



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 1, 2024

Administrator
Trinity Care Center
905 Elm Street
Farmington, MN 55024

RE: CCN: 245250
Cycle Start Date: July 24, 2024

Dear Administrator:

On July 24, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 24, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 24, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

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dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Poepping".

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER TRINITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 ELM STREET FARMINGTON, MN 55024		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments On 7/22/24 - 7/24/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 7/22/24 - 7/24/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found not in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		9/9/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

08/07/2024

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.

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F 677	Continued From page 1 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dependent resident, who received no fluids by mouth, oral care to promote comfort and hygiene for 1 of 3 residents (R19) reviewed for activities of daily living (ADLs). Findings include: R19's quarterly Minimum Data Set (MDS), dated 7/15/24, indicated R19 had severe cognitive impairment and was dependent on staff for all ADLs including oral care. The MDS further indicated R19 required a gastrostomy tube (g-tube; feeding tube) for nutrition. R19's care plan dated 7/22/22, indicated R19 was NPO (nothing by mouth) TF (tube feeding) and required assistance with oral care for "optimal oral health hygiene". The care plan directed the nursing assistants to ensure R19 was sitting upright at a 90-degree angle, wet toothbrush and use a small pea sized amount of toothpaste and brush teeth if R19 unable to do so himself and use a pink toothette to swab mouth and remove toothpaste when finished. R19's Observations by Resident, dated 7/1/24 - 7/23/24, indicated R19 received oral care seven times during the dates listed on 7/5/24 x 2, 7/13/24, 7/14/24, 7/19/24 x 2, and 7/21/24 x 2. During an interview on 07/22/24 at 2:25 p.m., R19's family member (FM) stated oral care was	F 677	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Oral cares were provided for R19 on 7/24/24 and staff were reminded of the expectation that any task in the care plan are to be completed as scheduled. All residents that require staff assistance with oral care have the potential to be impacted by this deficient practice. Oral care audits are scheduled on the EMAR to be completed daily by nurses. The Oral Hygiene Policy was reviewed by the DON on 7/31/24 and no changes were necessary. All nursing staff will be educated on this policy. Random audits will be completed to ensure oral cares are completed per resident's plan of care 3x/week for 2 weeks, then 2x/week for 2 weeks, then 1x/week for 4 weeks or until compliance is achieved. Results of audits will be reported to QAPI committee monthly for review and further recommendations.		

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F 677	Continued From page 2 not being done by the nursing assistants. FM stated oral care should be done twice a day and since R19 was not able to take any food or fluids by mouth speech therapy had provided education to the nursing staff on how to safely perform oral cares, but it was still not being completed. During a follow up interview on 7/24/24 at 7:28 a.m., FM stated she spent 12 hours every day with R19, coming in at 6 a.m. everyday and has not seen facility staff do oral at all this week, stating R19 almost always sleeps with his mouth open and was "sure it gets dry" stating, "I would like to see then do oral care." During observation and interview on 7/24/24 at 7:57 a.m., nursing assistant (NA)-C and NA-D were providing morning cares to R19. Registered nurse (RN)-D was also present providing medications to R19 via G-tube. NA-C and NA-D provided peri-care with a clean brief and repositioned R19 in bed. RN-D assessed R19's skin, lung sounds, and bowel sounds and applied A&D ointment to R19's skin on his buttocks. No oral care was performed by NA-C, NA-D, or RN-D. NA-D stated this was the typical morning routine and cares that were provided to R19. RN-D confirmed that was a typical morning routine and consisted of the cares and assessments provided to R19 each morning. During an interview on 7/24/24 at 10:01 nurse manager and registered nurse (RN)-C stated the expectation was for oral cares to be done with R19 BID, stating speech therapy did education with staff on how to properly do oral care and it "absolutely" needed to get done. An facility policy titled Oral Hygiene, revised	F 677	The DON or designee is responsible for compliance. Date certain: 9/9/24		

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F 677	Continued From page 3	F 677			
F 684 SS=D	5/25/23, indicated, "all residents will receive oral care as assessed to be appropriate and defined by the care plan." The purpose was to "promote cleanliness and prevent oral infection." Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor bruising and scabbing on a resident's left shin who was also on a blood thinner for 1 of 1 resident (R42) reviewed for non-pressure skin alterations. Findings include: R42's quarterly Minimum Data Set (MDS), dated 6/16/24, indicated R42 had severe cognitive impairment, required substantial to maximum assistance with activities of daily living (ADLs) and had received an anticoagulant during the seven day look back period. The MDS further indicated R42 had diagnoses of dementia, Parkinson's disease, depression, and psychotic disorder. R42's Current Orders, printed 7/25/24, indicated R42 had an order for Eliquis (a blood thinning	F 684	Wound assessment and cares were provided for R42 on 7/24/24. Monitoring and treatment of R42's wound will continue until healed and care plan was reviewed 7/24/24 with no changes necessary. All residents on a blood thinner medication are at increased risk of non-pressure skin alterations and have the potential to be impacted by this deficient practice. All residents on a blood thinner medication will have their care plans reviewed to ensure that NARs observe skin daily and nurses inspect skin weekly. The Accident/Incident Policy was reviewed by the DON on 7/31/24 with no changes necessary. All nursing staff will	9/9/24	

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F 684	Continued From page 4 medication used to prevent blood clots) 5 milligrams (mg) daily. The orders however lacked an order to monitor the skin alterations (bruising and scabbing) to R42's left shin. R42's care plan, printed 7/24/24, instructed staff to monitor R42 for potential side effects of Eliquis use to include "excessive bleeding and bruising, diarrhea or constipation, indigestion, dizziness, headaches, rashes, itching skin, hair loss, jaundice." The care plan further indicated R42 was at risk for skin breakdown related to atrial fibrillation (irregular heart rhythm), Parkinson's, edema (swelling related to excess fluid) and incontinence with interventions for the nurses to inspect R42's skin weekly and the nursing assistants to inspect R42's skin daily for bruises and edema. R42's last three Weekly General Observation - Skin Conditions, dated 7/6/24, 7/13/24, and 7/20/24, indicated "skin checked, no problems found." R42's electronic medical record (EMR) lacked any wounds that were currently being monitored under the Wound Monitoring section of the EMR. During observation and interview on 7/22/24 at 3:19 p.m., R42 was observed asleep in bed with his legs exposed, multiple bruising and scabbing were noted on his left shin. R42's family member (FM-2) stated she had noticed the bruising and scabbing to R42's shin on Sunday (7/21/24). During an interview on 7/24/24 at 8:11 a.m., nursing assistant (NA)-D stated she has noticed the bruising and scabbing on his left shin, stating R42 bruises easily and had bruising and scabbing	F 684	be educated on this policy including NARs report findings to the nurse, that nurses respond timely and document appropriate interventions. Random audits will be completed to ensure monitoring of skin is in place per resident's plan of care 3x/week for 2 weeks, then 2x/week for 2 weeks, then 1x/week for 4 weeks or until compliance is achieved. Results of audits will be reported to QAPI committee monthly for review and further recommendations. The DON or designee is responsible for compliance. Date certain: 9/9/24		

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F 684	Continued From page 5 on his shins for "a long time" confirming she has told the nurses about it. During an interview 7/24/24 at 8:55 a.m., licensed practical nurse (LPN)-B stated she had noticed the bruising and scabbing on R42's left shin, stating he often runs his shins into things while in his wheelchair and that he also "picks at his skin." During a follow up interview on 7/24/24 at 10:01 a.m., RN-C stated she assessed R42's legs and would be starting treatment and monitoring to his left shin. During an interview on 7/24/24 at 10:01 a.m., nurse manager and registered nurse (RN)-C indicated it was the expectation that any new or acute skin alterations would be addressed on an incident report which would then notify her for follow up, confirming she was not aware of any skin alterations with R42. She stated it would be important to monitor any skin alterations to monitor for any changes, improvements, or worsening. A facility policy on non-pressure skin concerns was requested and not received.	F 684			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688			9/9/24

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F 688	Continued From page 6 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide routine range of motion for 1 of 1 resident (R19) reviewed for ROM who was dependent on staff for all activities of daily living (ADLs). Findings include: R19's quarterly Minimum Data Set, dated 7/15/24, indicated R19 had severe cognitive impairment and was dependent on staff for all ADLs. R19's care plan, dated 7/22/22, indicated R19 should receive ROM daily with dressing. R19's Observations by Resident, dated 7/1/24 - 7/23/24, lacked any documentation of the nursing assistants providing ROM to R19. During an interview on 7/22/24 at 2:28 p.m., R19's family member (FM) stated R19 had stiff and contracted legs and was still working with therapy but was also supposed to receive daily ROM to his legs. FM stated she has not seen nursing staff do any ROM with R19.	F 688	ROM audits were initiated 7/31/24 for R19 to ensure ROM services were being provided. All residents that require range of motion ("ROM") services have the potential to be impacted by this deficient practice. ROM audits for R19 are scheduled on the EMAR to be completed daily by nurses. Random ROM audits will be completed for other residents. ROM and Restorative Nursing Program policies were reviewed by the DON and ROM policy was revised on 8/7/24 to include RN oversight responsibilities. All nursing staff will be educated on these policies. Random audits will be completed to ensure ROM services are completed and documented per plan of care 3x/week for 2 weeks, then 2x/week for 2 weeks, then 1x/week for 4 weeks or until compliance is achieved. Results of audits will be reported to QAPI committee monthly for review and further recommendations.		

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F 688	Continued From page 7 During a follow up interview on 7/24/24 at 7:28 a.m., FM stated she spent 12 hours every day with R19, arriving at 6a.m. every morning and confirmed she had not seen nursing staff do any ROM with R19 this week. During observation and interview on 7/24/24 at 7:58 a.m., nursing assistant (NA)-C and NA-D entered R19's room to provide morning cares to include peri care, a brief change and repositioning. R19 was observed to have stiff bilateral legs that were difficult to maneuver while providing cares. R19's bilateral legs also appeared to not be able to fully straighten. RN-D was also present providing medications and to assess R19's skin, lung sounds and bowel sounds. No ROM was performed by NA-C, NA-D, or RN-D. NA-D stated this was the typical morning routine and cares that were provided to R19. RN-D confirmed that was a typical morning routine and consisted of the cares and assessments provided to R19 each morning. During observation and interview on 7/24/24 at 11:11 a.m., (NA)-C and NA-D were entering R19's room to get R19 dressed and up in his wheelchair. R19 was dressed in pants, socks and shoes and a hospital gown was kept on as a top per daughter preference. R19 was transferred to his wheelchair via a full body mechanical lift. NA-C and NA-D left R19's room without providing ROM. During an interview on 7/24/24 at 10:45 a.m., registered nurse and restorative nurse (RN)-E stated nursing staff were instructed to and should be providing R19 ROM to his arms and legs while getting R19 dressed. RN-E confirmed they should also be documenting this under Observations by	F 688	The DON or designee is responsible for compliance. Date certain: 9/9/24		

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F 688	Continued From page 8 Resident after completion. A facility policy titled Range of Motion, revised 11/8/13, indicated the restorative ROM program was to provide residents with the assistance required to maintain and improve joint mobility and promote a greater sense of wellbeing. The policy indicated when a resident had ROM care planned, a general guide was to repeat the exercise 10 times per joint.	F 688			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper cleaning of a non-invasive ventilation machine to reduce the risk of complications (i.e., respiratory infection) for 1 of 1 residents (R48) observed for continuous positive airway pressure (CPAP) machine use. Findings include: The ResMed AirFit F20 Full Face Mask User Guide dated 12/20, indicated the mask should be disassembled, rinsed, cleaned with a soft brush until dirt was removed, cleaned with warm water	F 695	CPAP equipment for R48 was appropriately cleaned on 7/25/24 and an order for daily and weekly cleaning has been added to the EMAR. All residents with CPAP machines have the potential to be impacted by this deficient practice and will be reviewed for appropriate cleaning of equipment. Audits for residents with CPAP equipment will be completed to ensure CPAP's are clean and have an order for daily and weekly cleaning in the EMAR. The		9/9/24

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F 695	Continued From page 9 and a mild detergent, rinsed and air dried daily or after each use. The guide indicated the headgear should be cleaned with warm water and mild detergent and then rinsed and air-dried weekly. The ResMed AirSense 10 User Guide dated 2/21, indicated the non-invasive ventilation machine should be cleaned weekly including washing the water tub and air tubing with warm water and mild detergent and wiping the machine's exterior with a dry cloth. The guide recommended regular cleaning of the tubing, water tub, and mask for optimal therapy and prevention of the growth of germs. R48's annual Minimum Data Set (MDS) dated 6/18/24, indicated R48 had intact cognition and required maximal assistance with upper body dressing, personal hygiene, and bed mobility. The MDS indicated that R48 utilized a non-invasive ventilation machine. R48's diagnoses list dated 6/5/23, indicated R48 was diagnosed with obstructive sleep apnea (sleep-related breathing disorder), hypertension (high blood pressure), and COVID-19 (7/13/24). R48's Current Order summary dated 6/9/23, indicated staff were to assist R48 with applying her CPAP at night and removing it every morning. The order indicated staff were to ensure the machine had distilled water up to the fill line of the humidification chamber before CPAP placement but did not include daily cleaning of the CPAP. The summary included an order for weekly cleaning of the headgear, chin strap, mask, and tubing. R48's Medication Administration Record (MAR)	F 695	Cleaning/Disinfecting Resident Care Equipment Policy was reviewed by the DON on 7/31/24 with no changes necessary. All nursing staff will be educated on this policy. Audits will be completed to ensure CPAP's are clean 3x/week for 2 weeks, then 2x/week for 2 weeks, then 1x/week for 4 weeks or until compliance is achieved. Results of audits will be reported to QAPI committee monthly for review and further recommendations. The DON or designee is responsible for compliance. Date certain: 9/9/24		

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F 695	Continued From page 10 Summary dated 7/1/24 through 7/24/24, indicated weekly CPAP cleaning of the headgear, chin strap, mask, and tubing had occurred but did not include daily cleaning. The summary indicated the CPAP had been applied and removed daily during the period. During an interview and observation on 7/22/24 at 1:31 p.m., R48 stated staff did not clean the CPAP machine "very often", and it had looked like it needed to be cleaned for a while. R48's ResMed AirSense 10 with an attached ResMed AirFit F20 Full Face Mask was observed on R48's bedside table with a white substance partially covering the inside of the mask and a buildup of dust and a white substance on the outside of the machine. During an interview and observation on 7/23/24 at 11:32 a.m., R48's CPAP machine with an attached mask was observed on R48's bedside table with a white substance partially covering the inside of the mask and a buildup of dust and a white substance on the outside of the machine. Registered nurse (RN)-D stated the mask appeared dirty and needed to be cleaned and had not been cleaned today. RN-D stated that R48 had scheduled weekly cleanings of the CPAP machine on Sundays but did not have scheduled daily cleanings. RN-D stated she would sometimes "wipe down" the mask in the morning but did not detach the mask from the machine or use soap to clean it, other than for the weekly cleanings. During an interview on 7/24/24 at 11:23 a.m., RN-C, the nurse manager, stated R48's CPAP machine should be wiped down every day and the order was now updated to reflect this. RN-C	F 695			

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F 695	Continued From page 11 stated having a buildup of grime on the CPAP mask was "disgusting" and nursing staff should have been cleaning this. RN-C stated nursing staff should not need an order to know to wipe down a CPAP machine, it "should be basic nursing sense". The facility Cleaning/Disinfection Resident Care Equipment policy dated 1/25/22, indicated respiratory therapy equipment was a "semi-critical" item and should remain free from all microorganisms.	F 695			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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	F 761		9/9/24	

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F 761	Continued From page 12 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview and policy review, the facility failed to ensure medications were securely stored safely in 2 of 6 medication carts observed. Findings include: During observation and interview on 7/22/24 at 1:37 p.m., an unattended and unlocked medication cart was observed outside a nursing station of the long-term care unit named, "The Cottages". The unattended and unlocked medication cart was adjacent to the courtyard/dining room with several residents present. Registered nurse (RN)-A verified the medication cart was unlocked and stated, "I am responsible for the unlocked medication cart." RN-A stated unattended medication carts should always be locked to protect medications from unauthorized staff, residents, and visitors. During observation and interview on 7/24/24 at 8:30 a.m., an unattended and unlocked medication cart was observed outside a nursing station of a unit named, "The Chateau". The unlocked and unattended medication cart was adjacent to the courtyard/dining room with several residents present. Trained medication aid (TMA)-A approached the medication cart and verified they were responsible for the medication cart. TMA-A verified the medication was unlocked and unattended by staff. TMA-A indicated the medication cart should be locked to prevent a medication error and "so people can't get in it."	F 761	All medication carts were audited on 7/24/24 and all were found to be functioning properly and locked when unattended. All residents, staff and visitors have the potential to be impacted by this deficient practice. The Medication Administration Policy was reviewed by the DON on 8/2/24 with no changes necessary. All licensed nurses and TMA staff will be educated on this policy. Random audits will be completed to medication carts are locked when unattended 3x/week for 2 weeks, then 2x/week for 2 weeks, then 1x/week for 4 weeks or until compliance is achieved. Results of audits will be reported to QAPI committee monthly for review and further recommendations. The DON or designee is responsible for compliance. Date certain: 9/9/24		

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F 761	Continued From page 13 On 7/24/24 at 11:24 a.m., director of nursing (DON) stated, "I expect that if they (medication carts) are unattended, they are locked. This ensures they can't be accessed by unlicensed personal or residents."	F 761			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(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;	F 880		9/9/24	

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F 880	Continued From page 14 §483.80(a)(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. (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880			

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F 880	Continued From page 15 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 personal protective equipment (PPE) practices were implemented by staff during a COVID-19 outbreak at the facility. This had the potential to affect all residents residing in one unit (Chateau Unit) of the facility. Findings include: Review of CDC guidance updated, 3/14/24 , Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic indicated when a facility is in COVID-19 outbreak status "Source control is recommended more broadly as described in CDC 's Core IPC Practices in the following circumstances: By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days)" During survey entrance on 7/22/24 at 12:45 p.m., a large whiteboard was placed at facility main entrance with a stand up sanitizing unit, and two boxes of surgical masks. The whiteboard indicated, "Attention, effective 7/5/24 COVID OUTBREAK *Masking Required for everyone, Thank you".	F 880	TMA(A) was re-educated and issued corrective action on 7/29/24. All residents, staff and visitors have the potential to be impacted by this deficient practice. The Transmission Based Precaution Policy was reviewed by the DON on 7/29/24 with no changes necessary. All staff will be educated on this policy . Random audits will be completed on appropriate PPE usage 3x/week for 2 weeks, then 2x/week for 2 weeks, then 1x/week for 4 weeks or until compliance is achieved. Results of audits will be reported to QAPI committee monthly for review and further recommendations. The DON or designee is responsible for compliance. Date certain: 9/9/24		

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F 880	Continued From page 16 R10's annual Minimum Data Set (MDS) dated 6/25/24, indicated R10 had severely impaired cognitive skills, required substantial/maximal assistance with eating, oral hygiene, upper body dressing, and personal hygiene. Also, R10 was dependent for bathing and toileting. R10 diagnoses include Alzheimer's, dementia, aphasia (inability to comprehend or communicate), hemiplegia (paralysis on one side of the body), and anxiety. During observation and interview with infection control preventionist (IP) on 7/23/24 at 7:38 a.m., IP was observed stocking a PPE cart outside R10's room on the long-term care unit named, "Chateau". R10's door had signage which indicated, "Droplet Precautions". IP stated R10 tested positive for COVID-19 on 7/22/24 and verified the facility was in a COVID outbreak and all staff were required to wear surgical masks at all times unless entering a COVID positive room, which then required a N95 mask, PPE gown, gloves, and eye protection. During observation on 7/24/24 at 7:45 a.m., trained medication aide (TMA)-A was observed with a surgical mask below the nose and above mouth stood at medication cart outside nursing station adjacent to the Chateau dining room obtaining medications. Several residents were seated at the adjacent dining room tables. During observation on the Chateau unit on 7/24/24: - at 8:45 a.m., TMA-A was observed standing at a medication cart outside the Chateau nursing station adjacent to the dining room with her face mask below the nose and chin obtaining	F 880			

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F 880	Continued From page 17 medications. - at 8:47 a.m., TMA-A pulled the face mask up to cover her mouth but not her nose. -at 8:50 a.m., TMA-A was observed administering medications to a resident at the dining room table with her face mask below her nose. -at 8:58 a.m., TMA-A was observed walking down the Chateau hallway with a cup of medications in her hand. TMA-A had her face mask down below her chin exposing both nose and mouth. -at 9:22 a.m., TMA-A was observed standing at a medication cart outside nursing station adjacent to the Chateau dining room with her face mask below her nose and chin obtaining medications. Three people were sitting in the dining room. Two staff members were sitting in nursing station and one housekeeper, and a maintenance staff member walked past. -at 10:37 a.m., TMA-A was observed exiting the staff break room and walked down a hallway and past the whiteboard posted at the entrance of the facility which announced the COVID outbreak and requirement of all staff to wear a mask. TMA-A was wearing her face mask below her nose and mouth. -at 11:08 a.m., TMA-A was observed pushing a cart with lunch trays from the kitchen past the central dining room of residents and the entire transitional care unit (TCU) of the facility to the Chateau unit dining room. TMA-A was wearing face mask below her chin exposing nose and mouth.	F 880			

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F 880	Continued From page 18 During observation and interview with nursing assistant (NA)-A on 7/23/24 at 12:15 p.m., NA-A was working on the Chateau unit and was observed wearing a surgical mask and stated, "[staff] gotta wear it because of COVID outbreak. We have to wear it all times to prevent spreading infection to others and catching it too." During observation and interview with NA-B on 7/23/24 at 12:23 p.m., NA-B was working on the Chateau unit and was observed wearing surgical mask and stated, "[staff] wear mask at all times to prevent spread of infection. Should be above mouth and cover the nose at all times." During interview on 7/24/24 at 9:30 a.m., housekeeper (H)-A stated all staff are required to wear a surgical mask due to the facility being in COVID outbreak status and, "[staff] must have them when out in the resident areas". During interview on 7/24/24 at 9:32 a.m., H-B stated, "right now we [facility] are under COVID outbreak. [We are to] wear the mask at all times in resident areas. [It is] important to protect residents and ourselves and family and visitors as well." During interview on 7/24/24 at 9:34 a.m., with licensed practical nurse (LPN)-B, LPN-B stated, "We have to wear it all times to prevent infection spread." During interview on 7/24/24 at 10:12 a.m., with registered nurse (RN)-C, RN-C stated, "Staff have to wear them [surgical masks] at all times." During observation and interview with TMA-A on 7/24/24 at 11:10 a.m., TMA-A was standing at	F 880			

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F 880	Continued From page 19 medication cart located outside nursing station and adjacent to the Chateau dining room. TMA-A stated teh facility was in a COVID outbreak and it was important for staff to wear surgical mask over the mouth and nose, "to prevent [the] spread [of] infection." TMA-A verified R10 on the Chateau unit tested positive for Covid on 7/22/24. TMA-A also verified she failed to wear the face mask appropriately during multiple surveyor observations, "due to sweating and [sic]can't breathe." TMA-A stated all of the residents of the facility were vulnerable to infection. During interview with the director of nursing (DON) on 7/24/24 at 11:15 a.m., DON verified the facility was in a COVID outbreak and stated the expectation of all staff was to wear masks appropriately, "at all times". Facility policy titled Coronavirus Prevention, Screening, and Identification reviewed 10/11/2023 identified, "A breach of PPE can result in the spread of infectious pathogens. Breach of PPE can include but is not limited to: i. Inappropriate use of facial mask".	F 880			
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 883		9/9/24	

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F 883	Continued From page 20 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and	F 883			

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F 883	Continued From page 21 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that recommended pneumococcal vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided to reduce the risk of severe disease for 5 of 5 residents (R6, R8, R19, R45, R48) reviewed for immunizations. Findings include: A CDC Pneumococcal Vaccine Timing for Adults chart dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained for adults 65 years and older. The chart indicated when a resident had received the Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and the pneumococcal polysaccharide vaccine 23 (PPSV23) at greater than 65 years, the resident and provider may choose to administer the Pneumococcal 20-valent Conjugate Vaccine (PCV20). R6's annual Minimum Data Set (MDS) dated 6/18/24, indicated R6 was 96 years old at the time of assessment, had severely impaired cognition, and was diagnosed with kidney disease, dementia, and heart failure. R6's Resident Vaccinations record dated 7/23/24, indicated R6 had received the PPSV23 on 2/10/04 (greater than 65 years old at administration) and the PCV13 on 5/4/15.	F 883	Pneumococcal immunizations were offered and administered, if accepted, for R6, R8, R19, R45 and R48. All residents have the potential to be impacted by this deficient practice. All resident records were reviewed for compliance with Pneumococcal immunization and addressed appropriately. The Resident Immunization Policy was reviewed by the DON on 8/6/24 with no changes necessary. All nurse managers will be educated on this policy. Random audits will be completed for new admissions 1x/weekly for 6 weeks. Results of audits will be reported to QAPI committee monthly for review and further recommendations. The DON or designee is responsible for compliance. Date certain: 9/9/24		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER TRINITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 ELM STREET FARMINGTON, MN 55024		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 883	Continued From page 22 A call was attempted on 7/24/24 at 8:48 a.m. to R6's resident representative (RR)-A with no answer. R8's quarterly MDS dated 5/28/24, indicated R8 was 76 years old at the time of assessment, had moderately impaired cognition, and was diagnosed with kidney disease, diabetes, and dementia. R8's Resident Vaccinations record dated 7/23/24, indicated R8 had received the PPSV23 on 11/9/12 (65 years old at administration) and the PCV13 on 4/27/16. A call was attempted on 7/24/24 at 8:43 a.m. to R8's resident representative (RR)-D with no answer. R19's quarterly MDS dated 6/25/24, indicated R19 was 89 years old at the time of assessment, had severely impaired cognition, and was diagnosed with diabetes and dementia. R19's Resident Vaccinations record dated 7/23/24, indicated R19 had received the PPSV23 on 1/1/07 (greater than 65 years old at administration) and the PCV13 on 12/23/16. During an interview on 7/24/24 at 8:23 a.m., RR-B stated that no one from the facility had offered an additional pneumococcal vaccination for R19 before survey entrance but if they had, they would have wanted it. R45's annual MDS dated 7/16/24, indicated R8 was 86 years old at the time of assessment, had severely impaired cognition, and was diagnosed	F 883			

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NAME OF PROVIDER OR SUPPLIER TRINITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 ELM STREET FARMINGTON, MN 55024		
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F 883	Continued From page 23 with diabetes and dementia. R45's Resident Vaccinations record dated 7/23/24, indicated R45 had received the PPSV23 on 11/12/03 (65 years old at administration) and the PCV13 on 3/2/15. During an interview on 7/24/24 at 8:09 a.m., RR-C stated she did not recall anyone from the facility offering an additional pneumococcal vaccination for R45 before survey entrance but if they had, they would have wanted it. R48's annual MDS dated 6/18/24, indicated R48 was 79 years old at the time of assessment, had intact cognition, and was diagnosed with a heart dysrhythmia and hypertension. R48's immunization record dated 3/9/21, indicated R48 had received the PPSV23 on 9/1/10 (65 years old at administration) and the PCV13 on 1/15/15. During an interview on 7/24/24 at 10:29 a.m., R48 stated she had not been offered an additional pneumococcal vaccination before survey entrance, but if they had, she would have said yes. R6's, R8's, R19's, R45's, and R48's medical records were reviewed and did not indicate the PCV20 was offered or administered prior to survey entrance. During an interview on 7/24/24 at 10:26 a.m., the infection preventionist (IP) stated that the registered nurse (RN)-C, the nurse manager oversaw tracking and offering pneumococcal vaccinations and RN-C was the best source of	F 883			

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F 883	Continued From page 24 information regarding this. During an interview on 7/24/24 at 10:40 a.m., RN-C stated all five residents (R6, R8, R19, R45, R48) were eligible for a PCV20 dose but it had not been offered before survey entrance. RN-C stated the facility had difficulty getting a standing house order from their medical director and it had led to delays in offering and administering this vaccination. The facility Resident Immunization policy dated 9/29/23, indicated pneumococcal vaccines would be offered to residents according to the current CDC guidance.	F 883			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER TRINITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 ELM STREET FARMINGTON, MN 55024		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS FIRE SAFETY - BLDG 01 An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/23/2024. At the time of this survey, TRINITY CARE CENTER - BLDG 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

08/07/2024

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: 245250		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024	
NAME OF PROVIDER OR SUPPLIER TRINITY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 905 ELM STREET FARMINGTON, MN 55024			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. TRINITY CARE CENTER - BLDG 01 is a 1-story building with partial basement under the 2007 addition. The building was constructed at 4 different times. The original building was constructed in 1967 and was determined to be of Type II (222) construction.			K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024	
NAME OF PROVIDER OR SUPPLIER TRINITY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 905 ELM STREET FARMINGTON, MN 55024			
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K 000	Continued From page 2 In 1972, addition was constructed to the South Wing that was determined to be of Type II (222) construction. In 1995, another addition was constructed to the West Wing that was determined to be of Type II (111) construction. The 2008 addition is a 1-story building with a partial basement. and was determined to be of Type II(222) construction. Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. In the 2007 addition resident rooms, there are hardwire smoke alarms that are interconnected to the nurse call systems. The facility has a capacity of 70 beds and had a census of 66 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K 000			
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm			K 345			8/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024
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K 345	Continued From page 3 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 07/23/2024 between 9:30 and 12:30 PM, it was revealed by a review of available documentation that the fire alarm system was not annual tested. The last annual inspection occurred on 07/14/2023 by Johnson Control. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 345	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Annual Fire Alarm testing was completed on 8/5/24. Environmental Services Director was re-educated on the requirement on 8/5/24. Administrator will be notified by the Environmental Services Director (ESD) 60-days in advance of future fire alarm inspection due dates. Fire alarm inspection completion will take place at intervals not to exceed 365 days from the prior fire alarm inspection date. The ESD will be responsible for scheduling the inspections 60-days in advance of the due date to ensure the inspection vendor has proper advance notice of the inspection deadline to ensure the inspections are done on time. Environmental Services Director or designee is responsible for compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024
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K 345	Continued From page 4	K 345			
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 353	Date certain: 8/19/24 Annual Fire Sprinkler testing was completed on 8/5/24. Environmental Services Director was re-educated on the requirement on 8/5/24. Administrator will be notified by the Environmental Services Director (ESD) 60-days in advance of future sprinkler inspection due dates. Sprinkler system inspection completion will take place at intervals not to exceed 365 days from the	8/19/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024	
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K 353	Continued From page 5 On 07/23/2024 between 9:30 and 12:30 PM, it was revealed by a review of available documentation that the fire sprinkler system was not annual inspected. The last annual inspection occurred on 07/14/2023 by Johnson Control. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.			K 353	prior sprinkler system inspection date. The ESD will be responsible for scheduling the inspections 60-days in advance of the due date to ensure the inspection vendor has proper advance notice of the inspection deadline to ensure the inspections are done on time. Environmental Services Director or designee is responsible for compliance. Date certain: 8/19/24		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - TRINITY CC B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER TRINITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 ELM STREET FARMINGTON, MN 55024		
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K 000	INITIAL COMMENTS FIRE SAFETY - BLDG 03 An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/23/2024. At the time of this survey, TRINITY CARE CENTER - BLDG 03 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000			

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TITLE

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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: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - TRINITY CC B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER TRINITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 ELM STREET FARMINGTON, MN 55024		
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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 6. A detailed description of the corrective action taken or planned to correct the deficiency. 7. Address the measures that will be put in place to ensure the deficiency does not reoccur. 8. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 9. Identify who is responsible for the corrective actions and monitoring of compliance. 10. The actual or proposed date for completion of the remedy. TRINITY CARE CENTER - BLDG 03 is a 1-story building with no basement. The facility was constructed in 2018 and was determined to be of Type II (000) construction. The facility is fully protected throughout by an	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - TRINITY CC B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024	
NAME OF PROVIDER OR SUPPLIER TRINITY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 905 ELM STREET FARMINGTON, MN 55024			
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K 000	Continued From page 2 automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that are monitored for automatic fire department notification. Resident rooms have smoke detectors that are interconnected to the nurse call system and sends a supervisor signal to the fire alarm control panel. The facility has a capacity of 70 beds and had a census of 66 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K 000			
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 NEW Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7. 18.1.6.4, 18.1.6.5 Construction Type 1 I (442), I (332), II (222) Not allowed non-sprinklered Any number of stories 2 II (111) Not allowed non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 1 story sprinklered			K 161			8/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - TRINITY CC B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024	
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(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 161	Continued From page 3 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, this building does not meet the requirements for proper separation of multiple construction types. This deficient practice could could have a wide spread effect. Findings include: On 07/23/2024 between 9:30 and 12:30 PM, it was revealed by observation that the 2-hour fire separation had open pentation at end of conduit and not properly sealed joints through the wall of the 2018 building. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.			K 161	Open penetration in the 2-hour fire separation at the end of conduit was sealed on 8/6/24 by vendor Prime General and is now in compliance. Environmental Services Director was re-educated on the requirement on 8/5/24. The existing non-compliant fire wall that consists of improper sealing of penetrations has been addressed and corrected by Prime General Construction. Administrator will be notified of future work conducted at fire wall areas where penetrations may be made to complete work. The Environmental Services Director (ESD) will inspect future fire wall penetrations and ensure any contractor conducting work properly seals up		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - TRINITY CC B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER TRINITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 ELM STREET FARMINGTON, MN 55024		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 161	Continued From page 4	K 161	penetrations when work is completed. The ESD will report these findings to the Administrator.		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 18.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 07/23/2024 between 9:30 and 12:30 PM, it was revealed by a review of available documentation that the fire alarm system was not annual tested. The last annual inspection occurred on 07/14/2023 by Johnson Control.	K 345	Date certain: 8/19/24 Annual Fire Alarm testing was completed on 8/5/24. Environmental Services Director was re-educated on the requirement on 8/5/24. Administrator will be notified by the Environmental Services Director (ESD) 60-days in advance of future fire alarm inspection due dates. Fire alarm inspection completion will take place at intervals not to exceed 365 days from the prior fire alarm inspection date. The ESD will be responsible for scheduling the inspections 60-days in advance of the due date to ensure the inspection vendor has proper	8/19/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - TRINITY CC B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER TRINITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 ELM STREET FARMINGTON, MN 55024		
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K 345	Continued From page 5 An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 345	advance notice of the inspection deadline to ensure the inspections are done on time. Environmental Services Director or designee is responsible for compliance. Date certain: 8/19/24		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.5.1, 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of	K 353	Annual Fire Sprinkler testing was completed on 8/5/24. Environmental Services Director was re-educated on the requirement on 8/5/24.	8/19/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245250		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - TRINITY CC B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024	
NAME OF PROVIDER OR SUPPLIER TRINITY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 905 ELM STREET FARMINGTON, MN 55024			
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K 353	Continued From page 6 Water-Based Fire Protection Systems section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/23/2024 between 9:30 and 12:30 PM, it was revealed by a review of available documentation that the fire sprinkler system was not annual inspected. The last annual inspection occurred on 07/14/2023 by Johnson Control. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.			K 353	Administrator will be notified by the Environmental Services Director (ESD) 60-days in advance of future sprinkler inspection due dates. Sprinkler system inspection completion will take place at intervals not to exceed 365 days from the prior sprinkler system inspection date. The ESD will be responsible for scheduling the inspections 60-days in advance of the due date to ensure the inspection vendor has proper advance notice of the inspection deadline to ensure the inspections are done on time. Environmental Services Director or designee is responsible for compliance. Date certain: 8/19/24		