Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 22, 2025

Administrator
Trinity Care Center
905 Elm Street
Farmington, MN 55024

RE: CCN: 245250
Cycle Start Date: May 14, 2025

Dear Administrator:

On May 14, 2025, 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.

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 14, 2025 (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 November 14, 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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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May 22, 2025

Administrator
Trinity Care Center
905 Elm Street
Farmington, MN 55024

Re: State Nursing Home Licensing Orders
Event ID: NDQV11

Dear Administrator:

The above facility was surveyed on May 12, 2025 through May 14, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00101	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CARE CENTER	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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/12/25 - 5/14/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect discharge status for 1 of 1 residents (R65) reviewed for hospitalization. Findings include: R65's discharge Minimum Data Set (MDS) dated 3/26/25, identified R65 admitted to facility from a "Short-Term General Hospital" on 1/29/25, and discharged from facility on 3/26/25. The MDS identified R65's discharge status as discharging to "Short-Term General Hospital". R65's discharge summary dated 3/26/25, identified R65 discharged home with home health aide, physical therapy, and occupational therapy services. R65's nursing progress note dated 3/26/25, stated R65 discharged home.	2 550	Corrected	7/7/25

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2 550	Continued From page 3 During interview with MDS coordinator (MDS-C) on 5/13/25 at 2:18 p.m., MDS-C reviewed R65's MDS dated 3/26/25, and stated, "that is incorrect. [R65] discharged home and not to the hospital". During interview with R65 on 5/13/25 at 2:24 p.m., R65 stated he discharged directly home from the facility on 3/26/25, and did not go to the hospital. Policy titled MDS 3.0 Assessment revised 8/20/24, identified facility "will conduct comprehensive, accurate and standardized assessments known as minimum Data Set (MDS) for each resident". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for	2 555		7/7/25

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2 555	Continued From page 4 each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed and/or maintained to include known post-traumatic stress disorder (i.e., PTSD) to promote continuity of care and reduce the risk of complication (i.e., outbursts) for 1 of 1 resident (R11) reviewed who had PTSD. Findings include: R11's annual Minimum Data Set (MDS), dated 2/25/25, identified R11 had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS outlined R11 had no behavioral symptoms (i.e., physical, verbal behaviors) but did have a medical diagnosis of PTSD. On 5/12/25 at 2:01 p.m., R11 was interviewed about his care. R11 was asked if he'd be comfortable talking about his PTSD (as outlined on the MDS) to which R11 responded, "Go ahead." R11 then laughed and voiced aloud, "I don't even know what it is [PTSD]." R11 stated he had a history of military service and had served in	2 555	Corrected	

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2 555	Continued From page 5 combat situations prior, however, maintained he had no concerns with PTSD adding he was unsure what, if anything, staff was doing about it for him. R11's Trauma-Informed Care Questionnaire, dated 11/2019, identified R11 had served in World War II which he attributed as a traumatic event. The questionnaire outlined spacing to record what, if anything, helps when R11 would be feeling anxious, angry or sad to which a response was recorded, "Talk about it." The completed questionnaire was signed by both R11 and social worker (SW)-A. On 5/13/25 at 12:57 p.m., nursing assistant (NA)-A was interviewed, and verified they had worked with R11 multiple times prior. NA-A stated they had never seen behaviors from R11, such as hitting or swearing, however, had noticed him to be depressed. NA-A explained R11 would, at times, ask to speak with the pastor at the campus "in private" adding, "He's depressed and needs to talk to him." NA-A stated R11 would never complain outright of being depressed but NA-A added, "You can tell he's upset." NA-A stated they didn't think R11 had PTSD adding aloud, "I don't think so." NA-A stated they were unsure what, if any, triggers had been identified or should be avoided adding, "I've never heard anything." R11's care plan, printed 5/14/25, lacked evidence R11's trauma-related concerns or subsequent interventions to address them had been added to his comprehensive care plan until 5/14/25 (after survey started). A "Focus" was added which read, "I need trauma care related to: I am a veteran and served in WWII," along with interventions including explaining all cares prior to doing them, using family as a support systems, and talking	2 555		

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2 555	Continued From page 6 about his feelings when wanted. However, again, this 'Focus' and all of the corresponding interventions had dictation present which read, "Date Initiated: 05/14/2025." On 5/14/25 at 8:13 a.m., SW-A was interviewed, and verified they had reviewed R11's care plan. SW-A stated the campus had changed medical record systems back in October 2024 (seven months prior) and the trauma-related care plan didn't get carried over to their new system (as printed on 5/14). SW-A verified R11 had multiple MDS cycles since October 2024 and acknowledged the lack of a trauma-focused care plan had not been identified until now. SW-A stated they were the personnel who typically care-planned the trauma-related care concerns and, due to R11 being identified as not having it done, just completed a whole-house audit to ensure others had it care-planned. SW-A stated R11 was "the only one I missed." SW-A stated having trauma-related care issues care-planned was important so staff were aware of him being a veteran and of things which "could be alarming to him." A facility-provided Person Centered Care Planning policy, dated 4/2023, identified the care center would develop a comprehensive care plan to include measurable objectives to meet a residents psychosocial and/or medical needs. The policy outlined the comprehensive care plan would be developed within seven days of the comprehensive MDS assessment and would included, "Management of risk factors and prevent avoidable declines in functioning." SUGGESTED METHOD OF CORRECTION:	2 555		

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2 555	Continued From page 7 The director of nursing (DON) or designee should create and/or review or revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and enhanced barrier precautions (EBP) were utilized appropriately for 2 of 2 residents (R7, R16) reviewed for EBP. In addition, the facility failed to perform appropriate infection control processes for 1 of 1 resident (R21) on contact precautions observed during medication	21385	Corrected	7/7/25

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21385	Continued From page 8 administration. Findings Include: Enhanced Barrier Precautions CMS memorandum QSO-024-08-NH, dated 3/20/24, included "for residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing". R7's annual Minimum Data Set (MDS) dated 3/4/25, identified R7 was cognitively impaired, diagnosed with progressive neurological conditions and neurogenic bladder, and had an indwelling suprapubic catheter. The MDS indicated R7 required assist of one staff for transfers and had no history of falls in the facility. R7's Face sheet reviewed 5/12/25, indicated a banner with special instructions for EBP: enhanced barrier precautions-must wear gown and gloves with during high-contact resident cares activities, changing linens, all catheter cares. R7's orders reviewed 5/12/25, indicated R7 had a suprapubic catheter with enhanced barrier precautions revised on 9/18/24, and directed staff to wear a gown and gloves during high-contact resident cares activities, changing linens, and all catheter cares. R7's care plan dated 5/14/25, indicated personal	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00101	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CARE CENTER	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) COMPLETE DATE
21385	Continued From page 9 protective equipment (PPE) should be available and used during high-contact resident care activities. During observation on 5/12/25 at 4:13 p.m., an Enhanced Barrier Precaution (EBP) sign was affixed to R7's door, and indicated providers and staff must wear gloves and gown for high contact resident care activities such as, dressing, bathing/showering, transferring, changing linens, proving hygiene, and changing briefs. A Droplet Precautions sign was also on the door, while a barrel labeled "clean gowns" sat outside the door. There were no gloves, masks or face shields at the entry to R7's open door. R7 was calling out "hello" and leaning forward slightly in her recliner to peer out the open door in an attempt to get the attention of staff. Registered nurse (RN)-C and nursing assistant (NA)-B entered R7's room and RN-C put on a pair of gloves and closed the door. After a few moments the door was opened and neither of the staff were observed with a gown while R7 was transferred to the wheelchair. During an interview on 5/12/25 at 4:19 p.m., RN-C stated the droplet precaution sign on the door might lead someone to close it and she was concerned R7 could be at risk for falls. She stated the sign should never have been hung on R7's door and confirmed there were no active droplet precaution orders placed for R7. RN-C verified R7 was on EBP for a catheter and that neither of the staff were wearing gowns during the transfer, and confirmed staff should wear a gown and gloves during high contact resident care activities, changing linens, and with all catheter cares. R16's quarterly Minimum Data Set (MDS) dated 4/22/25 indicated R16 was severely cognitively	21385		

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	00101	A. BUILDING: _____ B. WING _____	05/14/2025

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21385	Continued From page 10 impaired, diagnosed with dysphasia and indicated R16 had a feeding tube. During observation on 5/13/25 at 10:30 a.m., two nursing assistants (NAs) entered R16's room to perform a bed bath wearing appropriate PPE for EBP. The NAs brought items into the room for the bed bath but did not have sufficient items to complete their tasks. Nursing assistant (NA)-D removed R16's gown, tucked the brief R16 was wearing between R16's legs, and rolled R16 on to the right side towards the wall while the NA trainee supported R16. When this portion of the bath was completed, additional washclothes were needed. NA-D stepped away from the bed, still wearing the same gloves and proceeded to open draws of the nightstand and the closet which contained shelves. Three additional washcloths, pillow cases, and a body pillowcase were obtained. NA-D continued with cares for R16 with the original pair of gloves. After R16 was turned onto his back, NA-D searched through R16's nightstand drawers and obtained a new brief from the lower drawer with the same first pair of gloves used for the bed bath. The brief was placed on R16, and NA-D turned and grabbed a bottle of powder from the nightstand, applied the powder, and placed it back on the nightstand. NA-D touched multiple surfaces in an attempt to locate an absorbent pad, found the pad in the wheelchair, and applied it under R16 while repositioning. NA-D removed the original pair of gloves at 10:58 a.m., did not perform hand hygiene, applied new pillowcases to R16's pillows, and adjusted R16's feet and legs. During an interview on 5/13/25 at 11:02 a.m., NA-D confirmed wearing the same gloves throughout cares with R16, and stated it was important to wear clean gloves when touching the	21385		

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21385	Continued From page 11 resident, and that touching residents and then items in the room could lead to cross contamination. NA-D also stated the importance of wearing gloves with residents on EBP, but did not think gloves were required when only positioning feet and legs. During an interview on 5/13/25 at 11:03 a.m., nursing assistant (NA)-C stated gloves should be changed after a resident was touched and before resident's things in the room were touched. During an interview on 5/13/25 at 1:03 p.m., registered nurse (RN)-A stated if a resident was on EBP, they would use a gown and gloves to transfer from a recliner to the wheelchair or when they were moved out of their room. RN-A also stated nursing assistants (NAs) should change their gloves after touching a brief, between cares like oral or peri cares, after they complete cares such as a bed bath, and before touching other areas in the room. Contact Precautions R21's entry tracking record Minimum Data Set (MDS) dated 5/6/25 indicated R21 had a short term hospital stay with original admission date to the facility in 2024. R21's quarterly MDS dated 1/28/25 indicated R21 was cognitively intact, was diagnosed with cardiorespiratory conditions and renal insufficiency. R21's orders dated 5/6/25 at 2:00 p.m., indicated R21 was on contact precautions due to Clostridium difficile (C. diff - a bacterium that can cause inflammation of the colon). The orders	21385		

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21385	Continued From page 12 directed staff to ensure personal protective equipment was being worn. R21's Face sheet included a banner with special instructions for contact precautions. R21's progress note dated 5/6/25 at 1:53 p.m., indicated R21 was re-admitted to the facility from the hospital with C-Diff and loose stools. Vancomycin (an antibiotic) 125 milligram (mg) capsules was started for nine days with a note that indicated the medication would not be available and that the nurse was notified. During interview and observation on 5/14/25 at 7:48 a.m., licensed practical nurse (LPN)-B performed hand hygiene at the medication cart and proceeded to the resident's room with four oral medications. A red pail labeled "clean gowns only" was outside the resident's room. A sign on R21's door identified R21 was under Contact Precautions, and indicated everyone must clean their hands and put on a gown and gloves when entering the room, and perform hand hygiene upon leaving. R21's door was open and LPN-B entered the room with a small cup that contained the medication and a spoon in one hand, and a larger cup filled with water and a straw in the other. LPN-B placed the water cup down and raised the head of the bed as R21 boosted and positioned herself. LPN-B did not put on a gown or gloves or perform hand hygiene in the room before or during the medication administration. Hand hygiene was performed after LPN-B returned to her cart. LPN-B confirmed R21 was on contact precautions, but stated gowns and gloves did not need to be worn during medication administration, since cares were not performed. During an interview on 5/14/25 at 9:36 a.m.,	21385		

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21385	Continued From page 13 infection control preventionist (ICPC) stated NAs were trained on standard precaution and potential contagious sources. ICPC stated gloves needed to be removed before opening draws to decrease the potential for cross contamination of body fluids. Staff were trained on how to give proper bed baths by being prepared, retrieving all their equipment, and changing gloves in between touching the resident and touching other items in the room. All staff were trained to wear a gown and gloves for Enhanced barrier precautions (EBP) with high contact activities including dressing, transferring, and making beds. ICPC indicated staff did not need to wear a gown if they were only handing the resident a call light or passing water and could use standard precautions. The ICPC also stated when administering medications to a resident on contact precautions, the resident's door could be open, but the nurse needed to wear a gown and gloves, even if the nurse used a spoon to administer the medication. ICPC stated this was important to prevent the nurse from contaminating their clothing and hands which could lead to cross contamination to other residents in the facility. During an interview on 5/14/25 at 12:36 p.m., registered nurse/case manager (RN)-E stated staff were trained in enhanced barrier precautions and should always wear a gown and gloves during cares unless it's a task like dropping off mail or getting a snack that involves minimal touch. Residents who require tube feedings are on EBP and require gown and gloves before touching the resident. RN-E would expect staff to change gloves after performing cares and before touching residents' furniture and personal items in the room. RN-E stated residents who are on contact precautions were welcome to have their	21385		

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21385	Continued From page 14 door open, the barrels with the clean gowns should be located outside the room, and staff were required to follow the guidelines on the contact precaution signs and gown and glove up every time they entered the room. RN-E confirmed, regardless of if R21 completed medication today (5/14/25), the contact precaution order went beyond the medication completion date to allow for the nurse to assess for loose stools and identify if R21 was symptomatic. RN-E confirmed R21 was currently on contact precautions. Facility policy titled Enhanced Barrier Precautions (EBP), amended 8/20/24 stated EBP are employed when performing the following high-contact resident care activities: dressing, bathing, showering, changing linen, transferring, hygiene care, toileting, peri care, emptying catheter bag, wound care, indwelling medical device care, and therapy treatment. A policy for contact precautions was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policy and procedures regarding Contact Precaution and Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE to wear. They could also do environmental rounds and audits, and re-education anytime Contact/EBP are placed. The DON, ICP or designee could take those findings/education to the Quality Assurance	21385		

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21385	Continued From page 15 Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		

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

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	245250	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/14/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/14/2025. At the time of this survey, TRINITY CARE CENTER was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2025

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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K 000	Continued From page 1 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. In 1972, addition was constructed to the South Wing that was determined to be of Type II (222) construction. In 1995, another	K 000		

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K 000	Continued From page 2 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 68 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2	K 324		7/7/25

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K 324	Continued From page 3 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper inspection and safety measures associate to residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by observation that the residential stove-range located BLDG 01 was not outfitted with a 120 min max timeout device or mechanism. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	1. The residential stove-range in BLDG 01 will be outfitted with a 120 min max timeout device that interlocks with the on/off switch safety device before 7/7/25. 2. There are no other stove-ranges that are affected in BLDG 01. 3. Administrator will be notified when the installation service is scheduled and completed related to the timeout device. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	

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K 346	Continued From page 4	K 346		
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by a review of available documentation that the facility initiation fire alarm out-of-service policy did not include in the notification and correct listing of the AHJ - Deputy State Fire Marshal Inspector assigned to the area in which the facility is located (point of contact and phone #) and other associated entities and agencies - which were properly identified in the restoration of service document . An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	1. The Fire Alarm System Out of Service policy was updated on 6/12/25 with correct listing of the AHJ – Deputy State Fire Marshal Inspector for facility location, Rick Huston. 2. The State Fire Marshal Division will be contacted, or website reviewed, to ensure knowledge of the current AHJ – Deputy State Fire Marshal Inspector assigned for facility location. A task reminder will be entered as a calendar event task at least annually within the Maintenance Care software used to schedule tasks for building compliance. 3. Administrator will be notified of future changes to ensure policies are accurate. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	7/7/25
K 353 SS=F	Sprinkler System - Maintenance and Testing	K 353		7/7/25

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TRINITY CARE CENTER	**905 ELM STREET** **FARMINGTON, MN 55024**

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K 353	Continued From page 5 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 observation, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.2.1.1.2(5). These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by observation that the sprinkler head located in the Cottage Housekeeping Room	K 353	1. Sprinkler heads located in the Cottage Housekeeping Room and Cottage Soiled Linen Room will be replaced before 7/7/25. 2. All other sprinkler heads were inspected and found to be in compliance. All sprinkler heads will be inspected twice annually thereafter and will be entered as a calendar event task within the Maintenance Care software used to schedule tasks for building compliance. 3. Administrator will be notified of future sprinkler head inspection results. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245250	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CARE CENTER	**905 ELM STREET** **FARMINGTON, MN 55024**

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K 353	Continued From page 6 exhibited signs of debris loading. 2. On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by observation that the sprinkler head located in the Cottage Soiled Linen Room exhibited signs of debris loading. An interview with the Maintenance Director verified these deficient finding at the time of discovery.	K 353	5. Date certain: 7/7/25	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2(6). This deficient finding	K 354	1. The Fire Sprinkler System Out of Service policy was updated on 6/12/25 with correct listing of the AHJ – Deputy State Fire Marshal Inspector for facility location, Rick Huston. 2. The State Fire Marshal Division will be contacted, or website reviewed, to ensure knowledge of the current AHJ –	7/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245250	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CARE CENTER	**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 354	Continued From page 7 could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by a review of available documentation that the facility initiation fire sprinkler system out-of-service policy did not include in the notification and correct listing of the AHJ - Deputy State Fire Marshal Inspector assigned to the area in which the facility is located (point of contact and phone #) and other associated entities and agencies - which were properly identified in the restoration of service docuemnt . An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	Deputy State Fire Marshal Inspector assigned for facility location. A task reminder will be entered as a calendar event task at least annually within the Maintenance Care software used to schedule tasks for building compliance. 3. Administrator will be notified of future changes to ensure policies are accurate. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 712	1. A Fire Drill matrix schedule will be	7/7/25

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	245250	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CARE CENTER	**905 ELM STREET** **FARMINGTON, MN 55024**

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K 712	Continued From page 8 and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by review of available documentation that documentation presented for review identified that fire drills lacked randomness in time and date separation. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	completed by 7/7/25 to ensure compliant dates and times are used going forward. 2. All Maintenance staff will be educated on the requirements. A Fire Drill matrix schedule will be completed in advance of a new calendar year and reviewed with the Administrator to ensure compliance. 3. The Fire Drill matrix schedule and actual dates and times of future fire drills will be shared with the Administrator and reported to QAPI at least quarterly to monitor compliance. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the	K 761	1. The corridor fire / smoke door	7/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245250	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/14/2025**

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K 761	Continued From page 9 facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by observation that the corridor fire / smoke door assemblies, upon test, did not self-close and seal the opening(s). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	assemblies were adjusted on 5/15/25 by the Environmental Services Director. 2. All other fire / smoke doors were inspected and found to be in compliance. A task reminder will be entered as a calendar event task within the Maintenance Care software used to schedule tasks for building compliance. 3. Administrator will be notified of future door inspection results and reported to QAPI at least quarterly to monitor compliance. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure.	K 920		7/7/25

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	245250	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/14/2025**

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K 920	Continued From page 10 Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by observation that in the Social Service Office, relocatable power taps were daisy-chained together and in use. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	1. The power cord found in the Social Service office was removed on 5/15/25 by the Environmental Services Director. 2. All other rooms were inspected and found to be in compliance. All staff will be educated on this requirement. A task reminder will be entered as a calendar event task up to monthly for 6 months within the Maintenance Care software used to schedule tasks for building compliance. 3. Administrator will be notified of future room inspection results and reported to QAPI at least quarterly to monitor compliance. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/14/2025. At the time of this survey, TRINITY CARE CENTER was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2025

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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K 000	Continued From page 1	K 000		

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 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 automatic sprinkler system and has a fire alarm system with smoke detection in corridors and

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K 000	Continued From page 2 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 68 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced	K 324		7/7/25

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K 324	Continued From page 3 by: Based on observation and staff interview, the facility failed to maintain proper inspection and safety measures associate to residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by observation that the residential stove-range located BLDG 03 was not outfitted with a 120 min max timeout device or mechanism. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	1. The residential stove-range in BLDG 03 will be outfitted with a 120 min max timout device that interlocks with the on/off switch safety device before 7/7/25. 2. There are no other stove-ranges that are affected in BLDG 03. 3. Administrator will be notified when the installation service is scheduled and completed related to the timeout device. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than four hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6.	K 346	1. The Fire Alarm System Out of Service policy was updated on 6/12/25 with correct listing of the AHJ – Deputy State Fire Marshal Inspector for facility location,	7/7/25

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K 346	Continued From page 4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by a review of available documentation that the facility initiation fire alarm out-of-service policy did not include in the notification and correct listing of the AHJ - Deputy State Fire Marshal Inspector assigned to the area in which the facility is located (point of contact and phone #) and other associated entities and agencies - which were properly identified in the restoration of service document . An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	Rick Huston. 2. The State Fire Marshal Division will be contacted, or website reviewed, to ensure knowledge of the current AHJ – Deputy State Fire Marshal Inspector assigned for facility location. A task reminder will be entered as a calendar event task at least annually within the Maintenance Care software used to schedule tasks for building compliance. 3. Administrator will be notified of future changes to ensure policies are accurate. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	
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	K 353		7/7/25

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K 353	Continued From page 5 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 observation, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.2.1.1.2(2). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by observation that the sprinkler head located in the RM 445 exhibited signs of oxidation. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	1. Sprinkler head located in Room 445 will be replaced before 7/7/25. 2. All other sprinkler heads were inspected and found to be in compliance. All sprinkler heads will be inspected twice annually thereafter and will be entered as a calendar event task within the Maintenance Care software used to schedule tasks for building compliance. 3. Administrator will be notified of future sprinkler head inspection results. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the	K 354		7/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245250	A. BUILDING **03 - TRINITY CC** B. WING _____	**05/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CARE CENTER	**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 354	Continued From page 6 sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2(6). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by a review of available documentation that the facility initiation fire sprinkler system out-of-service policy did not include in the notification and correct listing of the AHJ - Deputy State Fire Marshal Inspector assigned to the area in which the facility is located (point of contact and phone #) and other associated entities and agencies - which were properly identified in the restoration of service docuemnt . An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	1. The Fire Sprinkler System Out of Service policy was updated on 6/12/25 with correct listing of the AHJ – Deputy State Fire Marshal Inspector for facility location, Rick Huston. 2. The State Fire Marshal Division will be contacted, or website reviewed, to ensure knowledge of the current AHJ – Deputy State Fire Marshal Inspector assigned for facility location. A task reminder will be entered as a calendar event task at least annually within the Maintenance Care software used to schedule tasks for building compliance. 3. Administrator will be notified of future changes to ensure policies are accurate. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	
K 712 SS=C	Fire Drills CFR(s): NFPA 101	K 712		7/7/25

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K 712	Continued From page 7 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by review of available documentation that documentation presented for review identified that fire drills lacked randomness in time and date separation. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	1. A Fire Drill matrix schedule will be completed by 7/7/25 to ensure compliant dates and times are used going forward. 2. All Maintenance staff will be educated on the requirements. A Fire Drill matrix schedule will be completed in advance of a new calendar year and reviewed with the Administrator to ensure compliance. 3. The Fire Drill matrix schedule and actual dates and times of future fire drills will be shared with the Administrator and reported to QAPI at least quarterly to monitor compliance. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested	K 761		7/7/25

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K 761	Continued From page 8 annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by observation that the corridor fire / smoke door assemblies, upon test, did not self-close and seal the opening(s). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	1. The corridor fire / smoke door assemblies were adjusted on 5/15/25 by the Environmental Services Director. 2. All other fire / smoke doors were inspected and found to be in compliance. A task reminder will be entered as a calendar event task within the Maintenance Care software used to schedule tasks for building compliance. 3. Administrator will be notified of future door inspection results and reported to QAPI at least quarterly to monitor compliance. 4. Environmental Services Director, or designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords	K 920		7/7/25

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K 920	Continued From page 9 Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/14/2025 between 8:30 AM and 1:30 PM, it was revealed by observation that in resident RM 416, extension cords were found in use.	K 920	1. The extension cords found in Room 416 were removed on 5/15/25 by the Environmental Services Director. 2. All other rooms were inspected and found to be in compliance. All staff will be educated on this requirement. A task reminder will be entered as a calendar event task up to monthly for 6 months within the Maintenance Care software used to schedule tasks for building compliance. 3. Administrator will be notified of future room inspection results and reported to QAPI at least quarterly to monitor compliance. 4. Environmental Services Director, or	

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K 920	Continued From page 10 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	designee, is responsible for the corrective actions and monitoring of compliance. 5. Date certain: 7/7/25	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 4, 2025

Administrator
Trinity Care Center

905 ELM STREET
FARMINGTON, MN 55024

RE: CCN: 245250
Cycle Start Date: May 14, 2025

Dear Administrator:

On July 10, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 4, 2025

Administrator
Trinity Care Center

905 ELM STREET
FARMINGTON, MN 55024

Re: Reinspection Results
Event ID: NDQV12

Dear Administrator:

On July 10, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 14, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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