protection agency (EPA) disinfectants with a sporicidal claim against C-diff. The DON agreed staff had not followed the implementation of that policy. (4) The 4/30/17, Transmission Based Precautions policy indicated the purpose was to prevent the spread of pathogens to residents and staff. The DON and ICC were to determine, on an individual basis, the type of precautions needed. Once determined to be necessary, contact precautions were to be implemented. Contact precautions were defined as standard precautions, plus a private room or co-horting with a low risk roommate. In addition, the policy indicated gloves and a gown were to be worn upon entering a resident's room. (5) The facility had no policy on environmental cleaning per the DON and ICC at the time of the interview.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 37 (6) The revised January 2017, Infection Control-Personal Protective Equipment (PPE) policy identified the exact steps staff were to don and doff PPE gear. The DON agreed staff had not been educated on the policy and it was expected staff know where to find and review and ask questions as needed. (7) The 4/30/17, Hand Hygiene policy revealed the DON agreed staff had not followed the policy to wash hands before exiting room, and had inappropriately left PPE gear on when exiting R22's room. (8) The DON agreed the 4/30/17, Standard Precautions policy was not followed when staff had not performed hand hygiene after gloves were removed, when the PPE was worn outside the resident room, and when otherwise indicated to avoid cross-contamination. (9) The 4/30/17, Infection Control Surveillance policy's purpose was to detect infections that needed treatment and improve outcomes and processes. The current method of surveillance identified to only monitor residents with infections treated with antibiotics and not to monitor residents for symptoms to detect infections. Although the DON received reports of symptoms in daily standup, they were not incorporated into the ICP. The ICC stated a small facility could track this verbally and by shift notes rather than as part of IC surveillance. Both the DON and ICC agreed the daily stand up notes were not integrated with the surveillance program. The lack of coordination of employee illness into the ICP was discussed and the DON stated she felt it was "common sense" for staff not to come to work ill. The DON expected employees to refrain	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 441	Continued From page 38 from working if symptomatic but did not have a process to ensure this did not occur. The immediate jeopardy that began on 5/5/17, was removed on 5/21/17, at 12:30 p.m. when it could be verified by observation, document review and staff interview, the facility had educated all staff on proper PPE use prior to entering/leaving the resident room, had verified the use of an appropriate sporicidal cleaning product in the shower and the resident's room, had verified staff implementation of appropriate handwashing techniques, and had implemented infection control practices to prevent cross contamination to other residents who resided in the facility. However, non-compliance remained at the lower scope and severity of an F, widespread with no actual harm with potential for more than minimal harm, because the facility had not yet ensured ongoing infection control surveillance, and staff compliance and implementation of the facility's infection control policies.	F 441		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's	F 520		6/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 520	Continued From page 39 staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to develop a quality assessment and assurance (QAA) committee that established appropriate plans of action for identified infection control practices related to the prevention and control of C-diff infections. This practice had the potential to affect all 22 residents who currently reside in the facility. Findings include:	F 520	Corrective action put in place on 5/17/2017 - all in-house staff received education on isolation precautions by the DON and other staff prior to starting their duties met with the charge nurse and received education on isolation precautions to prevent and control C-diff infection. Measures put in place to ensure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 520	Continued From page 40 The facility's quality assessment and assurance (QAA) committee met monthly and discussed potential quality concerns. However, the QAA program lacked action plans related to infection control practices and failed to monitor staff implementation of infection control standards while caring for a resident with a highly contagious infection. When interviewed on 5/19/17, at 8:53 a.m. the infection control coordinator (ICC) stated she would report surveillance of infections to the QA (quality assurance) meeting monthly and quarterly to review the known medically treated infections in the facility. QA committee reviewed the information and put interventions in place to prevent future occurrence of infection. Documentation was lacking in the IC program to identify the interventions implemented, the recommendations made by the QA members and/or whether they were effective and changes/additions needed. The ICC indicated staff didn't document any of this as they were verbally discussed. The ICC was unsure if there is clear communication and/or direction from the QA committee as to what interventions need to be placed and if they were effective or need to be adjusted. The ICC lacked any documentation of education provided, audits of staff competency conducted by herself and/or on her behalf since her hire in October, 2016. Although the ICC indicated she had completed a few audits (staff observations), she could not recall what they were at the time of the interview. The last annual training was November 2016 and the ICC was not involved in the training. Review of the July 2014, Policies and Practices-	F 520	deficient practice will not recur - Re-developed the Infection Control RN position to include the RN working as a charge nurse 3 days/week to enable the RN to be more aware of resident condition changes and to be able to put infection precautions in place in a timely manner, with more hours in the position the RN will be able to identify situations timely and provide education as needed to address the situations. Also, revision of Quality Assurance Program to integrate infection control practices, to review and update infection control policies and procedures and to educate staff on new/revised policies and procedures. Development of a communication system to make all staff aware of infectious diseases and need for infection control practices/precautions to be put in place. Education on new/revised policies and procedures to be completed at an All Staff Meeting on 6/21/2017. Revise new hire orientation to include a more extensive training regarding infection control and increase all staff annual infection control inservicing to twice yearly. Infection control audits will be done monthly in nursing, laundry, housekeeping and dietary departments to ensure that infection control practices are being followed. These audits will be reviewed by department managers, infection control RN and discussed with each quarterly QA meeting - action plans will be developed as infection control issues are identified and followed up at each QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 520	Continued From page 41 Infection Control policy revealed the ICP was to establish guidelines for implementing precautions and provide guidelines for safe cleaning of reusable resident-care equipment. The QA committee was to oversee the implementation of those policies and ensure they were implemented and followed. The policy identified that all personnel were to be trained on IC policies upon hire and periodically thereafter, including where and how to use procedures and equipment. The depth of training was to be appropriate to direct care and job responsibilities. When interviewed on 5/19/17, at 8:55 a.m. the director of nursing (DON) agreed this policy had not been followed and was previously aware staff needed additional IC training, "Those are things I obviously knew." Interview with the administrator on 5/19/17, at 10:25 a.m. revealed the QA committee discussed how to know when C-Diff needs to be isolated and the length of time (hours,days) that a resident does not have loose stools. No further infection control issues were communicated. The facility failed to put systems in place to prevent the potential cross contamination of C-diff when R22 was diagnosed with a highly contagious infection and placed in isolation precautions. Lack of communication between nursing, dietary, laundry and housekeeping staff placed residents at risk for contracting the infection. The QA committee did not have the oversight required to protect residents and implement appropriate standards of practice related to infection control. See F411- Based on observation, interview, and	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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
F 520	Continued From page 42 document review, the facility failed to ensure nursing, housekeeping, laundry and dietary staff used proper infection control practices to prevent and control the transmission of Clostridium Difficile (C-diff) for 1 of 1 resident (R22) reviewed with diagnosis including the highly contagious infectious diseases Clostridium Difficile (C-diff), resulting in an Immediate Jeopardy (IJ) with the potential for serious harm, injury or death from C. Difficile gastritis for the 21 residents (R1, R2, R4, R5, R7, R8, R11, R14, R15, R16, R18, R20, R21, R23, R25, R31, R33, R34, R36, R37 & R38) who currently reside in the facility.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(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
K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Trimont Health Care Center was found not to be 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

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

Electronically Signed | 06/16/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(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
K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Trimont Healthcare Center was constructed as follows: The original building was constructed in 1963, is one-story, has a partial basement, is fully sprinklered and was determined to be of Type II(222) construction; The 1992 Chapel Addition is one-story, has no basement, is fully sprinklered and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. All Resident Rooms are equipped with single-station, battery-operated smoke alarms. The facility has a capacity of 36 beds and had a census of 23 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(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
K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 321 SS=F	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain hazardous areas are protected by a fire barrier having 1-hour fire resistance rating. This deficient practice could affect 23 of	K 321	On 5/29/2017 penetration in floor in storage area in hall between room 101 and 102 was sealed by pouring cement into penetration and leveled with existing	5/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(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
K 321	Continued From page 3 the 23 residents. Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) Findings include: On facility tour between 11:00 AM and 2:00 PM on 05/16/2017, observation revealed a floor penetration in the Storage Room between rooms 101 and 102. This penetration goes into the lower	K 321	floor. On 5/30/2017 remaining penetrations around plumbing cleanout caulked with fire caulk. Stainless steel cover on cleanout installed. The Maintenance Director will be responsible for correction and monitoring to prevent reoccurrence of the deficiency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	**303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176**

(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
K 321	Continued From page 4 level utility access area. This deficient practice was verified by the Facility Maintenance Director.	K 321		
K 341 SS=E	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the fire alram sysytem in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code.This deficient practice could affect 23 of the 23 residents. Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied,	K 341	On or before 6/26/2017 an electrician from Kuehl Electric will install a power indicator light on the fire annunciator panel located at the nurses station to show that the fire alarm is on and functioning. Maintenance Director will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	6/26/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(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
K 341	Continued From page 5 detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8. FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 05/16/2017, observation revealed the fire annunciator panel located near the Nurse's Station does not have any power indicator light to show that this panel is on and functioning. This deficient practice was verified by the Facility Maintenance Director.	K 341		
K 351 SS=E	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.	K 351		6/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(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
K 351	Continued From page 6 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to ensure that fire sprinklers were kept from obstructions that could effect the operation in accordance with NFPA 13. This deficient practice could affect 23 of the 23 residents. Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 05/16/2017, observation revealed that there were no fire sprinkler heads in the oxygen storage room and several linen supply closets. NOTE: All areas/rooms need to be checked to ensure fire sprinklers are in all areas of the	K 351	On 6/17/2017 Simplex will becoming to install sprinkler heads in the following areas: Storage between rooms 101 and 102 door to hall; Linen supply between rooms 107 and 108 door to hall; Linen supply between rooms 111 and 112 door to hall; Oxygen storage between rooms 113 and 114 door to hall; Linen closet between rooms 115 and 116 door to hall and Closet in basement bathroom. Maintenance director will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(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
K 351	Continued From page 7 Facility. This deficient practice was verified by the Facility Maintenance Director.	K 351		